Benefit Exception Inquiry Exception Request

Policy Title: Benefit Exception Inquiry (BEI) Request
Department: Government Programs
Business Unit: State Public Programs

Approved By: Director of SPP Products
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PRODUCTS AFFECTED:
- Medica DUAL Solution® – for Minnesota Senior Health Options (MSHO) enrollees
- Medica Choice Care℠ – for Minnesota Senior Care Plus (MSC+) enrollees
- Medica AccessAbility Solution® – for Special Needs Basic Care (SNBC) enrollees
- Medica AccessAbility Solution® Enhanced – for Special Needs Basic Care (SNBC-Integrated) enrollees

DEFINITIONS:

Benefit Exception Inquiry: a formal written request completed by the member’s assigned Care Coordinator or Care Coordination entity to request a service/item outside of the standard benefit set covered by the product, or request to exceed Department of Human Services (DHS) case mix cap for MSHO/MSC+ Elderly Waiver (EW) members. Medica allows flexibility in benefits provided for Special Needs Products.

Care Coordinator (CC): An employee or delegate of Medica who creates a person-centered care plan with assigned members and then coordinates the provision of covered services for those members among different health and social services professionals and across settings of care.

Clinical BEI Review Team: Consisting of an interdisciplinary team at Medica which include but are not limited to the following license type: Registered Nurse, Social Worker, Public Health nurse.
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**Denial Termination Reduction (DTR):** means: 1) the denial or limited authorization of a requested service, including decisions based on the type or level of service; requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of Medica to act within the timeframes regarding the standard resolution of grievances and appeals; 6) denial of a member’s request to dispute a financial liability, including cost sharing, or 7) for a resident of a Rural Area with only Medica, the denial of a member’s request to exercise his or her right to obtain services outside the network. Action means the same as “adverse benefit determination” in 42 CFR § 438.400(b).

**PURPOSE:**
To ensure all Medica member BEI’s are completed appropriately and in a timely manner using the applicable process and notification in accordance with Medica requirements.

**POLICY:**
Counties, Agencies, and Care Systems that provide services for Medica members must complete BEI process in accordance with Medica requirements.

**PROCEDURE:**
1. Care Coordinator will receive request from member for item/service that is not a covered benefit or exceeds the member’s benefit set. The Care Coordinator will verify coverage benefit by utilizing resources such as Minnesota Health Care Programs (MHCP) manual, Community Based Services Manual (CBSM), Medica Customer Service, Medicare.gov, county waiver case manager, etc.
2. If per the assessment and professional judgement of the CC the item/service is not a covered benefit but CC has determined it is an assessed need and/or affects member’s health and safety, CC may proceed with a BEI request.
   a. CC provides education regarding non coverage of the item/service request. If member requests Medica to cover item/service even after they have been educated that the item/service is not in the member’s benefit set, the CC will proceed with a DTR to provide member with appeal rights.
   b. Prior to a BEI request, the CC will consider:
      i. Is this service/item necessary for the health, welfare, and safety of member?
      ii. Does this service/item enable the member to function with greater independence?
      iii. Is this service/item of direct and specific benefit to the member
      iv. Is it the most cost effective solution?
      v. Are there other formal or informal services that can meet the identified need?

Note: The member accepts the non coverage, no further action is needed by the CC. A BEI does not need to be submitted to obtain a denial of coverage. The CC can proceed directly to a DTR if CC determines it is not an appropriate request.
1. The CC completes the BEI Form referencing the BEI Form Instructions document obtained from the Medica CC webpage located under “tools and forms”. If the BEI is indicated by the Care Coordinator to be URGENT, the process will be completed as soon as possible. An URGENT request can be submitted when they relate to immediate health and safety concerns of the member. URGENT must be indicated on the BEI Request Form or fax coversheet.
   a. Transportation requests are not considered urgent.
   b. Also not considered urgent is a BEI that was not sent in timely.
2. A CC supervisor will review the BEI request to ensure item/service meets criteria for BEI ensuring it is not a covered benefit, additional documentation is included with the request, rationale section documentation supports the request for the item/service, the form is completed thoroughly and accurately, etc. The CC will indicate on the inquiry form the date the supervisor reviewed the form. If this is section is marked “no” and/or no supervisor contact provided, it will be returned to the CC and not processed.
3. The CC will fax the completed BEI Form including any required supporting and additional documentation to the fax number on the BEI Form.
4. Medica will receive the request and has 14 calendar days to process the BEI.
5. If additional information is needed to complete the inquiry determination, a Medica staff person will reach out to the CC via email or phone to obtain the information. The CC must submit the requested information timely to adhere to the 14 calendar day turnaround time requirement. If unable to provide the requested information or it is not submitted timely, the inquiry will be denied. The CC will be notified via email of the BEI determination and any instruction and/or further steps they may need to take.
6. If the inquiry is APPROVED, an authorization letter will be sent to the member and the provider indicating the dates of the authorization. The CC will need to coordinate with the member and the provider and ensure the member receives the item/service.
7. If the inquiry is DENIED, the Care Coordinator will have a discussion with the member following the email notification from Medica that the inquiry was denied. A denial letter is not sent to the member or provider. If the member is satisfied with the action taken, the CC documents the contact in the member’s chart. If the member is not satisfied with the denial, the CC completes the DTR form immediately and submits it to Medica. The date on the DTR form is the date the CC communicated the inquiry decision to the member. The DTR should not reference a BEI denial. Rationale would indicate item or service is not a covered benefit, as appropriate.
8. If an item has been approved through BEI, and the member continues to have the need past the approval timeline, it is the Care Coordinator’s responsibility to submit the new/updated BEI request prior to the end of the current authorization.

**BEI REQUEST Exclusions:**

Medica will NOT accept BEI requests for the following reasons:
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1. The requested item or service is a covered benefit
2. The requested item or service requires a prior authorization as listed on the Medica Prior Authorization List. The request must follow the Prior Authorization process. This includes out of network provider requests, except for Personal Care Assistance (PCA).
3. Request is for pharmacy, dental, mental health, or claim denials from a previous request.
4. The requested item or service has previously been denied. Medica will not accept another BEI request for that service or item unless it was denied due to lack of information. If submitting a new BEI request it must include the additional information as requested. If not denied due to lack of information, CC should proceed with DTR to provide member with appeal rights, per member request. If the requested item or service was previously denied through the BEI process and a DTR was processed, the member can follow the appeal process.
5. Authorization requested by the provider for a service/item that does not require an authorization/referral.
6. The service/item was previously denied and member completed appeal process and decision was upheld. Or member is currently in the appeal process for the same service/item.

Medica will not accept BEI Requests if they are not complete. Examples indicated below. The CC can resubmit the BEI with the required information:

1. All sections on the form are not fully completed. Examples include:
   a. Boxes empty, provider information missing, cost not included, etc.
   b. Duration and/or cost of service request is not indicated
   c. Alternative resources is not addressed
2. Request is not checked that it has been reviewed by a supervisor and/or date is not indicated.
3. Missing pages
4. Transportation requests does not include addresses
5. Eyewear request does not list EyeKraft as a provider and/or it does not include documentation from EyeKraft
6. Rationale section is lacking content supporting information for the request
7. Required or additional supporting documents are not included in the BEI, examples include: EW cost cap tool, Service Plan, PT/OT/ST documentation, DME description of item, physician notes, ILS care plans, mental health, dietary consults.
   a. A prescription from a physician is not sufficient documentation without supporting physician notes.
8. Request for waivered service for SNBC members screening dates and notes are not indicated on the form.

CROSS REFERENCES:
Benefit Exception Inquiry (BEI) Form
Benefit Exception Inquiry (BEI) Form Instruction
Benefit Inquiry Exception Request

Medica Care Coordinator Training Manual: Medica AccessAbility Solution
Medica Care Coordinator Training Manual: Medica Dual-Solution/Medica Choice Care
MSC+

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