Policy Title:	Non-Covered Services		
Policy Number:	000448	**Department:**	CLM
Effective Date:	01/01/2017		
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Revision Date:	02/28/2017		

Purpose:

To define Neighborhood Health Plan of Rhode Island's (Neighborhood's) non-covered services.

Scope:

This policy applies to all lines of business.

Policy Statement:

This document outlines Neighborhood's non-covered services, and is the most current resource for the information contained herein.

Table of Contents:

1. Health Benefits Exchange

Individual Plans	Small Business Health Options Program
INNOVATION	STANDARD
ECONOMY	PARTNER
SECURE	CHOICE
COMMUNITY	PREMIER
VALUE	PRIME
PLUS	
PRINCIPAL	

Coverage Exclusions:

a. Adult Intensive Services (AIS):

AIS program includes, but not limited to, coverage for emergency or crisis evaluations which are available 24 hours a day 7 days per week, psychiatric assessment, medication evaluation and management, case management, psychiatric nursing services, and individual, group, and family

behavioral health therapy.

b. Alternative, holistic, naturopathic, and/or functional health:

Alternative medicine services, supplies or procedures are not covered. Biofeedback is not covered except for the treatment of urinary incontinence. Hypnotherapy is not covered.

c. Circumcision:

Circumcisions will not be covered if they are performed in any setting other than a hospital, day surgery, or a physician's office.

d. Cosmetic services:

Except as described in covered services, any service, supply or medication to change or improve appearance is not covered. This includes, but is not limited to:

- Cervicoplasty (Plastic surgery on the neck or on the cervix of the uterus);
- Sclerotherapy/ treatment for spider veins;
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other conditions);
- Subcutaneous injection of filling material;
- Testicular prosthesis surgery;
- Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry (modifying the size, contour, and elevation of breasts);
- Scar Revision, regardless of symptoms;
- Drugs, biological products, hospital charges, pathology, radiology fees and charges for surgeons, assistant surgeons, attending physicians and any other incidental services which are related to cosmetic surgery;
- Hair removal (including electrolysis epilation);
- Excision of excess skin or subcutaneous tissue including brachioplasty (arm lift) or abdominoplasty (tummy tuck) (except Panniculectomy as described in this Certificate);
- Hair transplants;
- Treatment of vitiligo (white patches on skin);
- Inverted nipple surgery;
- Gynecomastia surgery, including but not limited to mastectomy and reduction mammoplasty;
- Laser treatment for acne and acne scars;
- Liposuction/ suction assisted lipectomy (remove fatty deposits in the thighs, neck, arms, and stomach);
- Removal or destruction of skin tags;
- Tattooing or Tattoo Removal (except tattooing of the nipple/areola related to a mastectomy);
- Rhinoplasty (nose plastic surgery);
- Otoplasty (ear plastic surgery);
- Rhytidectomy (facelift);

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- Scalp hair prostheses made specifically for an individual, or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury;
- Osteoplasty (facial bone reduction);
- Repeated cauterizations or electrofulguration methods used to remove growths on the skin;
- Genioplasty (reduction and addition of material to the chin).

e. Custodial Care:

Custodial care, rest care, day care, or non-skilled care in any facility is not covered. This includes care in convalescent homes, nursing homes, homes for the aged, halfway houses, or other residential facilities.

f. Dental Care:

Preventive and restorative services, treatments and supplies are not covered.

g. Devices, Appliances and Prosthetics:

Non-covered services include, but are not limited to:

- Devices used specifically as safety items or to affect performance in sports-related activities;
- Orthotic appliances that straighten or re-shape a body part such as foot orthotics and cranial banding;
- Some types of braces, including over-the-counter orthotic braces;
- Devices and procedures intended to reduce snoring. Exclusions include, but are not limited to, laser- assisted uvulopalatoplasty, somnoplasty, and snore guards;
- Electric hospital grade breast pump purchases.

h. Eyeglasses, Lenses, or Frames:

Except as described in covered services, non-covered services include refractive eye surgery (including radial keratotomy) for conditions that can be corrected by means other than surgery, contact lenses, or contact lens fittings.

i. Experimental or New Services, Supplies, or Medications:

Neighborhood will not pay for any treatments that are tests of new treatments. This ban does not apply to services meeting coverage conditions under Rhode Island and federal law for:

- Treatment of Lyme disease;
- New therapies to prevent, detect, or treat cancer or other life-threatening diseases or conditions; or
- Off label uses of prescription drugs for the treatment of cancer.

j. Home Births:

Costs associated with the services provided by a doula.

k. Human Organ Transplants:

Transplants are not covered unless as specified by CMS.

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l. Infertility Services:

Infertility treatment is not covered for:

- Members who do not meet the definition of Infertility;
- Experimental infertility procedures;
- The costs of surrogacy;[1]
- Long-term (longer than 90 days) sperm or embryo cryopreservation unless the member is in active infertility treatment. (Note: We may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a member's future fertility. Prior authorization is required for these services.)
- Costs associated with donor recruitment and compensation;
- Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization;
- Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner;
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the member is the sole recipient of the donor's eggs. Prior authorization is recommended for these services;
- Use of donor egg and a gestational carrier;
- Costs for maternity care if the surrogate is not a member.

m. Items for Personal Care, Comfort or Ease:

This list includes television, telephone and beauty/ barber service or guest service.

- Charges gained when the member, for his or her convenience, chooses to remain an inpatient beyond the discharge hour.
- Supplies, equipment and services and supplies primarily for personal comfort.

n. Lodging:

Lodging is not covered even when related to receiving any medical service.

o. Network Restrictions:

Services must be rendered by network providers unless it is an emergency or prior approval has been received. Any services, programs, supplies or procedures provided in a non-conventional setting are excluded.

This includes, but is not limited to:

- Spas/resorts;
- educational, vocational, or recreational settings;
- Outward Bound, or wilderness, camp or ranch programs;
- Services performed outside of the United States and its territories.

[1]The costs of surrogacy means: All costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile member. These costs include, but are not limited to: costs for drugs needed for implantation, embryo transfer, and cryopreservation of embryos. A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo. A gestational carrier is a surrogate with no biological connection to the embryo/child.

This is the case even if the services, programs, supplies, or procedures are performed or provided by licensed providers, such as mental health professionals, nutritionists, nurses or physicians. Some examples of services that may be excluded if they are performed in a non-conventional setting are psychotherapy, ABA services, and nutritional counseling.

p. Pediatric Vision Care Services, Treatments and Supplies:

Pediatric vision care services exclude:

- Services and materials not meeting accepted standards of optometric practice.
- Special lens designs or coatings other than those described as covered services.
- Replacement of lost or stolen eyewear.
- Non-prescription (Plano) lenses.
- Two pairs of eyeglasses in lieu of bifocals.
- Insurance of contact lenses.

q. Services, Supplies or Drugs:

- Services, supplies, or medications required by a third party which are not otherwise medically necessary. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay. Services for which no charge would be made if you had no health plan.
- Services provided to a non-member, except as described in covered services.
- Care for conditions that are already covered under Federal, State or local legislation. This list includes workers' compensation, no-fault auto insurance, or other government programs besides Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Any additional fee a provider may charge.

r. Sexual Reassignment; Reversal of Voluntary Sterilization; or Over-the-counter Contraceptive Agents:

Medical or surgical procedures for sexual reassignment or reversal of voluntary sterilization or over-the-counter contraceptive agents are not covered.

s. Transportation:

Exclusions include, but are not limited to transportation by chair car, wheelchair van, or taxi.

t. Additional Coverage Exclusions: General exclusions include, *but are not limited to:*

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- Any provider charges for missing an appointment;
- Charges for copies of your records, charts or X-rays, or any costs associated with forwarding/mailing copies of your records, charts or X-rays;
- Electrolysis;
- Examinations, evaluations or services for educational or developmental purposes including vocational rehabilitation and retraining services
- Exercise classes;
- Office infection control charges;
- Personal trainer;
- Relaxation and massage therapies
- State or territorial taxes on services performed;
- Services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting.
- TENS units or other neuromuscular stimulators and related supplies;
- Weight loss programs and clinics – inpatient and out patient

2. Medicaid Managed Care Plan

Plan Name	Line of Business
ACCESS	RIte Care
TRUST	Rhody Health Partners
UNITY	Rhody Health Options

Coverage Exclusions:

a. Investigational or Experimental Services:

- Drug or device that lacks FDA approval.
- Requested treatment that is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials.
- Services which are delivered in connection with, or required by, an item or service not covered.
- Exception: investigational or experimental services are covered for cancer treatment per State regulation.

b. DME:

Purchase, repair, or replacement of materials or equipment, when the reason for these actions is the result of enrollee abuse.

Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:

- Explanation of continuing medical necessity for the item;
- Explanation that the item was stolen or destroyed;
- Copy of police, fire department, or insurance report if applicable;
- Repair of DME items not covered by Neighborhood;
- Repair of DME items covered under the provider's or manufacturer's warranty;

- Repair of a rented DME item.

c. Non-DME Items:

- Air conditioner (window or central);
- Air cleansers, purifiers or HEPA filters;
- Floor mats;
- Trampolines, mini trampolines;
- Suspension swings;
- Hypoallergenic pillows/bedding;
- Car seats;
- Food and food products for use in specialty diets (including but not limited to: gluten free, casein free).

d. Cosmetic Surgery:

- Cosmetic prosthetic devices;
- Cosmetic surgery includes, but is not limited to: body piercing, breast implant removal, tattoos or tattoo removal, tongue splitting or repair of tongue splitting, breast augmentation (exception: post mastectomy).

e. Dental:

- Orthodontia;
- All dental services, other than emergency dental and limited oral surgery.

f. Home Modifications (items for use in the home):

- Decks;
- Lifts – permanent;[2]
- Enlarged doorways;
- Environmental accessibility modifications such as grab bars and ramps;
- Fences;
- Handrails;
- Room additions and room expansions;
- Telephone alert systems;
- Telephone arms;
- Telephone service in the home.

g. Infertility related services and procedures:

- Home ovulation prediction kits;
- Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal;
- Any other service or procedure intended to create a pregnancy.

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[2] Lifts – "permanent" refers to lifts affixed to the home, not bed to chair lifts, which are conditionally covered.

h. Alternative Therapies:

- Animal therapy of any type;
- Dance Therapy;
- Psychodrama.

i. Additional Coverage Exclusions:

General exclusions include, *but are not limited to:*

- Academic performance testing;
- Acupuncture;
- Altered Auditory Feedback Devices;
- Diagnostic tests to evaluate the need for a non-covered service;
- Drugs used to treat sexual or erectile dysfunction;
- Educational test and training programs;
- Health club memberships;
- Lasik Surgery;
- Massage Therapy;
- Planned home births;
- Respite care (exception: hospice);
- Services provided outside the United States or its territories;
- Sperm banking;
- Vocational rehabilitation;
- Wigs (exception: alopecia and cancer treatment).

3. Medicare-Medicaid Plan

Plan Name	Line of Business
INTEGRITY	MMP

Coverage exclusions:

a. Investigational or Experimental Services:

- Drug or device that lacks FDA approval;
- Requested treatment that is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials;
- Services which are delivered in connection with, or required by, an item or service not covered;
- Exception: investigational or experimental services are covered for cancer treatment per State regulation.

b. DME:

Purchase, repair, or replacement of materials or equipment, when the reason for these actions is the result of enrollee abuse.

Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:

- Explanation of continuing medical necessity for the item;
- Explanation that the item was stolen or destroyed;
- Copy of police, fire department, or insurance report if applicable;
- Repair of DME items not covered by Neighborhood;
- Repair of DME items covered under the provider's or manufacturer's warranty;
- Repair of a rented DME item.

c. Cosmetic Surgery:

- Cosmetic prosthetic devices;
- Cosmetic surgery includes, but is not limited to: body piercing, breast implant removal, tattoos or tattoo removal, tongue splitting or repair of tongue splitting, breast augmentation (exception: post mastectomy).

d. Dental:

- Orthodontia;
- All dental services, other than emergency dental and limited oral surgery.

e. Infertility related services and procedures:

- Home ovulation prediction kits;
- Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal;
- Any other service or procedure intended to create a pregnancy.

f. Additional Coverage Exclusions:

General exclusions include, *but are not limited to:*

- Academic performance testing;
- Acupuncture;
- Altered Auditory Feedback Devices;
- Cord blood banking;
- Diagnostic tests to evaluate the need for a non-covered service;
- Drugs used to treat sexual or erectile dysfunction;
- Educational test and training programs;
- Electrosleep Therapy;
- Health club memberships;
- Intravenous Histamine Therapy;
- Lasik Surgery;
- Planned home births;
- Sex reassignment surgery;
- Sperm banking;

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- Thermogenic Therapy;
- Trampolines, mini trampolines;
- Transcendental Meditation;
- Suspension swings;
- Vocational rehabilitation;
- Wigs (exception: alopecia and cancer treatment).

4. Coding

For plan specific listings of non-covered CPT, ICD-10 Diagnosis, and HCPCS codes, please choose one of the links below:

- Health Benefits Exchange Plan Non-Covered Codes -
Medicaid Managed Care Plan Non-Covered Codes -
Medicare/Medicaid Plan Non-Covered Codes

5. Disclaimer

This guideline is informational only, and not a guarantee of reimbursement.

Claim payments are subject to Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. All services billed to Neighborhood for reimbursement are subject to audit.

Effective dates noted reflect the date the long standing policy was documented or updated to assist with provider education, unless otherwise noted. Neighborhood reserves the right to update this policy at any time.

6. Document History

Date	Action
02/28/17	Document written and published.