



KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 3.01-P Excluded Services has been updated and is provided here for your review and approval.

| Reviewer | Date | Comment/Signature |
|-------------------|------------|--|
| Doug Hayward | 12/8/20 | <i>Doug Hayward</i> |
| Dr. Tasinga | 11/9/2020 | <i>M Tasinga</i> |
| Alan Avery | 10/23/2020 | Approved without changes-Alan Avery |
| Deb Murr | 11/9/2020 | <i>Debra C Murr, MD</i> |
| Robin Dow-Morales | 10/20/2020 | Approved without changes – Robin Dow-Morales |
| Nate Scott | 9/16/2020 | Approved without changes. – Nate Scott |
| Louis Iturriria | 9/16/2020 | Approved without changes. – Louis Iturriria |
| Shannon Miller | 9/15/20 | Approved without changes. – Shannon Miller |

(CEO decision(s))

Board approval required: Yes ___ No QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____
DMHC submission: _____
Provider distribution: _____



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|------------------------------------|------------------------------------|------|------------------|-------------------|--|
| KERN HEALTH SYSTEMS | | | | | |
| POLICY AND PROCEDURES | | | | | |
| SUBJECT: Excluded Services | | | POLICY #: 3.01-P | | |
| DEPARTMENT: Utilization Management | | | | | |
| Effective Date: 01/31/1996 | Review/Revised Date: 12/08/2020 | DMHC | X | PAC | |
| | | DHCS | | QI/UM COMMITTEE | |
| | | BOD | | FINANCE COMMITTEE | |

| | |
|---|------------|
| _____ | Date _____ |
| Douglas A. Hayward Chief Executive Officer | |
| _____ | Date _____ |
| Chief Medical Officer | |
| _____ | Date _____ |
| Chief Operating Officer | |
| _____ | Date _____ |
| Chief Health Services Officer | |
| _____ | Date _____ |
| Director of Claims | |
| _____ | Date _____ |
| Director of Member Services | |
| _____ | Date _____ |
| Director of Marketing | |
| _____ | Date _____ |
| Director of Utilization Management | |

POLICY:
 Kern Health Systems (KHS) covers benefits in accordance with the following legislative, regulatory, and contractual requirements²:

- ❖ The Knox-Keene Act
- ❖ CCR Title 10 §2699.6700 through 2699.6703
- ❖ CCR Title 22 §§ 51301 through 51365
- ❖ CCR Title 22 §§ 59998 through 59999
- ❖ KHS Medi-Cal Product contract with the Department of Health Services (DHS)

All other services and benefits are excluded unless specifically included as a result of the decision of the KHS Board of Directors.

PROCEDURE:

The following table identifies excluded benefits and limitations. In addition to those limitations included in the table, services are subject to utilization controls and prior authorization requirements.

| Benefit/Services | Exclusions or Limitations |
|--|--|
| Audiological Services | Services are limited to 2 visits per calendar month. Additional services can be considered based on medical necessity. |
| California Children’s Services (CCS) | Services that are eligible for coverage under the CCS program are carved out of KHS’ contract with DHS and are therefore excluded. KHS works to ensure CCS services are coordinated and provided as described in <i>KHS Policy and Procedure #3.16-P: California Children’s Services</i> . |
| Childhood Lead Poisoning Case Management | Childhood lead poisoning case management is carved out of KHS’ contract with DHS and is therefore excluded. Members are referred to the Kern County Department of Public Health Lead Poisoning Prevention Program for case management. KHS is responsible to ensure contracted providers who perform periodic health assessments on children between the ages of six months to six years, comply with current federal and state laws and industry guidelines for health care providers issued by CLPPB, including any future updates or amendments. <i>Referenced APL-18-007</i> . |
| Chiropractic Services | Chiropractic services are reimbursable only to FQHCs and RHCs providing chiropractic services through KHS. <i>Referenced APL-15-003</i> |
| Common Household Items ³ | Common household items and articles of clothing are excluded. |
| Covered by Other Insurance ⁴ | Services, which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan when member has a source of insurance are excluded. KHS shall provide the services at the time of need, and the member shall cooperate to assure that KHS is reimbursed for such benefits. |

| Benefit/Services | Exclusions or Limitations |
|--|--|
| Covered by Workers' Compensation | Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which benefits are provided or payable under any Worker's Compensation benefit plan are excluded. |
| Dental Services | Dental services are carved out of KHS' contract with DHS and are therefore excluded. KHS is responsible to provide limited services related to dental conditions as described in <i>KHS Policy and Procedure #3.06-P: Dental Services</i> . Anesthesia for dental procedures may be covered under KHS benefits if medically necessary. |
| Developmental Disabilities | Medicaid Home services are carved out of KHS' contract with DHS and are therefore excluded. KHS works with members to encourage treatment as described in <i>KHS Policy and Procedure #3.03-P: Kern Regional Center Services (Developmental Disabilities and Early Intervention)</i> . Behavioral Health and Intervention Treatment for both Autism Spectrum Disorder/Non Autism Spectrum Disorder are covered benefits as described in <i>KHS Policy and Procedure #3.72-I Behavioral Health Therapy</i> . |
| Durable Medical Equipment | <ul style="list-style-type: none"> ❖ The following items are excluded: <ul style="list-style-type: none"> ➤ Modification of automobiles or other highway motor vehicles ➤ Books or other items primarily educational in nature ➤ Air conditioners, air filters, or heaters ➤ Food blenders ➤ Reading lamps, or other lighting devices ➤ Bicycles, tricycles, or exercise equipment ➤ Television sets ➤ Orthopedic mattresses, recliners, rockers, seat lift chairs, or other furniture items ➤ Waterbeds ➤ Stairway chairlifts, or other devices which are temporarily or permanently affixed to, or installed in, any part of a home, for the purpose of transporting persons between floors. |
| Emergency Services for Non-Emergency Conditions ⁵ | ❖ Emergency services for non-emergency conditions are excluded. |

| Benefit/Services | Exclusions or Limitations |
|---|---|
| Experimental, Investigational, Outmoded, or Non-Efficacious Services ⁶ | <p>Those medical, surgical (including implants), or other health care procedures, services products, drugs or devices which are either experimental or investigational, not recognized in accordance with generally accepted medical standards as being safe and effective for use in the treatment in question, or outmoded or not efficacious are excluded.</p> <p>In exception to the above, the following experimental and/or investigational treatments are covered:</p> <ul style="list-style-type: none"> ➤ Those that Independent Medical Review determine must be covered as described in <i>KHS Policy and Procedure #14.51-P – Independent Medical Review</i> ➤ Cancer clinical trials as described in <i>KHS Policy and Procedure #3.53 – Cancer Treatment Services</i> ➤ Investigational services that meet the requirements of CCR Title 22 §51303 (h) |
| Hearing Aids | Replacement hearing aids are covered only if the prior hearing aid has been lost, stolen, or irreparably damaged due to circumstances beyond the member’s control. With the exception of those batteries covered under the EPSDT Supplemental Services program, replacement hearing aid batteries are not covered. |
| Hospice Care | An individual who voluntarily elects hospice care waives the right to payment for all non-hospice services related to the terminal condition. ⁷ The election may be revoked at any time. |
| Infertility Treatment ⁸ | Diagnosis of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive systems are not excluded. |
| Inpatient Hospital Services | Personal or comfort items or a private room in a hospital are excluded unless medically necessary. |
| Local Education Agency (LEA) Services | Local Education Agency (LEA) assessment services provided to any student and any (LEA) services provided pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) are excluded. |
| Long Term Care and Skilled Nursing Care | KHS is responsible to provide limited long term care as described in <i>KHS Policy and Procedure #3.42-P: Nursing Facility Services and Long Term Care</i> . |

| Benefit/Services | Exclusions or Limitations |
|--|--|
| Medications | <p>Non-formulary medications are covered under limited circumstances as described in <i>KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests</i>.</p> <p>Certain drugs for the treatment of HIV/AIDS, alcohol and substance abuse, and mental health conditions are carved out of KHS' contract with DHS and are therefore excluded. These drugs may be reimbursable by the Medi-Cal Program at the fee for service (FFS) rate. See <i>KHS Policy and Procedure #3.14-P: Mental Health Services</i> for a list of excluded psychotherapeutic drugs. See Attachment A for a list of excluded drugs for the treatment of HIV/AIDS. See Attachment B for a list of excluded drugs for the treatment of alcohol and substance abuse.⁹</p> |
| Not Medically Necessary ¹⁰ | <p>Services, supplies, items, procedures, or equipment, which are not medically necessary as determined by KHS are excluded. Services deemed to be not medically necessary include but are not limited to the following:</p> <ul style="list-style-type: none"> ➤ Drugs or medications for cosmetic purposes¹¹ ➤ Examinations at frequencies unrelated to medical needs including: the member's desire for medical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses or insurance.¹² ➤ Eyeglasses used primarily for protective, cosmetic, occupational or vocational purposes or eyeglasses prescribed for other than the correction of refractive errors or binocularity anomalies¹³ ➤ Hysterectomy performed solely for the purpose of rendering a woman permanently sterile or when there is more than one purpose for the procedure and the hysterectomy would not be performed except for the purpose of rendering the woman permanently sterile¹⁴ |
| Not Ordered by Primary Care Practitioner (PCP) | <p>Most services not ordered by the member's PCP are excluded. Exceptions include:</p> <ul style="list-style-type: none"> ➤ Emergency services ➤ Family planning ➤ Indian Health Center services ➤ Pregnancy services ➤ STD/HIV/AIDS services |

| Benefit/Services | Exclusions or Limitations |
|--|--|
| Not Primarily Medical in Purpose ¹⁵ | <p>Services and supplies not primarily medical in purpose are excluded. These include but are not limited to¹⁶:</p> <ul style="list-style-type: none"> ➤ Articles of clothing ➤ Toothbrushes, toothpaste, and denture cleaners ➤ Shaving soap and lotions ➤ Cigarettes, cigars, pipes, and tobacco ➤ Cosmetics ➤ Hair combs and brushes ➤ Tissue wipes ➤ Cotton, adhesive tapes, and elastic bandages |
| Occupational Therapy | KHS does not limit services for occupational therapy. Frequency of services are based on medical necessity. |
| Orthoptics | Orthoptics are excluded. |
| | ❖ |
| Physical Therapy | <p>Services do not include the use of Roentgen rays or radioactive materials or the use of electricity for surgical purposes including cauterization. Services are limited to treatment immediately necessary to prevent or reduce anticipated hospitalization or to continue a necessary plan of treatment after discharge from the hospital.</p> |
| Pleoptics | Pleoptics are excluded. |
| Podiatry Services | <p>Routine nail trimming is not covered. KFHC does not limit services for podiatry services. KHS may review for medical necessity on a case-by-case basis.</p> |
| Prior to Effective Date | Any services which are received prior to the subscriber's effective date of coverage are excluded. |
| Reconstructive Surgery ¹⁷ | <p>Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance are excluded. Reconstructive surgery to restore and achieve symmetry incident to a mastectomy is not excluded.</p> |
| Speech Pathology | KHS does not limit services for speech pathology. Frequency of services are based on medical necessity. |
| Spiritual Healing and Prayer | <p>Healing by prayer or spiritual means are carved out of KHS' contract with DHS and are therefore excluded. Services may be reimbursable directly from the Medi-Cal Program.</p> |

| Benefit/Services | Exclusions or Limitations |
|---------------------------|---|
| Substance Abuse Treatment | Substance abuse treatment is carved out of KHS' contract with DHS and is therefore excluded. KHS works with members to encourage treatment as described in <i>KHS Policy and Procedure #3.10-P: Alcohol and Substance Abuse Treatment Services</i> . |
| Transplants | KHS is responsible to provide limited transplant services as described in <i>KHS Policy and Procedure #3.02-P: Major Organ Transplant</i> . |
| Transportation | Transportation is covered in accordance with medical necessity determinations. |
| Tuberculosis Treatment | Direct Observed Therapy (DOT) for treatment of tuberculosis is carved out of KHS' contract with DHS and is therefore excluded. KHS works with members to encourage treatment as described in <i>KHS Policy and Procedure #3.46 – Tuberculosis Treatment</i> . |
| Vision Supplies | <p>Replacement eye appliances are covered only if the prior appliance has been lost, stolen, or significantly damaged due to circumstances beyond the member's control. The following supplies are not covered:</p> <ul style="list-style-type: none"> ➤ Double segment bifocal or no-line multifocal lenses ➤ Multifocal contact lenses <p>Eye appliances to supplement an existing eye appliance, regardless of the source of the existing appliance are limited to the following:</p> <ul style="list-style-type: none"> ➤ Two pairs of single vision glasses, one for distance vision and one for near vision, in lieu of multifocal eyeglasses when there are indications that multifocal lenses cannot be worn satisfactorily ➤ Low vision aids, including single vision eyeglasses prescribed as a low vision aid ➤ Ptosis crutches, occluders, bandage contact lenses, prosthetic eyes, and prosthetic scleral shells ➤ Overcorrection single vision or bifocal eyeglasses for concurrent use with contact lenses. Prescription eyeglasses for alternative use by a person who has and is able to wear contact lenses are not covered. Contact lenses shall not subsequently be covered after a member has been provided prescription eyeglasses because the patient could not wear contact lenses. |

1.0 DELEGATION MONITORING AND OVERSIGHT

KHS is responsible for ensuring that all delegates comply with all applicable state and federal law and regulations, contract requirements, and other DHCS guidance including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and

subcontractors.

ATTACHMENTS:

- **Attachment A:** *Excluded Drugs for the Treatment of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)*
- **Attachment B:** *Excluded Drugs for Alcohol and Heroin (Opioid) Dependence Treatment*

REFERENCE:

Revision 2020-10: Routine review of policy. References to APL-18-007 Blood Lead Testing and APL 15-003 Chiropractic Services in addition to Policy and Procedure #3.72-I Behavioral Health Therapy Developmental Disabilities by Chief Health Services Officer. **Revision 2016-12:** Reference to acupuncture was removed. Acupuncture is a covered benefit. **Revision 2016-09:** Revision to Chiropractic Services regarding reimbursement. Corrected reference to policy on page four. No requested revision by DMHC during audit review. **Revision 2014-11:** Policy submitted as part of DMHC Material Modification. Policy approval pending as of 08/2014. Policy revised to comply with Mental Health Carve-In (12-2013). Healthy Families language removed due to transition to Medi-Cal. **Revision 2006-10:** Routine revision. Revised per DHS Workplan Comments 7c (4/26/06). **Revision 2003-06:** Revised per DHS comment 03-04-03. **Revision 2002-11:** Routine Revision. **Formerly:** #3.05 – Excluded Services. Number changed due to P&P manual revision.

²DHS Contract §6.7.1.1

³ CCR Title 22 §51303 (I) and §51320 (b) and §59998 (a)(7)(A)

⁵ CCR Title 10 §2699.6703 (a)(6)

⁶ CCR Title 22 §51303 (g) and (h); CCR Title 10 §2699.6700 (a)(4) and §2699.6703 (a)(5)

⁷ CCR Title 22 §51349 (f)

⁸ CCR Title 10 §2699.6703 (a)(8)

⁹ DHS Contract 03-76165 A03, Exhibit A, Attachment 11-A.

¹⁰ CCR Title 10 §2699.6703 (a)(3)

¹¹ CCR Title 10 §2699.6700 (a)(4)

¹² CCR Title 10 §2699.6700 (a)(2)(D)

¹³ CCR Title 22 §51317 (a)(4)

¹⁴ CCR Title 22 §51305.6 (a)

¹⁵ CCR Title 22 §51303 (I)

¹⁶ CCR Title 22 §59998 (a)(7)

¹⁷ CCR Title 22 §51305 (I) (I); CCR Title 10 §2699.6700 (a)(23) and §2699.6703 (a)(13)

**EXCLUDED DRUGS FOR THE TREATMENT OF HUMAN
IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY
SYNDROME (AIDS)¹**

Generic Name

Abacavir Sulfate
Abacavir Sulfate/Lamivudine/Zidovudine
Abacavir/Lamivudine
Amprenavir
Atazanavir Sulfate
Emtricitabine
Enfuvirtide
Indinavir Sulfate
Efavirenz
Lamivudine
Saquinavir
Lopinavir/Ritonavir
Ritonavir
Delavirdine Mesylate
Saquinavir Mesylate
Tenofovir Disoproxil/Emtricitabine
Tenofovir Disoproxil Fumarate
Nelfinavir Mesylate
Nevirapine
Stavudine
Zidovudine/Lamivudine
Fosamprenavir Calcium

¹ 03-76165 A-01

**EXCLUDED DRUGS FOR ALCOHOL AND HEROIN (OPIOID)
DEPENDENCE TREATMENT²**

Generic Name

Buprenorphine HCL

Buprenorphine HCL and Naloxone HCL dihydrate

² 03-76165 A-03