IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	Care Plan Option	**Guideline #**	UM_OTH 16
		Original Effective Date	11/14/18
Section	Other	**Revision Date**	2/9/2022

COVERAGE POLICY

IEHP provides its IEHP DualChoice CalMediConnect Plan (Medicare-Medicaid Plan) Members Care Plan Option (CPO) service at its sole discretion and in accordance with the Member's individualized care plan, as determined by the Member's Care Team. CPO services may include, but are not limited to, those listed on the attached Care Plan Option Service Grid. This grid also describes the criteria for each CPO service. Criteria for additional services are listed within the Community Health Services section of UM Subcommittee Approved Authorization Guidelines as noted in the Care Plan Option Service Grid.

COVERAGE LIMITATIONS AND EXCLUSIONS

Please see the attached Care Plan Option Service Grid.

ADDITIONAL INFORMATION

N/A

CLINICAL/REGULATORY RESOURCE

CCI 3-Way Contract, Section 2.4.3, effective January 1, 2018.

DEFINITION OF TERMS

Care Plan Option (CPO) Services – A CPO service is optional under the Member's Individualized Care Plan (ICP). A CPO service is designed to only supplement, not replace, the required Medi-Cal services under the Member's ICP. CPO services are offered entirely at the health plan's discretion.

REFERENCES

CCI 3-Way Contract, Section 2.4.3, effective January 1, 2018.

DISCLAIMER

IEHP Clinical Authorization Guidelines (CAG) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Authorization Guidelines (CAG) express IEHP's determination of whether certain services or supplies are medically necessary, experimental and investigational, or cosmetic. IEHP has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). IEHP makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in the Clinical Authorization Guidelines (CAG). IEHP expressly and solely reserves the right to revise the Clinical Authorization Guidelines (CAG), as clinical information changes.

Care Plan Option Service Grid

IMPORTANT: The Member's Care Team shall determine whether the Member may benefit from CPO services.

CPO Service	Description of Service	Criteria	Recommended Limitations
Nutrition (Meals)	Enteral sustenance deemed necessary for health		
Transportation	Movement or transfer from location to location outside of the covered benefit	• CM referral; **and** • Addressing social determinants of health; **and** • Does not meet criteria for transportation benefit as defined in the APL, DPL or UM Subcommittee transportation criteria	At the recommendation of the ICT/Care Team and per the CPO Approval Threshold Grid
Habilitation (Training to persons with disabilities to meet their daily living needs)	For Member to gain skills that allow them to reside in the community	Any one (1) of the following: • Retraining after traumatic brain injury • Training for cognitive disability • Intellectual disability diagnosis	Length of treatment: up to six (6) consecutive months of treatment
Home modification	Services aimed to support safety and activity performance in the home	Refer to UM_CSS 07, Environmental Accessibility Adaptions (Home Modifications)	
Respite Care (in home or out-of-home)	Short term or temporary care of the sick or disabled, designed to provide relief to the regular caregiver	Members who meet criteria for Nursing Facility (NF) level of care.	One hundred and sixty (160) hours per benefit year. Member must have the ability to go in or out-of-home.
Personal Care and Chore Type Services	Assistance in dressing, grooming, and hygiene beyond those covered by In-Home Supportive Services (IHSS)	Members who preliminarily meet IHSS criteria and pending County assessment.	Hours necessary to keep Member at least restrictive level of care and/or to prevent acute readmission.

CPO Service	Description of Service	Criteria	Recommended Limitations
Assistive devices as defined by the State Personal emergency response systems; assistive technology	Devices designed, made, or adapted to assist a person perform a particular task.	**Personal emergency response systems** • Member is identified as at risk for falls; and • Member is appropriate for around the clock supervision **Assistive technology** Must provide reasonable expectation that technology will assist Member to avoid a more restrictive care level and meet health goals.	Limited to the cost of one (1) month of custodial care in a facility (estimated at $4,500).
Other There may be items/services identified by the ICT which is not specifically listed above.	Any additional identified services deemed reasonable by the ICT to support the Member's health and safety goals	Must provide reasonable expectation that service/item will assist Member avoid a more restrictive care level and meet health goal.	Limited to the cost of one (1) month of custodial care in a facility (estimated at $4,500).