

## Marketplace National Regional Benefit Interpretation Document

Benefit Name	EXPERIMENTAL AND INVESTIGATIONAL SERVICES
Applicable State	California, Florida, Idaho, Illinois, Kentucky, Michigan, Mississippi, Nevada, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin
Benefit Definition	<p>This policy addresses experimental and/or investigational procedures, items, treatments, studies, tests, drugs, and equipment.</p> <p>Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <b>A. FEDERAL/STATE MANDATED REGULATIONS</b> </div> <p><b>Note: The most current federal/state mandated regulations for each state can be found in the links below.</b></p> <p><b>CALIFORNIA:</b>  <a href="#">CA HSC 1370.4</a>- Experimental or Investigational Therapies</p> <p><b>WASHINGTON:</b>  <a href="#">WAC 284-46-507</a>: Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <b>B. STATE MARKET PLAN ENHANCEMENTS</b> </div> <p><b>None</b></p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <b>C. COVERED BENEFITS</b> </div> <p><b>IMPORTANT NOTE:</b> Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.</p>

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

## **EXPERIMENTAL OR INVESTIGATIONAL SERVICES**

### **ALL STATES:**

Experimental and/or Investigational procedures, items, treatments, studies, tests, drugs, and equipment may be covered when:

- Mandated by State or Federal Law (Section A above)  
or
- As determined medical necessary by a Molina Healthcare Medical Directors

Molina Healthcare defines the terms "experimental" or "investigational" or "unproven" (E/I/U) as the use of a technology defined as: medical, surgical, behavioral procedures, equipment, devices, laboratory tests and pharmaceuticals, that has not been recognized as having proven benefit in clinical medicine for any condition, illness, disease or injury being treated. A technology will be deemed, experimental, investigational or unproven by the Molina Health Care if one or more of any the following criteria exist listed in the Molina Clinical Policy for Experimental and Investigational.

## **MORE INFORMATION**

Refer to Benefit Interpretation Policy titled **Clinical Trials**

### **D. NOT COVERED**

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

## **EXPERIMENTAL OR INVESTIGATIONAL SERVICES**

**CALIFORNIA, FLORIDA, ILLINOIS, KENTUCKY, MICHIGAN, MISSISSIPPI, NEVADA, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, WISCONSIN:**

Molina and Passport do not cover Experimental or Investigational services; however, this exclusion does not apply to Services covered in Approved Clinical Trials Benefit Policy

### **IDAHO, WASHINGTON:**

**Experimental or Investigational Services:** Any medical service including procedures, medications, facilities, and devices that Molina has determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are Experimental or Investigational, Molina will consider whether the services are in general use in

the medical community in the State of Idaho or Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

This exclusion does not apply to any of the following:

- Services covered in “Approved Clinical Trials” Benefit Policy in the Covered Services section

Please refer to the “External Review or Appeal” section of the EOC for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

#### E. DEFINITIONS

[See Glossary](#)

#### F. POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
7/1/2023	<ul style="list-style-type: none"> <li>• Added NV 2024 EOC Language</li> </ul>

#### Prior Authorization

For the MHI PA Matrix, if a code is NOT listed, it could EITHER be:

- Covered and No PA Required
- Not Covered

You cannot use the MHI PA Matrix to make coverage determinations.

[PA Lookup Tool](#)

#### Approval

Departments	Product	CIM	Clinical Management
Date	10/26/2021	3/3/2022	10/26/2021
Revised (for 1/1/2023)	11/15/2022	4/5/2023	11/15/2022
Revised (for 1/1/2024)	12/15/2023		12/8/2023