NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

UNDERSTANDING HEALTH CARE BILLS

What Is Medical Necessity?

Medical necessity is a term used by health insurance companies to describe the coverage that is offered under a benefit plan. In the policy and benefit summary, the language that informs a person about what is covered under their insurance plan will generally describe benefits that are available "when medically necessary." So, what does this mean?

How does medical necessity affect coverage for my health care services?

The way your health plan defines medical necessity impacts how it decides which health care services it will pay for. Generally, health plans pay a portion of the bill for covered services that fit the definition of medical necessity.

Health insurance plans will provide a definition of "medical necessity" or "medically necessary services" in the policy. There may also be a definition that is found in state law. The following elements may be included within a definition for "medical necessity." These are services that are:

- provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and except for clinical trials that are described within the policy, not for experimental, investigational, or cosmetic purposes;
- necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms;
- within the generally accepted standards of medical care in the community; and/or
- not solely for the convenience of the insured, the insured's family or the provider.

Policy language may also include provisions to consider:

- the cost effectiveness of the requested treatment;
- alternative services or supplies for covered services; and/or
- the setting where medically necessary services are eligible for coverage.

Self-funded plans that are not under state insurance regulatory authority typically hire Third Party Administrators to administer their health benefits. The Summary Plan Description, which describes the covered services and issued to covered employees, may include a definition for medical necessity.

Medicare defines "medically necessary" as health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Each state may have a definition of "medical necessity" for Medicaid services within their laws or regulations.

How is "medical necessity" determined?

A doctor's attestation that a service is medically necessary is an important consideration. Your doctor or other provider may be asked to provide a "Letter of Medical Necessity" to your health plan as part of a "certification" or "utilization review" process. This process allows the health plan to review requested medical services to determine whether there is coverage for the requested service. This can be done before, during, or after the treatment.

A "precertification review" is conducted before the treatment has been provided and allows the health plan to decide if the requested treatment satisfies the plan's requirements for medical necessity. This can be done by reviewing the Letter of Medical Necessity, medical records, and the plan's medical policies for coverage.

A "concurrent review" occurs during the treatment to decide if the ongoing treatment is medically necessary.

A "retrospective review" occurs after the treatment has been provided to decide if the services were medically necessary, experimental, cosmetic or sometimes whether there was truly a need for emergency services.

What is a medical policy?

Definitions for medical necessity include a requirement that the treatment is within the accepted standards in the medical community. This is defined in the health plan's medical policy.

A health plan must make its medical policy available to you if it is used to make a decision to deny you coverage.

What about experimental, investigational or cosmetic services?

Some definitions of medical necessity include the requirement that they are "not for experimental, investigational or cosmetic purposes". Health plans may use their medical policies to determine if a treatment is considered experimental for your condition. This holds true for conditions that can be considered cosmetic but may also have a medical purpose. Medical records may be used to help make medical necessity determinations, but decisions may be based on the available scientific literature as well.

Does medical necessity affect emergency services?

Emergency services may be reviewed retrospectively to see if the care was appropriate to your diagnosis and medically necessary for an emergency level of care. The standard for making this coverage decision is made on the "prudent layperson" standard, which allows that a precertification is not necessary if a prudent layperson would believe that an emergency condition existed and that a delay in treatment would worsen that condition.