MEDICAL POLICY

Medical Policy Title	**Medically Necessary Services**
Policy Number	**11.01.15**
Current Effective Date	**October 16, 2025**
Next Review Date	**October 2026**

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. The Health Plan provides benefits for services that are considered **medically necessary,** that are included in the member's contract (institutional care, medical care and services, technology, tests, treatments, drugs, dental care and supplies).

II. Services will be deemed **medically necessary** only when **ALL** of the following criteria are met:

- A. Services are appropriate and consistent with the diagnosis and treatment of the patient's medical condition;
- B. Services are required for the direct care and treatment or management of the patient's condition;
- C. If not provided, the patient's medical condition would be adversely affected;
- D. Services are provided in accordance with standards of generally accepted medical practice;
- E. Services are not primarily for the convenience of the patient, the patient's family, the provider of services, or another provider;
- F. They are the most appropriate service(s), rendered in the most efficient and economical way and at the most economical level of care that can safely be provided.

III. Inpatient level of care is only **medically necessary**, when the medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided in any other setting (e.g., outpatient, physician's office, or at home).

IV. **Medical necessity** of a service is determined by the Health Plan and may consider **ANY or ALL** of the following criteria:

- A. Review of the patient's medical records. When no medical records are received (e.g., clinical note from requesting provider, lab tests, imaging studies, non-operative management if appropriate), the request will be denied not medically necessary;
- B. Reports in peer-reviewed medical literature;
- C. Reports and guidelines, published by nationally recognized health care organizations, which include supporting scientific data;
- D. Professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;

E. Opinions of health professionals in the generally recognized health specialty involved;

F. Opinions of the attending professional providers;

G. Any other relevant information brought to the attention of the Health Plan.

V. A prescription, order or recommendation by a provider does **NOT** make a service:

A. Medically necessary;

B. The most appropriate treatment; or

C. That it will be covered by the Health Plan.

RELATED POLICIES

Corporate Medical Policy

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

I. Under the New York Insurance Law, if a service has been authorized as medically necessary through the prior authorization process, the Health Plan may not deny a claim for the service unless the member is no longer covered on the date of service; the claim was not submitted in accordance with the contractual timeframes for submitting claims; the member's benefits are exhausted at the time the claim is received; the prior authorization was based on incomplete or inaccurate information; or there is a reasonable basis to believe that the member or provider has engaged in fraud. In the event that the Health Plan authorizes as medically necessary a course of treatment limited by number, time period or otherwise, then a request for treatment beyond the authorized course of treatment shall be deemed to be a new request, and any denial of such a request shall not be governed by the preceding sentence.

II. Determination as to a service being considered medically necessary or not medically necessary is made only through the Health Plan by an appropriate clinical peer reviewer. In most cases, a physician who is a Health Plan Medical Director acts as the clinical peer reviewer. Medical opinions of professional societies, peer review committees or other groups of physicians that are submitted for review will be evaluated. A clinical peer reviewer is a practitioner in the same profession and same or similar specialty as the practitioner who manages the care or provides the service.

III. Medical necessity determination will be based on documentation of clinical information available to provider at the time the order was created for the service. Documentation needs to support the requested service (please refer to the specific Corporate Medical Policy for the service).

DESCRIPTION

The purpose of this medical policy is to define the term "medically necessary" or "medical necessity" and to provide clarification as to the criteria utilized by the Health Plan in determining whether requests for pre-service (e.g., prior authorization), concurrent, or post-service (e.g., initial

determination, reconsideration, or appeal) approval are medically necessary.

Medically necessary, or medical necessity, is defined as health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

I. In accordance with generally accepted standards of medical practice, which are based on:
   A. Credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community when available;
   B. Physician specialty society recommendations;
   C. The views of prudent physicians practicing in relevant clinical areas;
   D. Any other clinically relevant factors; and

II. Clinically appropriate in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury or disease; and

III. Not primarily for the convenience of the patient, patient's family, patient's physician, or any other health care provider; and

IV. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

SUPPORTIVE LITERATURE

Not Applicable

PROFESSIONAL GUIDELINE(S)

Not Applicable

REGULATORY STATUS

New York Insurance Law § 3224-a establishes clear standards to ensure that health care claims are processed and paid promptly and fairly by insurers.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
Multiple Codes	

HCPCS Codes

Code	Description
Multiple Codes	

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

American Academy of Pediatrics. Essential contractual language for medical necessity in children. Policy statement. Pediatrics 2013 Aug;132(2):398-401.

Health Plan contracts.

New York State Legislature [Internet]. Insurance Law § 3224-a: Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services. N.Y. Ins. Law § 3224-a (2025). [accessed 2025 Jul 30] Available from: https://www.nysenate.gov/legislation/laws/ISC/3224-A

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

There is currently no National Coverage Determination (NCD) or Local Coverage Determination (LCD) for Medically Necessary Services.

Medicare Benefit Policy Manual [accessed 2025 Jul 30]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.

- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
09/23/04, 10/27/05, 10/26/06, 10/24/07, 10/23/08, 10/28/09, 10/28/10, 12/08/11, 12/06/12, 12/12/13, 12/11/14, 12/10/15, 12/08/16, 12/14/17, 12/13/18, 12/12/19, 12/10/20, 12/16/21, 12/22/22, 10/19/23, 10/17/24, 10/16/25	
Date	**Summary of Changes**
10/16/25	• Annual Review; policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
09/23/04	• Original effective date