MEDICAL POLICY

Medical Policy Title	**Medically Necessary Services**
Policy Number	**11.01.15**
Current Effective Date	**October 22, 2026**
Next Review Date	**October 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(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** when **ALL** of the following criteria are met:

- A. Services are appropriate and consistent with the diagnosis and treatment of the Individual's medical condition;
- B. Services are required for the direct care and treatment or management of the Individual's condition;
- C. Individual's medical conditions would be adversely affected if service is not provided;
- D. Services are provided in accordance with standards of generally accepted medical practice;
- E. Services are not primarily for the comfort, convenience or custodial care of **any** of the following:
  1. the patient;
  2. the patient's family;
  3. the provider of services; **or**
  4. any other 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 **medically necessary**, when the treatment or diagnosis of medical symptoms or conditions cannot safely be provided in any other setting (e.g., outpatient, physician's office, or at home).

RELATED POLICIES

Corporate Medical Policy

7.01.11 Cosmetic and Reconstructive Procedures

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. Determinations regarding medical necessity are 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. Services that are characterized as comfort, convenience or custodial, and it is a service that is otherwise covered under the member's subscriber contract, then the Health Plan will request additional, pertinent information in order to make a determination. Upon receipt of the information requested, the Health Plan Medical Director will review the request for medical necessity. The determination will be based on the criteria indicated in the appropriate Health Plan policy and will be subject to the then-current law governing medical necessity.

IV. A provider's prescription, order, or recommendation does **NOT** guarantee that a service:

   A. Is medically necessary;

   B. Is the most appropriate treatment; or

   C. Will be covered by the Health Plan.

V. Medical necessity determinations are based on documentation of clinical information available to the provider at the time the service was ordered. Documentation must support the service requested in accordance with the applicable Corporate Medical Policy. The Health Plan may consider any of the following to make a medical necessity determination:

   A. Review of the patient's medical records. When no medical records are received (e.g., clinical notes from requesting provider, lab tests, imaging studies, non-operative management if appropriate), the request will be denied not medically necessary;

   B. 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.

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.

Generally accepted standards of medical practice are based on:

- Credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community when available;
- Physician specialty society recommendations;
- The views of prudent physicians practicing in relevant clinical areas;

Comfort

Items and/or services that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member (except for hospice care) are defined as comfort items. Devices or equipment deemed presumptively non-medical and considered to be comfort items include, but are not limited to, environmental control devices (heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners), physical fitness equipment, first aid supplies, and precautionary equipment (e.g., safety grab bars, training equipment, etc.).

Convenience

Items and/or services that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member (except for hospice care) AND that are primarily for the convenience of the patient and/or the caregiver are classified as convenience items. Examples of convenience items include, but are not limited to elevators, stairway elevators (stair lifts), ergonomic chairs, ramps, and home or car adaptive equipment.

Custodial

Custodial care refers to routine maintenance or supportive care that does not require the services of trained and skilled professional personnel.

Custodial care and/or services are primarily intended to assist an individual with personal care activities, including but not limited to, walking, transferring in and out of bed, bathing, dressing, feeding, toileting, meal preparation, and supervision of medications that can be self-administered and do not require the ongoing attention of trained medical or paramedical personnel.

In determining whether a person is receiving custodial care, the patient's medical record is reviewed, using established criteria, and consideration is given to the level of care and medical supervision required and furnished.

*The description for each of the four terms of this policy is based on the generally accepted language used by the Centers for Medicare & Medicaid Services (CMS). Any other clinically relevant factors.

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	

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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 2026 Jul 07] 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 2026 Jul 07]

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, 10/22/26

Date	Summary of Changes
10/22/26	• Annual Review; policy intent unchanged. Moved policy statement regarding documentation to guidelines.
10/16/25	• Annual Review; policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
09/23/04	• Original effective date