

MEDICAL NECESSITY DETERMINATION**Effective Date:** September 1, 2025**Review Dates:** 12/01, 11/02, 11/03, 11/04, 12/05, 12/06, 12/07, 12/08, 12/09, 12/10, 12/11, 12/12, 12/13, 11/14, 11/15, 11/16, 5/17, 5/18, 5/19, 8/19, 8/20, 8/21, 8/22, 8/23, 8/24, 8/25**Date Of Origin:** December 19, 2001**Status:** Current

Related policies: Technology Assessment #91430

Summary of Changes**Addition:**

- To be considered medically/clinically necessary, services and supplies must not be primarily for the convenience of the member or the health care provider.
- Medical devices and products, biologics, and drugs must have regulatory approval or clearance, when applicable.
- New sections: Government Regulations, and FDA/Regulatory.
- Exclusions: Cosmetic, experimental and/or investigational, or benefit excluded procedures.
- Formatting.

Deletion:

- Medicare coverage criteria will be used in the absence of medical policy, plan documents, or technology review.

I. POLICY/CRITERIA

- A. Medically/Clinically Necessary is defined as services or supplies needed to diagnose or treat a medical or behavior health condition, illness, disease, or injury. Whether services or supplies are Medically/Clinically Necessary is determined in accordance with Priority Health's medical and behavioral health policies, Federal and State laws or regulations, or criteria developed by third party utilization management delegates that have been approved by Priority Health's Medical Affairs Committee.

Unless specifically or otherwise defined in Federal or State laws or regulations, in order to be considered medically/clinically necessary, the services or supplies must:

1. Be widely accepted as effective on health outcomes;
2. Be appropriate for the diagnosis of the condition, illness, disease, or injury;
3. Be essential, based upon nationally accepted evidence-based standards;
4. Cost no more than a treatment that is likely to yield a comparable health outcome as standard of care or established alternatives;

5. Not be primarily for the convenience of the member or health care provider.
 6. Be the most appropriate level of care and site of service which can be safely and reasonably provided.
 7. In addition, for procedural services the following apply:
 - a. Surgically appropriate for the condition or diagnosis based on nationally accepted, evidence-based standards; and
 - b. Personally appropriate following use of a shared decision-making process to ensure full informed consent; and
 - c. Medically appropriate based on adequate management of medical comorbidities and risk factors for death or complications.
 8. Medical devices and products, biologics, and drugs must have final marketing approval or clearance from the Food and Drug Administration (FDA) or appropriate governmental regulatory bodies if applicable.
- B. The determination of whether proposed care is a covered service is independent of, and should not be confused with, the determination of whether proposed care is Medically/Clinically Necessary. Determinations of coverage are based on plan documents, member's specific benefits, Federal and State laws or regulations, and Priority Health Medical Policy when applicable.
- C. Medical necessity determination is made by Priority Health's Medical Director, or anyone acting at the medical director's direction, in consultation with other physicians. Medically/Clinically Necessary behavioral health and substance use disorder services are determined by Priority Health's Behavioral Health Department.
- D. In the absence of applicable plan documents, medical policy, or technology review, coverage and medical necessity decisions will be based on medical director review.
1. Technology reviews, outlined in medical policy *Technology Assessment #91430*, may include literature reviews, formal technology assessments, and inputs from providers.
- E. Exclusions, including, but not limited to:
1. Cosmetic therapies and procedures intended to change or restore appearance: See Cosmetic and Reconstructive Surgery Procedures medical policy # 91535.
 2. Experimental and/or investigational or benefit excluded devices, drugs, procedures, services, supplies, or treatments: See Experimental/Investigational/Unproven Care/ Benefit Exceptions medical policy # 91117.
 3. Luxury Treatment Programs. There is no evidence to support that Luxury Treatment Programs are superior to standard therapy or medically necessary. Luxury Treatment Programs are defined as treatment programs which offer resort-style amenities including, but not limited to, spas, health hydrotherapies, nature cure clinics, resort-style geographic

locations such as secluded beach, mountain, or country settings and experiences that are meant to integrate with and go beyond standard rehabilitative activities, such as fine dining, horseback riding, or swimming.

4. Programs that utilize interventions that are not based on a federal registry of evidence-based interventions such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices Resource Center.

II. GOVERNMENT REGULATIONS

Medicare: Refer to the [CMS Online Manual System \(IOMs\)](#) and Transmittals.

Particular services excluded from coverage: [42 CFR 411.15](#)

Coverage and authorization of services: [42 CFR 438.210](#)

For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to [CMS Medicare Coverage Database](#).

Medicaid: Refer to the Michigan Department of Health and Human Services: [Medicaid Provider Manual](#) for definitions of medical necessity.

III. FDA/REGULATORY

The FDA is responsible for regulating human drugs and biological products, animal drugs, medical devices, tobacco products, food (including animal food), cosmetics, and electronic products that emit radiation. The FDA does not approve or provide clearance for medical procedures.

IV. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the [Priority Health Provider Manual](#).

V. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*

- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.*

VI. REFERENCES

1. Centers for Medicare & Medicaid Services. [Medicare Coverage Determination Process](#) (Accessed June 10, 2025)
2. Long TF; Committee on Child Health Financing; American Academy of Pediatrics. Essential contractual language for medical necessity in children. *Pediatrics*. 2013 Aug;132(2):398-401. doi: 10.1542/peds.2013-1637. Epub 2013 Jul 29. PMID: 23897913.
3. Michigan Department of Health and Human Services. [Medicaid Provider Manual](#) (Accessed July 30, 2025).
4. National Association of Insurance Commissioners. [Understanding Health Care Bills: What is Medical Necessity](#) (Accessed July 30, 2025).

APPENDIX A

The following ICD-10 Codes do not support medical necessity and are not covered for commercial (fully-funded and self-funded) and Medicaid plans.

Medical services not covered for these diagnoses include but are not limited to:

Anesthesia services
Injections and injectable medications
Imaging & radiology
Laboratory and pathology services
Physician medicine Services
Surgery & Reconstructive Surgery

F40.10	Social phobia, unspecified
F43.10 - F43.9	Reaction to severe stress, and adjustment disorders
F50.8	Other eating disorders
F51.01 - F51.9	Primary insomnia/Hypersomnia not due to a substance or known physiological condition
F52.0 - F52.9	Sexual dysfunction not due to a substance or known physiological condition
F63.0 - F63.9	Impulse disorders
F65.0 - F65.9	Paraphilias
F66	Other sexual disorders
F81.01 – F81.9	Specific developmental disorders of scholastic skills
F91.0 - F91.9	Conduct disorders
F93.0 - F93.9	Emotional disorders with onset specific to childhood
F94.0 - F94.9	Disorders of social functioning with onset specific to childhood and adolescence
F98.21	Rumination disorder of infancy
F98.3	Pica of infancy and childhood
F98.8	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F98.9	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
G47.29	Other circadian rhythm sleep disorder
I83.90 - I83.93	Asymptomatic varicose veins of lower extremities
R37	Sexual dysfunction, unspecified
R41.83	Borderline intellectual functioning
R45.0 - R45.850	Symptoms and signs involving emotional state
R45.86	Emotional lability
R45.87	Impulsiveness
R45.89	Other symptoms and signs involving emotional state
R46.0 – R46.89	Symptoms and signs involving appearance and behavior
Z04.8 - Z04.9	Encounter for examination and observation for specified and unspecified reasons
Z31.0	Encounter for reversal of previous sterilization
Z31.42	Aftercare following sterilization reversal
Z31.84	Encounter for fertility preservation procedure
Z40.8 – Z40.9	Encounter for prophylactic surgery and unspecified
Z41.1	Encounter for cosmetic surgery
Z41.3	Encounter for ear piercing
Z41.8 – Z41.9	Encounter for procedure for purposes other than remedying health state and unspecified
Z42.8	Encounter for other plastic and reconstructive surgery following medical procedure or healed injury
Z46.0 – Z46.89	Symptoms and signs involving appearance and behavior
Z53.1	Procedure and treatment not carried out because of patient's decision for reasons of belief and group pressure
Z55.0 – Z55.9	Problems related to education and literacy
Z56.0 – Z56.9	Problems related to employment and unemployment
Z57.0 – Z57.9	Occupational exposure to risk factors and other contaminants
Z59.0 – Z59.9	Problems related to housing and economic circumstances
Z60.0 – Z60.9	Problems related to social environment
Z62.0 – Z62.9	Problems related to upbringing
Z63.0 – Z63.9	Other problems related to primary support group, including family circumstances
Z64.0 – Z64.4	Problems related to certain psychosocial circumstances

Z65.0 – Z65.9	Problems related to other psychosocial circumstances
Z69.011	Encounter for mental health services for perpetrator of parental child abuse
Z69.021	Encounter for mental health services for perpetrator of non-parental child abuse
Z69.12	Encounter for mental health services for perpetrator of spousal or partner abuse
Z69.82	Encounter for mental health services for perpetrator of other abuse
Z71.84	Encounter for health counseling related to travel
Z71.89	Other specified counseling
Z72.3	Lack of physical exercise
Z72.6 – Z72.9	Problems related to lifestyle
Z73.0 – Z73.9	Problems related to life management difficulty
Z76.0	Encounter for issue of repeat prescription
Z86.51	Personal history of combat and operational stress reaction
Z86.59	Personal history of other mental and behavioral disorders

Third Party Requirements: Services required or recommended by third parties, such as courts, schools, employers, or accrediting/licensing agencies, related to getting or keeping a job, getting or keeping any license issued by a governmental body, getting insurance coverage, foreign travel, adopting children, obtaining or maintaining child custody, school admission or attendance and participation in athletics.

Non-Covered Services include but are not limited to:

- physical examinations more than once per year performed by your PCP (if applicable or other Health Professional. Subject to plan coverage),
- diagnostic services
- surgical or medicine service

ICD-10 Dx Codes that will process as “Third Party”:

Z00.8	Encounter for other general examination
Z02.0 – Z02.9	Encounter for administrative examination
Z04.6	Encounter for general psychiatric examination, requested by authority

AMA CPT Copyright Statement:

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Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

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