NO. 91447

MEDICAL NECESSITY DETERMINATION

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Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. 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.

Policy scope: This policy establishes the criteria and framework used to determine whether healthcare services, procedures, devices, drugs, or supplies are medically necessary. A service includes, but is not limited to, a diagnostic service, procedure, test, treatment, facility service, equipment, drug, biologic, device, or supply.

Related policies:

- Technology Assessment No. 91430
- Experimental/Investigational/Unproven Care/ Benefit Exceptions No. 91117
- Cosmetic and Reconstructive Surgery Procedures No. 91535
- Category III Current Procedural Terminology (CPT®) Codes No. 91636

I. MEDICAL NECESSITY CRITERIA

A. Definition of Medical Necessity

Medically necessary services or supplies are those needed to diagnose, treat, cure, relieve, manage, or prevent worsening of a medical or behavioral health

condition, illness, disease, injury, or its symptoms, and that meet accepted standards of medical practice. This definition is consistent with federal standards requiring services to be reasonable and necessary for diagnosis or treatment and aligned with accepted standards of medical care.

B. Medical Necessity Requirements

Unless specifically or otherwise defined in Federal or State laws or regulations, a service or supply is considered medically necessary when it meets **all** of the following:

1. **Clinical Appropriateness**
   - **a.** Be appropriate for the member's diagnosis, clinical condition, illness, disease, injury, or symptoms

2. **Accepted Standards of Care**
   - **a.** Be consistent with nationally accepted evidence-based standards of medical practice (see Section "F" Below)

3. **Effectiveness**
   - **a.** Be supported by evidence demonstrating effectiveness on clinically meaningful improvement, maintenance, or prevention of deterioration in the member's health, functional status, or clinical condition.

4. **Safety**
   - **a.** Meets standards of safety and effectiveness generally recognized in the United States

5. **Not for Convenience**
   - **a.** Not be primarily for the convenience of the member, caregiver, family, or health care provider

6. **Appropriate Place of Service**
   - **a.** Care must be provided at the most appropriate place of service which can be safely and reasonably provided.

7. **Consideration of Alternatives**
   - **a.** When clinically appropriate alternatives are available, consideration may be given to treatments expected to achieve comparable health outcomes using the least intensive and most cost-effective professionally acceptable approach.

8. **Regulatory Status**

a. When applicable, medical devices, biologics, drugs, and other regulated products must have final marketing approval, clearance or authorization from the Food and Drug Administration (FDA) or other appropriate governmental regulatory authority.

9. Additional Requirements for Procedural Services

a. Procedures must be clinically and surgically appropriate for the member's condition or diagnosis based on nationally accepted, evidence-based standards; and

b. The member must be appropriately informed regarding risks, benefits, and appropriate alternatives consistent with accepted standards of informed consent; where applicable; and

c. Procedures must be medically appropriate based on evaluation and adequate management of relevant medical comorbidities and risk that may affect procedural safety, outcomes or complications (e.g., death).

C. Medical Necessity Determination Process

Medical necessity determinations are made in accordance with the following:

1. Applicable Criteria

a. Whether services or supplies are medically necessary is determined in accordance with applicable Priority Health medical and behavioral health policies, Federal and State laws, and/or regulations; or criteria developed by third party utilization management delegates that have been approved by Priority Health's Medical Affairs Committee.

2. Clinical Review Authority

a. Medical necessity determinations are made by a Priority Health Medical Director, or anyone acting at the medical director's direction, in consultation with other physicians, as appropriate.

b. Medical necessity determinations for behavioral health and substance use disorder services are made in accordance with Priority Health's Behavioral Health Department.

c. In the absence of applicable plan documents, medical policy, or technology review, coverage and medical necessity decisions will be based on medical director review.

i. Technology reviews, outlined in medical policy: Technology Assessment No. 91430, may include literature reviews, formal technology assessments, and inputs from providers

3. **Provider Recommendation**
    a. The fact that a provider prescribes, orders, recommends, or approves a service does not, in itself, establish that the service is medically necessary.

D. Coverage vs. Medical Necessity

1. **Medical Necessity and Coverage Are Distinct Determinations**
    a. The determination of whether a proposed service or supply is a covered benefit is independent of, and should not be confused with, the determination of whether the proposed service or supply is considered medically 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.

2. **Coverage Requirements**
    a. A determination that a service is medically necessary does not guarantee that the service is a covered benefit.
    b. Coverage is determined by:
        i. Applicable member-specific benefit plan documents
        ii. Applicable federal and state laws and/or regulations
        iii. Applicable Priority Health medical policies

E. Evidence-Based Standards

Medical necessity determinations are informed by the best available evidence and applied to the individual member's clinical circumstances. For purposes of this policy, generally accepted evidence-based standards of medical practice may include:

1. **Scientific Evidence**
    a. Peer-reviewed medical literature and scientific studies
    b. Systematic reviews and meta-analyses
    c. Randomized controlled trials
    d. Observational studies when higher-level evidence is not available

2. **Clinical Practice Guidance**
    a. Nationally recognized clinical practice guidelines
    b. Specialty society recommendations

3. **Regulatory and Governmental Sources**
    a. Governmental and regulatory guidance
    b. Technology assessments

4. **Reference Sources and Expert Opinion**
    a. Standard clinical reference sources
    b. Expert consensus when sufficient evidence is not available

5. **Application of Evidence**
    a. Medical necessity determinations are based on the best available evidence and the individual member's clinical circumstances
    b. Nationally recognized clinical practice guidelines are an important component of medical necessity determinations and help ensure alignment with current standards of care and evolving clinical evidence.

F. Exclusions

The following are generally not considered medically necessary, unless otherwise required by law, regulation, or benefit design:

1. **Cosmetic Services**
    a. Cosmetic therapies and procedures (services) primarily intended to change or restore appearance
    b. See medical policy: *Cosmetic and Reconstructive Surgery Procedures No. 91535*

2. **Experimental, Investigational, Unproven Services**
    a. Services considered experimental, investigational and/or unproven;
    b. See medical policy: *Experimental/Investigational/Unproven Care/ Benefit Exceptions No. 91117*

3. **Benefit Exclusions**
    a. Devices, drugs, procedures, services, supplies, or treatments that are excluded under the member's applicable benefit plan.
    b. See medical policy: *Experimental/Investigational/Unproven Care/ Benefit Exceptions No. 91117*

4. **Insufficient Evidence**
    a. Services that are not supported by credible scientific evidence

5. **Convenience Services**
    a. Services provided for convenience

6. **Non-Medical Services**
    a. Services requested for social, educational, vocational, legal, administrative, custodial, recreational, or other non-medical purposes.

7. **Luxury Treatment Programs**
    a. There is insufficient evidence to demonstrate that luxury treatment programs are superior to standard treatment programs or medically necessary.
    b. Luxury treatment programs are defined as treatment programs which offer resort-style amenities including, but not limited to, spas, health hydrotherapy services, nature cure clinics, resort-style geographic locations (e.g., secluded beach, mountain, or country setting) and experiences that are meant to integrate with and go beyond standard rehabilitative activities, such as fine dining, horseback riding, or recreational activities (e.g., swimming).

8. **Non-Evidence-Based Programs**
    a. Programs utilizing interventions that are not supported by a federal registry of evidence-based standards or established interventions. An example includes
        i. The Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices Resource Center.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

III. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

The U.S. Food and Drug Administration (FDA) regulates 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.

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

IV. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, 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, refer to the Priority Health Provider Manual.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

V. APPLICATION TO PRODUCTS

Coverage is subject to the 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); 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. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, 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

General

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6. National Comprehensive Cancer Network (NCCN). Guidelines and compendia as a health policy tool [Internet]. Plymouth Meeting (PA): NCCN; [date unknown] [cited 2026 Jul 1]. Available from: https://www.nccn.org/business-policy/policy-and-advocacy-program/policy-priorities/policy-priority-guidelines-as-a-health-policy-tool

APPENDIX A

(ICD-10 Exclusions)

The following ICD-10 Codes do not support medical necessity

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
Z04.9	Encounter for examination and observation for 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.

Services considered “Third Party” 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:

Z02.0 - Z02.9	Encounter for administrative examination
Z04.6	Encounter for general psychiatric examination, requested by authority

SUMMARY OF CHANGES

Deletions
- Removed outdated references.

Additions
- Added a safety requirement within the medical necessity criteria requiring services to meet generally accepted standards of safety and effectiveness.
- Added language under “Medical Necessity Determination Process”-clarifying that a provider recommendation alone does not establish medical necessity.
- Added a defined Evidence-Based Standards section describing the types of evidence used in medical necessity determinations, including scientific literature, clinical practice guidelines, governmental guidance, technology assessments, and expert consensus.
- Added exclusions for services lacking credible scientific evidence, convenience services, and non-medical services.
- Added language clarifying that medical necessity and coverage are separate determinations.

Changes
- Converted policy into new medical policy template.
- Updated policy structure to include separate sections for Definition of Medical Necessity, Medical Necessity Requirements, Medical Necessity Determination Process, Coverage vs. Medical Necessity, Evidence-Based Standards, Exclusions, CMS Coverage Determinations, and Regulatory Information.
- Updated references and supporting source materials used in policy development.

Clarifications
- Updated policy language for clarity and consistency.
- Clarified the criteria and framework used to evaluate medical necessity determinations.

Past committee review dates: 12/2001, 11/2002, 11/2003, 11/2004, 12/2005, 12/2006, 12/2007, 12/2008, 12/2009, 12/2010, 12/2011, 12/2012, 12/2013, 11/2014, 11/2015, 11/2016, 05/2017, 05/2018, 05/2019, 08/2019, 08/2020, 08/2021, 08/2022, 08/2023, 08/2024, 08/2025, 08/2026

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