Division of Insurance
SOUTH DAKOTA DEPT. OF LABOR & REGULATION

Health Care Bills:
Understanding Medical Necessity

What is medical necessity?

Typically, health insurance plans only provide benefits for treatments or services that are "medically necessary." So, what does that mean?

Your policy will define medically necessary. But usually "Medically necessary" or "medical necessity" means health care a prudent physician, using professional standards and judgment, would give a patient. These are services that:

- Evaluate, diagnose, or treat an illness, injury, disease, or its symptoms;
- Follow generally accepted standards of medical practice;
- Are "clinically appropriate," meaning the level of care would be effective to treat the patient's illness, injury, or disease;
- Aren't primarily for the convenience of the patient, health care provider, or insured's family;
- Don't cost more than another service or series of services that would be at least as effective; and
- Are not for experimental, investigational, or cosmetic purposes.

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

Medical necessity limits health insurance payments for cosmetic procedures, treatments that haven't been proven to be effective, or treatments that are more expensive than others that also are effective.

How is "medical necessity" determined?

A doctor's prescription or order for a service is the first evidence of medical necessity. If the insurer ask/s for more proof that the claim meets the standard for medical necessity, it may ask your doctor or other provider for a "Letter of Medical Necessity." The request for a letter typically is part of a "certification" or "utilization review" process. This process lets the insurer review medical services to decide if they cover the service. This can be done before, during, or after the treatment.

In a "precertification review," the insurer decides if the requested treatment satisfies the plan's requirements for medical necessity *before* the treatment is provided. The insurer typically reviews the Letter of Medical Necessity, medical records, and the plan's medical policy.

In a "concurrent review," the insurer decides if the treatment is medically necessary *while* it's ongoing.

In a "retrospective review," the insurer decides if services already provided were medically necessary or, in the case of emergency services, whether they truly required emergency care. The decision is made *after* you receive the treatment.

What are medical guidelines?

All insurers follow guidelines that determine if a treatment is within accepted standards in the medical community. An insurer must make its medical guidelines available to you if it used them to make a decision to deny you coverage.

Are experimental, investigational, or cosmetic services medically necessary?

Some definitions of medical necessity specifically exclude services for "experimental, investigational, or cosmetic purposes." An insurer's medical guidelines determine if a treatment is considered experimental for your condition. An insurer also follows its medical guidelines to decide if treatments that could be considered cosmetic also have a medical purpose. Insurers may use medical records to decide if services are medically necessary, but they also may base decisions on the available scientific literature.

Does medical necessity affect coverage for emergency services?

After you receive emergency services, insurers may review your care to decide if emergency care was appropriate for your diagnosis and medically necessary. To decide, insurers use a "prudent layperson" standard. Getting approval before you receive medical services (precertification) isn't necessary if a prudent layperson would believe there was an emergency condition and delaying treatment would make that condition worse.

If you have a dispute with your insurer about the amount or terms of the claim, contact the Division of Insurance for assistance.