Medical Necessity and Noncovered Services other than CPT Category III Noncovered Services

Origination: August 23, 2017
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Next Review: August, 2019

DEFINITION OF Medical Necessity
Medical necessity requires items and services to be safe and effective, consistent with generally accepted professional medical standards of care (e.g., not considered experimental or investigational) for the symptoms or diagnosis of the illness or injury under treatment, not provided primarily for the convenience of the member, the attending physician or other physician or supplier; and that the items or services be furnished at the most appropriate level that can be provided safely and effectively to the member.

POLICY STATEMENT
Coverage will be provided for each procedure(s) or service(s) when it is determined to be medically necessary when the medical criteria and guidelines shown below are met.

BENEFIT APPLICATION
Please refer to the member’s individual Evidence of Coverage (E.O.C.) for benefit determination. Coverage will be approved according to the E.O.C. limitations, if the criteria are met.

Coverage decisions will be made in accordance with:
- The Centers for Medicare & Medicaid Services (CMS) national coverage decisions;
- General coverage guidelines included in original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member’s particular Evidence of Coverage (E.O.C.), the E.O.C. always governs the determination of benefits.

INDICATIONS FOR COVERAGE

Not Applicable
WHEN COVERAGE WILL NOT BE APPROVED
1. Specific exclusion contained in the Medicare law (i.e. acupuncture);
2. Not proven safe and effective (not medically reasonable and necessary); or
3. Procedure that is always considered cosmetic in nature

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION
This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable codes: See procedure code for specific procedure or service.

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

SPECIAL NOTES
1. A list of Noncovered services without an assigned code can be found listed on LCD L36954 at www.cms.gov.

References:

Policy Implementation/Update Information:
Revision Date:

Approval Dates:
Medical Coverage Policy Committee: August 23, 2017

Policy Owner: Carolyn Wisecarver, RN, BSN
Medical Policy Coordinator