

Medical Necessity: What Is It?

My daughter's therapist has recommended that she have individual therapy once a week, but my health insurance plan informed me that they will not pay for these sessions because "they are not medically necessary." What does this mean?

Medical necessity is a term that health care plans use to determine whether a particular treatment, test or procedure is necessary for a patient's health or to treat a diagnosed medical problem and is consistent with generally accepted professional standards. Services that are considered not medically necessary will not be reimbursed. An example is California's definition of medical necessity for MediCal services – "treatment that is reasonable and necessary to prevent significant illness of disability, relieve severe pain, or save someone's life." Other health care plans have their own definition of what medically necessary is.

Not medically necessary is one of the more common reasons that health care plans give for denying services. This is particularly true for mental health and substance use abuse treatment services. In a survey conducted by the National Alliance on Mental Illness, treatment was deemed not medically necessary twice as often for mental health services as for medical services. Some plans have their own internally developed guidelines that are more restrictive than the generally accepted professional standards for mental health and substance use abuse treatment. These guidelines are considered proprietary and, therefore, difficult to access to determine the criteria used for denying services. In practice what happens is these guidelines attempt to quantify the outcomes of the treatment plan but do not take into consideration that treatment for mental health and substance use abuse conditions is unique and cannot be quantified in the same way as treatment for physical health conditions. For example, when looking at diabetes, high blood pressure and other medical conditions, objective information is available to the provider to assess the condition. When evaluating the severity of depression or the aftereffects of trauma, it is much more difficult to assess and empirically test a mental health symptom.

When an insurance plan denies coverage for a mental health or substance use abuse condition because it is not medically necessary, it is important to challenge that decision by appealing the decision. Nationwide more than 50 percent of appeals of denials of coverage or reimbursement are successful in favor of the covered individual. The California Department of Managed Health Care reports that a denial of coverage is overturned 60 percent of the time. Individuals may not win at the first level of appeal with the insurance company, but there is a high likelihood of success by persisting through the appeals process.

If you have any questions or concerns about your coverage, you can contact the Help Center for the Department of Managed Health Care at 1-888-466-2619 or www.HealthHelp.ca.gov.