Illinois Insurance Facts
Illinois Department of Insurance
Medical Necessity

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Whether you submit a claim after treatment or attempt to pre-certify a proposed treatment, insurance companies and HMOs will review that claim or pre-certification request to determine if the services are medically necessary. If the insurance company or HMO determines the service is not medically necessary, they will deny the claim or pre-certification request.

Almost all insurance companies and HMOs pay claims based upon the concept of medical necessity. This Fact Sheet explains what medical necessity means and how to appeal adverse decisions by your insurer or HMO.

What Is Medical Necessity?

"Medically Necessity" means health care services and supplies provided by a health care provider appropriate to the evaluation and treatment of disease, condition, illness or injury and consistent with the applicable standard of care, including the evaluation of experimental and/or investigational services, procedures, drugs or devices.

If you are a member of an HMO, or an insurance company that requires you to use a gatekeeper (primary care physician), your primary care physician is responsible for deciding if a proposed treatment or service is medically necessary. However, both the HMO and insurer may require the primary care physician to obtain approval from its Medical Director.

Examples of hospitalizations and other health care services and supplies that are not considered Medically Necessary include:

- Inpatient hospitalizations for treatment that could be safely and adequately provided on an outpatient basis;
- Continued inpatient hospital care, when the patient's medical symptoms and condition no longer required a continued stay in the hospital;
- Cosmetic surgery;
- Treatment provided for the convenience of the patient, such as an elective Caesarean Section;
- An advanced procedure or treatment provided without first trying less invasive, less expensive treatments.

Insurance companies and HMOs exclude coverage for treatment that is not medically necessary because they do not want to extend benefits for unnecessary treatment or for care that might be potentially dangerous or harmful to their member. Decisions as to what care and services are "necessary" are medical determinations based upon the opinion of the attending provider. The fact that your doctor prescribes a treatment or procedure does not mean the insurance company or HMO will agree that it is medically necessary.

Most major medical policies and all HMOs require that you pre-authorize elective inpatient hospital stays and major surgical procedures. Failure to pre-authorize the service can result in a

penalty or denial of the claim. If your policy requires pre-authorization, follow the proper procedure so you know whether or not coverage is available. If your policy does not require pre-authorization of the service, you will not know if it is covered until the claim is submitted.

NOTE: Preauthorization by an insurance company is not a guarantee that benefits will be paid. All policy provisions, such as preexisting condition waiting periods apply. Additionally, benefits are only payable if you are eligible for coverage on the date the service is provided.

How To Appeal A Denial Due To Medical Necessity

If an insurer or HMO denies a pre-authorization request or a claim due to lack of medical necessity, you may appeal the decision.

Internal appeal procedures are set forth within the Managed Care Reform and Patient Rights Act. You or your physician can file an oral or written appeal with the insurance company or HMO. For urgently needed treatment, the Act requires an insurer or HMO to request necessary information needed to evaluate the appeal within 24 hours and to render a decision within 24 hours after receipt of all required information. All other appeals must be handled within 15 business days of receipt of all necessary information.

Internal appeals must be conducted by a utilization review organization (URO) registered with the Department of Insurance. A list of registered UROs is available at http://www.insurance.illinois.gov/URO/UROlist.aspx. The following requirements apply to an internal appeal conducted by a URO:

- Review must be performed by a registered utilization review entity
- Review must be conducted within required time-frames
- Initial clinical review cannot be denied unless it is reviewed by a health care professional who holds a current license in the same licensure category as the ordering provider or as a doctor of medicine or osteopathic medicine
- Initial denial notice is in writing, and includes the principal reasons for denial, a statement that clinical rationale will be provided upon request, and instructions for appeal.
- Availability of a peer to peer conversation between the reviewer and your provider when care is determined not to be medically necessary;
- An appeal to the initial review is conducted within required time-frames
- Appeal reviewer must be conducted by a clinical peer, who is board certified, and is in the same profession and in a similar specialty as typically manages the medical condition
- Appeal reviewer cannot be the individual who made the original denial, nor the subordinate of that individual.

If the appeal is denied, you are entitled to an external independent review. Information regarding external independent review requirements is available on our fact sheet entitled, Independent Review of Denied Health Insurance Claims at http://insurance.illinois.gov/ExternalReview/Fact_sheet.pdf.

For More Information

Call theOffice of Consumer Health Insurance (OCHI) toll free at (877)527-9431
or visit us on our website at http://www.insurance.illinois.gov/

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