

[All Articles](#)

# Medical Necessity: How It's Decided, and What Improves Your Chances of Approval

## CONTENTS

[What Is Medical Necessity?](#)  
[What Reviewers Look For in Medical Records](#)  
[How Medical Necessity Affects Insurance Coverage](#)  
[Why Insurance Denies Care as Not Medically Necessary](#)  
[How Medical Necessity Decisions Play Out in Real Situations](#)  
  
[How Advocates Strengthen Medical Necessity Requests Through Documentation](#)  
[How Appeals and Reconsideration Work](#)  
[Special Situations Where Advocacy Matters Even More](#)  
  
[You Don't Have to Navigate Medical Necessity Alone](#)  
[FAQ: Frequently Asked Questions About Medical Necessity](#)

## KEY POINTS

- **Medical necessity determines coverage:** Insurance companies decide whether to approve tests, treatments, medications, or equipment based on clinical guidelines and insurance policies.
- **Documentation drives decisions:** Reviewers rely on medical records, diagnostic results, and evidence-based medicine to decide whether a service is clinically appropriate.
- **Denials often relate to process:** Missing documentation, prior authorization requirements, cost considerations, or step therapy rules frequently lead to denied claims.
- **Advocacy can change the outcome:** Clear alignment with medical guidelines, complete records, and timely appeals or reconsideration requests can strengthen a medical necessity determination.

When patients are told something is "not medically necessary," it can feel upsetting and confusing. You may think, "My doctor recommended this. Why won't my insurance pay for it?" The phrase often appears without a clear explanation, even though it can determine whether care moves forward.

Medical necessity is the standard that insurance companies use to make coverage decisions about tests, treatments, medications, and equipment. It is a determination about whether a request meets specific clinical guidelines and insurance policies.

Medical necessity affects nearly every coverage decision. It shapes approvals, delays, and denials. This article will walk you through what medical necessity means, how decisions are made, and how having an advocate can make the process easier.



## What Is Medical Necessity?

Insurance companies use a formal clinical definition of medical necessity. In plain language, they ask whether the service is clinically appropriate and supported by generally accepted standards of medical practice.

In other words, they want to know:

- Is this treatment right for this condition?
- Is it supported by medical science?
- Is it expected to help this patient?

These decisions rely on prudent clinical judgment and whether the treatment is likely to show effectiveness for the patient's illness. It should address a real health problem.

This is where context matters. Your daily symptoms, how long you have been struggling, and what treatments you have already tried all help show that there is a true deviation from normal wellbeing. Advocates help translate medical language into your real-life story so reviewers understand what you are actually going through.

## What Reviewers Look For in Medical Records

A medical necessity determination is usually made by a reviewer who works for your insurer. That reviewer performs a medical records review. They read your doctor's notes, look at test results, and compare your case to evidence-based medicine. Most of this information is pulled from electronic medical records and other documentation systems, which are governed by HIPAA privacy rules that control how health information is shared. They may rely on published scientific research and other scientific literature when reviewing your case.

Most of the time, this is done through retrospective review. That means the reviewer looks only at paperwork. They do not meet you in person. Because of this, decisions are sometimes made without seeing the full picture. If your records are incomplete or unclear, the reviewer may not understand how serious your situation is.

Advocates make sure your documentation, history, and personal context are complete and clearly presented.



## How Medical Necessity Affects Insurance Coverage

Medical necessity is closely tied to your insurance coverage. Some services require a prior authorization review before they can be provided, meaning the insurance company must approve the request in advance. Other services are reviewed after care has already been delivered.

For people with Medicare, the Centers for Medicare and Medicaid Services (CMS) establishes national coverage rules through its National and Local Coverage Determinations (NCDs and LCDs), which define when specific services meet medical necessity criteria. These policies outline when care is covered, when additional documentation is required, and when certain services fall under Medicare exclusions.

Private insurance plans often rely on their own medical policies, which may differ from Medicare standards and vary significantly between insurers.

Sometimes your doctor may write a letter of medical necessity explaining how your care aligns with accepted standards of medical practice and the insurer's written criteria. Understanding these requirements in advance can help prevent delays. Advocates help patients clarify what documentation is needed before a coverage decision is made.

## Why Insurance Denies Care as Not Medically Necessary

Denied claims can feel very discouraging. In many cases, the care itself is not the problem. Common reasons include:

- missing documentation
- incomplete diagnostic results
- not meeting specific pre-authorization requirements

Sometimes the insurance company believes an alternative service should be tried first. Cost considerations can also play a role. Insurance plans may compare relative costs between treatments and prefer lower-cost options when possible. Often, the issue is not whether the treatment could help. The issue is whether the paperwork clearly shows it meets medical necessity rules.

## How Medical Necessity Decisions Play Out in Real Situations

Medical necessity rules can feel abstract. In practice, they often show up in situations like these:

**An MRI for lower back pain**

A patient with new lower back pain requests an MRI right away. Many insurance policies require conservative treatment first, such as physical therapy or medication, unless diagnostic results suggest nerve damage or significant deterioration in health. If documentation does not show serious warning signs, the request may be denied during prior authorization review.

#### **Additional physical therapy sessions**

A plan may approve a set number of visits. If improvement is slower than expected, the provider must document therapeutic results and explain why continued care remains clinically appropriate under generally accepted standards of medical practice. Without that documentation, additional visits may not meet medical necessity rules.

#### **Step therapy for prescription medications**

Some plans require patients to try an alternative service, often a lower-cost drug, before approving a newer medication. This relates to cost considerations and relative costs between treatment options. If the first medication fails or causes side effects, a new request can be submitted with updated medical records showing why a different option is medically necessary.

#### **Cosmetic versus functional procedures**

Cosmetic treatments are typically excluded from coverage. However, a procedure that appears cosmetic may be covered if it addresses a medical standard such as impaired vision or significant functional limitation. Clear documentation helps distinguish convenience of the patient from treatment for a true health condition.

#### **Experimental or investigational treatments**

Experimental treatments often face stricter scrutiny. Reviewers may look for published scientific research, comparative effectiveness data, or formal cost-effectiveness analysis before approving newer therapies. If strong scientific literature supports the request, that evidence can strengthen an appeal.

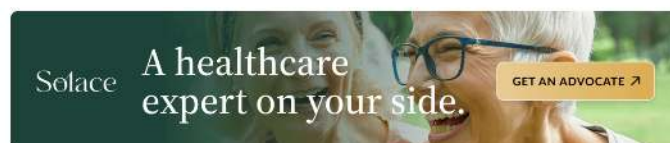
In each of these examples, the decision usually does not hinge on whether care might help. It hinges on whether the request clearly aligns with professional guidelines, medical standards, and the insurer's written insurance policies.



## How Advocates Strengthen Medical Necessity Requests Through Documentation

Advocates play a key role in strengthening medical necessity reviews. They help gather and organize medical records so nothing important is missing. They make sure the request aligns with medical guidelines and reflects evidence-based medicine.

They also work with providers to clarify therapeutic results and ensure the documentation reflects an individual assessment of your condition. This means your unique situation is clearly explained, not just listed in general terms. When the case is clear and organized, it is easier for reviewers to understand why the service is needed.



## How Appeals and Reconsideration Work

If you receive a denial, you usually have the right to file an appeal or request reconsideration. An appeal allows your case to be reviewed again. You can submit additional medical records, provide more explanation, or ask for another review.

In some situations, the review can move to a federal level, especially for certain government programs. Many denied claims are approved after more information is provided. Advocates

guide patients through this process. They track deadlines, gather documents, and support communication with the insurance company until a new coverage decision is made.

## Special Situations Where Advocacy Matters Even More

Some situations are reviewed under different medical necessity rules.

### Emergency services

Emergency care is often judged using the prudent layperson standard. This means services are covered if a reasonable person would believe the situation was an emergency at the time, even if the final diagnosis turns out to be less serious.

### Experimental or investigational treatments

Experimental treatments face stricter review because there may be less established research supporting them. Reviewers may look closely at published scientific literature, comparative effectiveness data, or professional guidelines before approving newer therapies.

### Mental health services and inpatient care

Mental health services are evaluated under the same medical necessity rules as physical healthcare, but they can involve additional layers of oversight. Federal parity laws require many insurance plans to apply comparable standards to mental health and medical or surgical benefits. Even so, insurers may use concurrent review for inpatient care, reassessing treatment at regular intervals to determine whether continued hospitalization remains clinically appropriate. Documentation must clearly show risk, symptom severity, and progress toward therapeutic results.

### State-level variation

There can also be state-level variations in Medicaid programs and differences between insurance policies. What is covered in one state may not be covered in another.

In these more complex situations, an advocate's support can make a meaningful difference.



## You Don't Have to Navigate Medical Necessity Alone

Medical necessity decisions are rarely simple. They depend on documentation, medical guidelines, insurance policies, and how clearly your story is told. A [patient advocate](#) cannot promise approval. But they can strengthen how your case is presented, [make sure your records align](#) with coverage criteria, and help you respond strategically if a request is questioned or denied.

Getting help early can protect access to healthcare and support better health outcomes. It can also reduce stress and prevent small issues from turning into bigger delays. If you are facing confusion, a delay, or denied claims, know that you do not have to manage it alone. An advocate can make the process clearer, calmer, and more manageable.

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FAQ: Frequently Asked Questions About Medical Necessity

### What does “not medically necessary” actually mean?

When a service is labeled “not medically necessary,” it means the insurer determined that the request did not meet its clinical guidelines or insurance policies. The decision is based on written criteria, medical records, and evidence-based medicine, not simply on whether a provider recommended the treatment.

### Who makes a medical necessity determination?

Medical necessity determinations are typically made by reviewers working for the insurance company. They conduct a medical records review, compare documentation to professional guidelines and scientific literature, and decide whether the service is clinically appropriate under the plan’s rules.

### Why are services denied even if my doctor recommends them?

A physician’s recommendation does not automatically satisfy insurance requirements. Denied claims often result from missing documentation, unmet prior authorization requirements, step therapy rules, or failure to meet defined coverage criteria. Insurers may also weigh cost considerations or require an alternative service before approving a more expensive option.

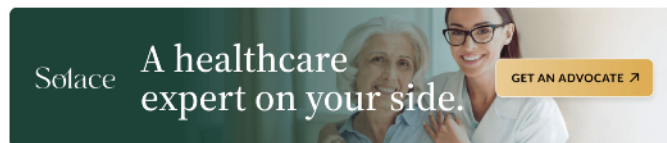
### Can a denial for lack of medical necessity be appealed?

Yes. Most insurance plans allow an appeal or request for reconsideration. Submitting additional medical records, updated diagnostic results, or clarification from your provider can sometimes change a coverage decision. In certain cases, especially within Medicare plans, the review may move to a higher or federal level.

### How can a patient advocate help with medical necessity reviews?

A patient advocate can organize medical records, clarify documentation, align requests with medical guidelines, and coordinate appeals when needed. By strengthening how your case is presented, advocacy can influence how a medical necessity determination is evaluated and reduce delays in care.

*This article is for informational purposes only and does not replace medical advice. Information is subject to change. For medical guidance, consult your healthcare provider.*



#### REFERENCES

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Dr. Andrew Hwang is a Family Medicine physician at Solace who has spent over two decades working within the healthcare system—first as a medical student and resident, then as a practicing physician for more than 12 years. A graduate of the University of Kansas School of Medicine, he’s witnessed firsthand how often patients struggle to access the care they need, particularly those from underserved communities. These experiences fuel his passion for patient advocacy and his commitment to helping every person he meets through his work at Solace.

When he’s not helping patients navigate the healthcare system, Dr. Hwang enjoys golfing, playing bass guitar, and spending time with his cats. His down-to-earth approach and genuine care for others reflect his belief that everyone deserves compassionate, accessible healthcare—and someone in their corner to help make it happen.

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