



**MEDICAL POLICY
No. 91086-R5**

COMPLICATIONS TO NON-COVERED CARE

Effective Date: August 1, 2006

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Date Of Origin: June 30, 1988

Status: Current

I. POLICY/CRITERIA

Complications to non-covered care are covered if determined to be medically necessary.

- A. Care or services normally expected to precede or follow non-covered care are not a covered benefit. Services that are normally performed as part of the non-covered care (e.g., laparoscopy with GIFT) are not a covered benefit, regardless of the reason for the service.
- B. Treatment of unexpected medical complications of non-covered care (e.g., post-operative bleeding, wound infection, allergic reaction to tattooing) is a covered benefit.
- C. The medical director will determine, on a case-by-case basis, when coverage resumes following non-covered care.

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the [Priority Health Provider Manual](#).

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*

- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.*

IV. CODING INFORMATION

These codes may define the conditions described within this policy and should not be considered inclusive:

ICD-10 Codes

H59.88	Other intraoperative complications of eye and adnexa, not elsewhere classified
H59.89	Other post procedural complications and disorders of eye and adnexa, not elsewhere classified
L76.81 - L76.82	Other intraoperative and post procedural complications of skin and subcutaneous tissue
M96.89	Other intraoperative and post procedural complications and disorders of the musculoskeletal system
N98.0 - N98.9	Complications associated with artificial fertilization
T80.0xxA - T80A9XS	Complications following infusion, transfusion and therapeutic injection
T81.10xA - T81.9xxS	Complications of procedures, not elsewhere classified
T85.01xA – T85.9xxS	Complications of other internal prosthetic devices, implants and grafts
T88.0xxA – T88. 9xxS	Other complications of surgical and medical care, not elsewhere classified

Special Note: *See "Experimental/Investigational/Unproven Care/Benefit Exceptions" Policy.*

AMA CPT Copyright Statement:

All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.