

To:
Occupational
Therapists
Physical
Therapists
Rehabilitation
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Speech and
Hearing Clinics
Speech-Language
Pathologists
Therapy Groups
HMOs and Other
Managed Care
Programs

How “medically necessary” is applied when evaluating prior authorization requests for therapy services

This *Wisconsin Medicaid and BadgerCare Update* contains information about how the definition of medical necessity is specifically applied to prior authorization (PA) requests for physical, occupational, and speech language therapy services. Refer to the November 2001 *Update* for general information regarding the PA review process.

Introduction

The November 2001 *Wisconsin Medicaid and BadgerCare Update* provided information regarding the term “medically necessary” as defined in Wisconsin Administrative Code, as well as additional general information related to the prior authorization (PA) review process.

The purpose of this *Update* is to provide further guidance on how the definition of medical necessity is specifically applied to physical, occupational, and speech therapy services.

Application of medical necessity to prior authorization requests

Wisconsin Medicaid relies on its definition of medical necessity to determine whether a particular item, service, or procedure may be paid for with Medicaid funds.

Wisconsin Medicaid uses the PA process to determine medical necessity and to

assure that appropriate therapy services are provided to Medicaid participants. Wisconsin Medicaid uses the standards of medical necessity to assist in defining thresholds for decision making. It is important to remember that Wisconsin Medicaid may only approve a PA request if all the standards of the definition of medical necessity are met.

Health care professionals licensed in physical therapy, occupational therapy, and speech language pathology employed by the Medicaid program apply the definition of medical necessity in HFS 101.03(96m), Wis. Admin. Code, on a case-specific basis. These standards permit incorporation of individualized risks, benefits, and preferences and also allow for reasonable differences in providers’ judgments and beliefs about available treatments. Refer to Attachment 1 of this *Update* for the complete definition of medically necessary under HFS 101.03(96m), Wis. Admin. Code.

The determination of medical necessity is based on the documentation submitted by the provider. Therefore, it is essential that the information be complete, accurate, and specific to each individual’s current condition and needs to justify the service requested.

On a PA request for therapy services, Wisconsin Medicaid consultants look for:

- A comprehensive assessment that identifies potentially remediable impairments and objectively measures functional skills and performance.
- An individualized plan of care that addresses the patient's specific set of problems.
- An identification of the expected outcomes of intervention.
- An expectation of how long it will take to achieve the desired outcomes, including requested frequency and duration of intervention and discharge criteria.

This comprehensive information about the individual helps to establish the functional potential of the recipient and forms the basis for determining whether the recipient will benefit from treatment. Medicaid consultants rely on this written documentation as a critical part of the determination of medical necessity. The information provided in the PA request is reviewed to determine whether or not therapy services provided at a certain point in time will be effective in achieving predictable, demonstrable, and attainable results to each individual in a cost-effective manner. The focus of medically necessary therapy services in the Wisconsin Medicaid program is on intervention activities designed to produce specific outcomes. These outcomes should have a functional basis.

Each PA request presents an individual-specific situation and circumstance and is reviewed on the facts of the case. No single factor such as diagnosis or age of the recipient will result in immediate approval or automatic denial of a PA request for therapy services.

In 96% of the PA requests adjudicated for therapy services, providers document in sufficient detail to justify the medical necessity of the therapy service.

Common reasons given for Medicaid therapy consultants' findings of lack of medical necessity include:

- Documentation fails to support that intervention by a skilled professional is needed.
- Baseline performance is not documented in terms of current level of function or skills of the individual.
- Clinical information is not provided in sufficient detail to suggest that treatment goals are reasonable given the current age and health status of the individual, or that attainment of the goals would result in predictable functional improvement to the individual.
- Individual has failed to make progress toward the targeted goals and objectives in a reasonable time period and the therapist has not modified the treatment plan or objectives in spite of the anticipated outcomes not being achieved.

It is essential that providers review each PA request before submission to ensure that it includes the critical information necessary to support the request, in compliance with Wisconsin Medicaid's definition of medical necessity as it is defined in the administrative code.

Before submitting a PA request it is important that the following questions are considered and answered in the PA request:

- What specific results are expected from this intervention?

- What factors led to the determination that this intervention is necessary?
- What unique skills of a therapist are required to meet the goals in the plan of care?
- Are there other, more cost-effective means available to meet the individual’s needs?

Attachment 2 is a list of general principles for providers to consult when they are submitting PA requests.

Examples of how “medically necessary” is applied to prior authorization requests

The following information and case examples are offered to illustrate how the standards of “medically necessary,” as defined in HFS 101.03(96m), Wis. Admin. Code, are applied by Medicaid therapy consultants when adjudicating PA requests.

HFS 101.03(96m)(a) — Required to prevent, identify or treat a recipient’s illness, injury or disability;

Example 1: Many individuals having the same diagnosis may have certain characteristics in common; however, the physical expression and functional severity of their conditions can vary greatly. As a result, documentation in the PA request must include a medical diagnosis as well as a problem statement (treatment diagnosis) related to the medical diagnosis that identifies the specific treatment needs of the individual.

For example, physical therapy (PT) is requested for a four-year-old child with spastic diplegic cerebral palsy and a gross motor age equivalency of 44-48 months. A plan of care to address “continued development of age-appropriate mobility skills” would not meet the

Medicaid application of this standard because no impairments, functional limitations, or disabilities have been identified. The reviewer would question how the requested service treats an illness, injury, or disability. If the therapist identified tight hamstrings but provided no evidence that hamstring contractures were causing any functional problems, the same questions remain.

If instead, the physical therapist’s evaluation identified functional limitations including problems with climbing, frequent falls when walking from the bus to home, or other restrictions in outdoor mobility due to tight hamstrings, it may be appropriate to authorize a limited course of PT. In this case, PT may be necessary to improve dynamic range of motion and lower extremity strength, to facilitate functional skill acquisition, and to educate the recipient/caregivers on a home program including recommendations about when to seek medical attention for developing problems, such as worsening contractures.

Example 2: A nine-year-old is an independent household ambulator and presents with hypotonic trunk muscles. He has been receiving occupational therapy (OT) for the past six months. The new PA request includes continued treatment strategies of trunk elongation and rib cage mobilization with ongoing goals of preparing for strengthening/stability exercises and preventing frequent respiratory infections. No documentation of trunk range of motion, upper body strength testing, or frequency of respiratory infection is provided.

Measurable goals reflect treatment that is expected to reduce identified impairments, produce sustained changes in function, and are

necessary to describe how treatment will affect injury, illness, or disability. The medical necessity of the plan of care would be questioned because no deficits are reported and no evidence is provided to support that soft tissue mobilization has resulted or would likely result in any sustainable change in the client's trunk control or any improvement in functional performance over time. The PA documentation does not support that a correlation exists between improving rib cage mobility and decreasing the client's susceptibility to respiratory infections. The PA request would be returned requesting this additional information.

Example 3: A PA is submitted for speech and language therapy for a four-year-old child. The child only speaks at home and was referred by the family doctor for a speech and language assessment. The standardized/non-standardized tests performed by the therapist indicate that the child's receptive and expressive language skills are age appropriate. The PA requests therapy twice per week to improve the recipient's social language skills. In this situation, the Medicaid consultant may question if the services of a speech-language pathologist are required, since the standardized tests indicate the child's language skills are age appropriate and did not identify an injury, illness, or disability potentially remediable by a speech-language pathologist.

HFS 101.03(96m)(b)1 — Meets the following standards: Is consistent with the recipient's symptoms, or with the prevention, diagnosis or treatment of the recipient's illness, injury or disability;

Example 1: The client is a 35-year-old with cerebral palsy who is seven weeks post ankle fusion. Prior to surgery, she had been able to ambulate with a walker in her home. The PA

request includes a physical therapy plan of care to assess and/or teach transfer skills and evaluate orthotics and equipment needs. This plan of care reflects a situation where episodic therapy is warranted to maximize functional capacity following an orthopedic intervention. This PA request would be approved because it is consistent with treatment of the client's recent change in medical condition.

Example 2: A 16-year-old with a remote history of anoxic brain injury is dependent for all activities of daily living (ADLs). An OT PA request is submitted to increase head control at midline from the recipient's current level of 3-5 seconds to 5-10 seconds. No progress has been documented in this area following extensive intervention to improve head control. When functional limitations persist for long periods and have not been remediable, compensatory strategies may be more appropriate. The PA request would be returned for additional information to support the benefit of continued direct treatment for improving head control as an effective or functional intervention.

Example 3: A PA is submitted for speech and language therapy for a 45-year-old client diagnosed with mental retardation, emotional disturbance, and seizure disorder. His sheltered workshop supervisor referred the client for a speech evaluation because over the past two months, both workshop staff and home caregivers have had difficulties understanding him due to decreased speaking rate and slurred speech. Upon assessment, the client's speech regression appears to coincide with the start of a new medication.

Without additional information, the Medicaid consultant would return the PA questioning whether the client's decreased intelligibility may

be related to the medication. Documentation of sufficient clinical information may then result in approval of speech therapy for a brief episode of care to improve intelligibility.

HFS 101.03(96m)(b)2 — Is provided consistent with the standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

Example 1: A PA request for sensory integration therapy is submitted for a nine-year-old with pervasive developmental disorder (PDD). Goals include decreased behavioral outbursts in natural environments like a noisy gym or shopping mall, improved sleeping patterns, and better ability to “self regulate.” The PA would be returned asking the provider to explain how skills learned in therapy would be generalized from the controlled environment of the clinic setting to the child’s natural environment(s) of home, school, or community. The Medicaid consultant may further question whether these issues would be more appropriately addressed by a behavioral therapist or through a consistent behavioral management home program.

HFS 101.03(96m)(b)3 — Is appropriate with regard to generally accepted standards of medical practice;

Example 1: A PA is submitted with the therapist reporting that an individual is “not testable” or with the majority of the therapy evaluation obtained from unstructured observation or from other sources. If the treating therapist is unable to establish an individual’s baseline functional skills and limitations, it will be impossible to later evaluate and document any changes that may result from therapeutic intervention. Initiating treatment without performing a comprehensive

assessment that includes baseline measurements of the individual’s abilities and physical impairments is not appropriate with regard to generally accepted standards of practice. If a problem area is not/cannot be tested during the initial evaluation, it should be explained why data could not be obtained and that subsequent PAs will contain baseline data for reported problem areas as well as interval progress. This PA would be returned asking for additional information.

Example 2: An occupational therapist or speech-language pathologist working with a child with a history of dysphagia submits a PA request with a goal for the child to tolerate a wider variety of foods. No clinical assessment of the child’s oral motor/swallowing skills or results from a radiological swallow study have been documented to indicate that the proposed oral intake is safe. The PA request would be returned requesting this additional clinical information to assure that the treatment goals are appropriate.

HFS 101.03(96m)(b)4 — Is not medically contraindicated with regard to the recipient’s diagnosis, the recipient’s symptoms or other medically necessary services being provided to the recipient;

Example 1: An 85-year-old is eight weeks post hip fracture with subsequent open reduction and internal fixation. The plan of care submitted with the PA includes goals of transferring with assistive device, achieving independence on stairs, and increasing unilateral weight bearing for improved balance, strength, and endurance while walking. No weight bearing restrictions or hip precautions are included in the information submitted. In the absence of this standard medical information, the reviewer may question whether the goals are appropriate (or possibly

contraindicated) depending on the recommended post-operative hip precautions. Also, the requested frequency or intensity of therapy may be inappropriate depending on the recipient's weight bearing status.

Example 2: For a recipient with the recent onset of dysphagia and a swallow study that indicates aspiration, an oral motor evaluation and initial course of treatment is medically necessary to see if swallowing abilities can be improved. If a subsequent request is submitted that indicates the individual has been unable to maintain his/her weight with oral feedings or if clinical signs of aspiration such as cough or respiratory infection persist, then continued speech therapy to address improving oral feeding skills without assessing the need for further dietary modifications (change in liquid/solid consistency) may be medically contraindicated. This PA would be returned for additional clinical information to support the safety of the requested therapy.

HFS 101.03(96m)(b)5 — Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;

In assessing whether a service is experimental in nature, the Department of Health and Family Services shall consider whether the service is a proven effective treatment for the condition for which it is intended or used, as evidenced by:

- The current and historical judgment of the medical community (as reflected by medical research, studies, or publications in peer-reviewed journals);
- The extent to which other health insurers provide coverage for the service;
- The current judgment of experts or specialists in the medical area which the service is to be used; and

- The judgment of the Wisconsin Medicaid Medical Audit Committee of the Wisconsin Medical Society or of any other committee which may be under contract with the department as identified in Wisconsin Administrative Code.

The following interventions have been determined to be experimental: Facilitated Communication and Auditory Integration Therapy. The Wisconsin Medical Society has also determined that electrical stimulation for the treatment of open wounds can only be applied to Stage III or IV decubiti. Prior authorization for continued treatment is considered only if granulation tissue has formed or a 25% reduction in the affected area has occurred within 45 days of initiating electrical stimulation. Any PA request for electrical stimulation that falls outside these parameters is considered unproven and would be denied.

HFS 101.03(96m)(b)6 — Is not duplicative with respect to other services being provided to the recipient;

Example 1: A 78-year-old with a diagnosis of Alzheimer's disease resides in a nursing home that specializes in the care of Alzheimer patients. The client transfers with moderate assistance and receives physical therapy two times per week for gait training and to improve transfer skills. The client's transfer and ambulation skills have not progressed over the past month and the nursing staff has been instructed in safe transfer and ambulation techniques. The PT plan of care recommends continued PT services designed to maintain the client's abilities, stating that the client requires the skills of a therapist because she has Alzheimer's. Caregivers who have been properly instructed by a physical therapist

regarding the client's unique set of problems should be skilled in working with this patient. Therefore, this PA request would be denied because it is duplicative to the client's maintenance care program.

Example 2: A child with autism is receiving intensive behavioral services with treatment goals of improved peer play, turn taking, sharing, and concentrating on conversation. The OT PA request includes goals for the child to participate in a group game following rules with proper sequencing and attention to task. In this case, the requested therapy is not coordinated with the goals and activities of all other medical, educational, and vocational disciplines involved with the client. The clinical intent of both services appears to be directed toward achieving the same outcome. Therefore, the PA request would be returned for clarification.

Example 3: A PA request is submitted for speech and language therapy for a six-year-old child diagnosed with developmental delays and dysphagia. All of the child's nutrition is provided by mouth. The diet is modified to ground consistency solids and thickened liquids. The child currently receives speech therapy at school and the Individualized Education Plan (IEP) includes facilitation of oral motor exercises supervised by an aide five times per week for 20-30 minute sessions. The school speech therapist re-evaluates the child's oral motor skills monthly. The plan of care submitted by the community-based provider focuses on oral motor exercises. In this situation, the Medicaid consultant may question if the requested speech therapy is duplicative of the services being performed in the school.

HFS 101.03(96m)(b)7 — Is not solely for the convenience of the recipient, the recipient's family or a provider;

Example 1: A child with a history of traumatic brain injury receives PT services at school during the academic year. The IEP does not include recommendations for Extended School Year (ESY) PT over the summer months. Physical therapy services are being requested at a community-based clinic during the summer because, without therapy, the client's day lacks structured activities. Unless the services being requested require the professional skills of a therapist, the request may be viewed as an alternative to recreational or other community-based activities and appears to be submitted solely for convenience.

Example 2: An OT PA request is submitted to provide range of motion and strengthening. The individual has skills that are sufficient to perform the program at home with supervision or in a community or recreational setting. In this case, the PA would be returned for additional information to explain why the skills of a therapist are required.

Example 3: A PA request is submitted for speech therapy for a 38-year-old diagnosed with developmental delays. The client lives in a group home and communicates with an augmentative communication device. Previous therapy and product manuals have been provided for the client and caregivers to program and use the device. The PA requests speech therapy services for the purpose of creating a new communication page for the device. In this case, the Medicaid consultant would question if the service being requested is solely for convenience and if the client's

caregiver or a family member familiar with the device could create a new page.

HFS 101.03(96m)(b)8 — With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

Example 1: A physical therapist has requested therapy services three times per week to work on a plan of care that is focused on repetition of skills to build endurance. A PA request for PT services at this frequency would be modified or denied. It would be more cost-effective for the client to work on building endurance through a home exercise program. Modification would allow the therapist to monitor the client's progress and to revise the home program as needed, instead of providing direct therapy to work on repetition of an already achieved skill. Programs that involve ongoing muscle strengthening and fitness often involve instructing the client to carry out activities independent of assistance or stressing recreational activities that encourage mobility and reinforce functional movement.

Example 2: An OT request is received to provide range of motion for a client who resides in a nursing home. A restorative nursing plan is in place and meets the functional needs of this individual. The therapy plan of care being requested does not include more advanced functional outcomes, requiring the skills of a therapist. Occupational therapy services, in addition to restorative nursing, are not cost-effective and the PA request would be denied.

HFS 101.03(96m)(b)9 — Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient;

Example 1: A 10-year-old child with cerebral palsy has received many years of OT. His current level of functional upper extremity dressing skills includes the ability to push his arm through his sleeve only when the shirt is held over his head and the sleeve is held in place for him. No volitional grasp or release is demonstrated. The OT plan of care is submitted for ongoing direct treatment to improve independent living skills. For this individual, it appears that he has reached a plateau, that no functional gains in upper extremity dressing skills can reasonably be anticipated, and that compensatory strategies and equipment are the most appropriate level of service that can be effectively provided. The direct skills of an occupational therapist may no longer be necessary at this time to maximize his functional performance. A more appropriate level of service may be provided by an occupational therapist on a consultative basis to monitor compensatory strategies and equipment and to evaluate further direct OT needs.

Example 2: A PA is submitted for speech and language therapy to improve intelligibility in a nine-year-old child with a diagnosis of dyskinetic cerebral palsy. A review of the child's extensive therapy history indicates that there has been little functional improvement in the child's intelligibility. Standardized tests and subjective reporting also indicate that the child's intelligibility has not changed appreciably in three years despite receiving both school and community-based speech therapy services. The child has acquired an augmentative communication device to supplement his

speech. In this situation, the Medicaid consultant would question if community-based speech therapy focused on improving intelligibility remains the most appropriate level of service that can effectively be provided to this recipient.

Relationship of medical necessity definition to clinical practice principles

In conclusion, therapy services reimbursed by Wisconsin Medicaid reflect the following principles of clinical therapy practice:

- An intervention plan should not be based solely on the presence of a medical diagnosis.
- Frequency or duration of treatment is determined by rate of change as a result of therapy, rather than level of severity¹.
- Decisions about direct service intervention are contingent on timely monitoring of patient/client response and progress made toward achieving the anticipated goals and expected outcomes².
- The need for the service has been determined by the primary caregivers working together on behalf of the individual.
- Families/caregivers affect the priorities for intervention through their direct and proactive participation in the therapeutic process and should be encouraged to participate in all treatment decisions.
- Intervention is unlikely to promote lasting functional improvements if the only opportunity to develop new skills occurs during sessions with the therapist.

¹ American Occupational Therapy Association (AOTA).

² Guide to Physical Therapy, 2001 American Physical Therapy Association, p. 46.

- Therapeutic intervention strategies include an educational focus and home program that enables the family/caregiver and eventually the individual to facilitate and reinforce long-term gains.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at www.dhfs.state.wi.us/medicaid/.

ATTACHMENT 1

Definition of "medically necessary"

As defined under HFS 101.03(96m), Wis. Admin. Code, "medically necessary" means a medical assistance service under ch. HFS 107 that is:

HFS 101.03(96m)(a)

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

HFS 101.03(96m)(b)

(b) Meets the following standards:

HFS 101.03(96m)(b)1

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

HFS 101.03(96m)(b)2

2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

HFS 101.03(96m)(b)3

3. Is appropriate with regard to generally accepted standards of medical practice;

HFS 101.03(96m)(b)4

4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

HFS 101.03(96m)(b)5

5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;

HFS 101.03(96m)(b)6

6. Is not duplicative with respect to other services being provided to the recipient;

HFS 101.03(96m)(b)7

7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

HFS 101.03(96m)(b)8

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

HFS 101.03(96m)(b)9

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

ATTACHMENT 2

Wisconsin Medicaid general principles for therapy prior authorization requests

The prompts listed below are intended for use by physical, occupational, and speech therapists in their review of each prior authorization (PA) request before submission to Wisconsin Medicaid. It is essential that the documentation submitted includes the critical concepts necessary to support the individual request, and complies with Wisconsin Medicaid's definition of medically necessary as defined in Wisconsin Administrative Code.

- Documentation includes a **medical diagnosis** as well as a **problem statement** (treatment diagnosis) that identifies the specific treatment needs of the individual.
- Clinical information is provided in sufficient detail to support that treatment goals are reasonable given the current age and health status of the individual, and that attainment of the goals would result in **predictable and functional improvement** to the individual.
- **Baseline performance** is documented in terms of current level of function or skills achieved.
- Progress is described in objective, measurable terms that demonstrate the **desired outcome from therapy** in terms of functional improvements that can be generalized to settings outside the immediate treatment environment.
- The information provided should establish the **functional abilities** and limitations of the individual.
- Plan of care is **individualized** and addresses the recipient's specific set of problems.
- Therapy is **coordinated** with the goals and activities of all other medical, educational, and vocational disciplines involved with the individual.
- Therapy services requested are cost-effective when compared to other services available to assist the individual in achieving or maintaining sufficient functional ability to perform daily activities appropriate to his or her level of development.
- **Short-term objectives** should be written in terms of realistic skills attainable by the end of the requested PA.
- **Long-term objectives** should describe what the individual would be able to functionally do at the end of the episode of care for the problems being treated (not necessarily at the end of the requested PA).
- Upon **discharge** from the episode of care for the problems being treated, the individual may continue to require supportive services. Therapist should include a **plan** to educate the child/adult/caregiver(s) and transition responsibility for the therapy program to him or her as well, so that therapy can remain effective throughout the person's life cycle.