

North Carolina Department of Public Instruction

Exceptional Children Division

Supporting Teaching and Related Services Section

Laurie Ray

Physical Therapy & Medicaid Consultant

919.636.1827

laurie_ray@med.unc.edu

Lauren Holahan

Occupational Therapy & Medicaid Consultant

919-428-7201

lauren_holahan@med.unc.edu

Medical Necessity and Related Service Provision

Generally speaking, most definitions of medical necessity incorporate the principle of providing services which are:

- "reasonable and necessary" and
- "appropriate" in light of clinical standards of practice.

The lack of objectivity inherent in these terms often leads to widely varying interpretations by practitioners and payors, which can result in service provided not meeting the definition and, as such, not being funded.

Connecticut Second Circuit Court of Appeals, has decided numerous cases in which medical necessity is mentioned. They described what the term means, saying:

- "unless the contrary is specified, the term "medical necessity" must refer to what is medically necessary *for a particular patient*...
- Determining medical necessity therefore *entails an individual assessment rather than a general determination* of what works in the ordinary case. "

<http://www.cga.ct.gov/2007/rpt/2007-r-0055.htm>

Since, in the North Carolina school-based context, the Medicaid LEA Policy states:

3.2 Specific Criteria - "Service is covered when it is medically necessary and is outlined in an IEP/IFSP. All services must be medically necessary as defined by *the policy guidelines (national standards, best practice guidelines, etc.) recommended by the authoritative bodies for each discipline* and are outlined in an IEP/IFSP."

Then, a related service provider working in schools would need to assess each intervention session, using their own clinical reasoning, to determine if the session, in whole or part, met the following standards:

- 1) The intervention was designed to prevent, diagnose, correct, or ameliorate a physical or mental condition that threatens life, causes pain or suffering, or results in illness, disability, or infirmity
- 2) The intervention was designed to maintain or preclude deterioration of health or functional ability
- 3) The intervention was individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness, disability, or injury for which the student is being served at school
- 4) The intervention is not in excess of the student's needs as identified in the IEP
- 5) The intervention was necessary and consistent with generally accepted professional standards
- 6) The intervention was designed reflective of the level of service that can be safely provided and for which no equally effective treatment is available

- To be clear, these guidelines apply only AFTER the standards for educational relevance have been met
- Services provided in schools are primarily concerned the student's educational (e.g., academic and functional) progress.
- Consideration of medical necessity in school-based is conducted mostly in hindsight, rather than in intervention planning, and should never alter scope of service described in the student's IEP
- The documentation *following* IEP and intervention plan development—the treatment notes and the progress reports—make the case for medical necessity of a particular intervention session

Questions to ask when determining medical necessity of services provided at school:

- Does this intervention require your licensed skills?
- Would the student be able to participate and without your services?
- Would the student participate as his/her peers do without your services?
- Would you provide the same service at a clinic, home or hospital?

Questions your documentation should answer:

- Why did the student present for services today?
- What services/interventions did the student receive?
- What was observed during the service/intervention?
- What was the student response and outcomes from the service/intervention?
- Is follow up or change required?

Medical necessity – from ASHA

Definitions of Medical Necessity:

Medicare defines medical necessity as a “service that is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member.” The service must be consistent with the symptoms of the illness or injury, be provided within generally acceptable professional medical standards, not performed for the convenience of the patient or physician, and furnished at a safe level and in a setting appropriate to the patient’s medical needs. Some insurers and health plans further define medical necessity, in addition to Medicare’s definition, as services that prevent, diagnose or treat conditions, illness, and injury; that are not part of scholastic or vocational training; and are not investigational (National Institute for Health Care Management, 1995; and Blue Cross Blue Shield Federal Employees Health Benefit, from Appeals Made Easy, 2001).

Medical necessity – from APTA

Physical therapy, as part of an individual’s health care, is considered medically necessary as determined by the licensed physical therapist based on the results of a physical therapy evaluation and when provided for the purpose of preventing, minimizing, or eliminating impairments, activity limitations, or participation restrictions. Physical therapy is delivered throughout the episode of care by the physical therapist or under his or her direction and supervision; requires the knowledge, clinical judgment, and abilities of the therapist; takes into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client. Physical therapy is provided using evidence of effectiveness and applicable physical therapy standards of practice and is considered medically necessary if the type, amount, and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease.

Medical necessity – from AOTA

While there is no federal definition of medical necessity for Medicaid services in general, services required under EPSDT are subject to a federal provision that speaks to medical necessity. According to 42 USC S.1396d(a)(4)(B), Medicaid will pay for EPSDT services that are, “necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered under the state plan.” This provision provides a basic definition of medical necessity for services provided under federal EPSDT requirements.

Most states have developed a Medicaid provider handbook, either for all providers or specifically for school-based providers. These handbooks outline state criteria for medical necessity and are typically available through the state’s Medicaid web site.

States also define medical necessity in their state plan, in general or specifically in relation to school-based services. While each state develops their own definition.

Medical necessity – from CMS:

“reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”

Medical necessity – from Carolinas Center for Medical Excellence, Medicaid reviewer Audra Renzi:

“When determining medical necessity for OT requests, CCME reviewers first consider the medical history, goals and goal baselines submitted to determine if the recipient has an identified deficit that can be addressed by skilled OT. This is primarily based on professional and clinical experience and knowledge. If so, the reviewer looks further at the plan of care frequency/duration to determine if appropriate for the therapy setting and severity of the deficit and compares it to the recommended treatment intensity, frequency and duration in the relevant AOTA guideline. The guidelines are also used to support the need for discharge if certain criteria are met, such as plateau, non-compliance, etc.”

Medical necessity – from NC LEA Medicaid Policy:

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

OT, PT, Speech/Language-Audiology, Psychological/Counseling services and Nursing Services are not covered when the above medical criteria are not met. Medicaid reimburses for medically necessary services only.

1.1 Physical Therapy (PT)

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Physical Therapy Association in the most recent edition of Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns.

Exception: A specific “treatable” functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific “reversible” functional impairment that impedes ability to participate in productive activities.

1.2 Occupational Therapy (OT)

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Occupational Therapy Association in the most recent edition of Occupational Therapy Practice Guidelines Series.

Exception: A specific “treatable” functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific “reversible” functional impairment that impedes ability to participate in productive activities.

1.3 Speech/Language-Audiology Therapy

Medicaid accepts the medical necessity criteria for Speech/Language-Audiology therapy treatment as follows:

- a. *Basic Elements of Coverage of Speech-Language Pathology and Dysphagia Services* (http://cms.hhs.gov/manuals/pub13/pub_13.asp; Section 3101.10A) and *Special Instructions for Medical Review of Dysphagia Claims* (http://cms.hhs.gov/manuals/108_pim/pim83c06s07.asp#Sect10) have been replaced by CMS with Publication 100-3 Medicare National Coverage Determinations Manual 170.3-Speech Language Pathology Services for the Treatment of Dysphagia (Rev.55, Issued: 05-05-06, Effective :10-01-06, Implementation: 10-2-06) and Publication 100-2 The Medicare Benefit Policy, Chapter 15, Covered Medical and Other Health Services, Sections 220 and 230.3 (Rev 36, Issued:06-24-05, Effective: 06-06-05, Implementation:06-06-05) These publications can be found at <http://www.cms.hhs.gov/manuals/IOM/list.asp> and
- b. ASHA guidelines regarding bilingual services (<http://www.asha.org>) *Position Statement Clinical Management of Communicatively Handicapped Minority Language Population* and
- c. The following criteria for Birth to 21 Years: (please see policy for detailed criteria)