



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

**MEDICAL NECESSITY
FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
SERVICES**

General Information

Medical Necessity For Speech-Language Pathology And Audiology Services is published by the American Speech-Language-Hearing Association. It provides information to practitioners to assist them in advocating for appropriate coverage of services, particularly with regard to the concept of medical necessity. An outcome of the 2004 Health Care Reimbursement Focused Initiative is to provide ASHA members with access to information and tools to effectively negotiate with private health plans to ensure appropriate coverage of services and equitable reimbursement rates. This document is one of the strategies that addresses that outcome.

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Introduction

Health plans will only pay for services that meet its medical necessity standards that are generally defined as a determination that a service is reasonable and necessary for the diagnosis or treatment of an illness or an injury. Speech-language pathologists and audiologists must document how the services they provide meet the requirement to treat the various types of disorders present in children and adults. This paper provides the following regarding medical necessity:

- background and general discussion
- definitions
- information on denials
- why speech-language pathology and audiology services qualify
- how payers determine
- related legal issues
- disabilities

Background

The term “medical necessity” has been used by health plans for many years to define limits of coverage, despite a lack of agreement on what constitutes medical necessity. Over the years, the term has evolved from a health plan concept directed by physicians to a cost-saving measure used by health plan administrators and medical directors. According to Singer et al., in a report to the California HealthCare Foundation in August 1999 on *Decreasing Variation in Medical Necessity Decision Making*, several factors have contributed to the redefining of medical necessity. These include 1) the growth of managed care and shifts in the health care delivery system away from the traditional insurance model; 2) a lack of consensus within the medical community of treatment options and 3) the small amount of clinical evidence about the merits of one treatment over another for the same condition. Singer et al. call for a new definition of medical necessity that removes the “vagueness” of the term and establishes a standard process for applying it.

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 and Health Plan Denials

A few specific service areas are responsible for most health plan appeals, and many of these deal with services on the margin between care that treats and care that is life-enhancing but not life-sustaining, according to a study in the Feb. 19, 2003 *Journal of the American Medical Association*. Medical necessity disputes accounted for 36.9% of appeals; disputes over contractual limits of coverage accounted for 36.6%; and disputes over access to out-of-network services made up 19.7% of appeals.

Contractual disputes were overturned 33.2% of the time. Among contractual disputes, 61% of the cases focused on **speech therapy**, physical therapy, foot orthotics, dental care, alternative medicine treatments, investigational therapies, and infertility. Contractual disputes involved a patient directly contesting stated exclusions in the policy language. Authors of the study, David Studdert of Harvard School of Public Health and Carole Gresenz of RAND, offer that more careful and concise contractual language may reduce this type of dispute.

Out-of-network disputes had a 35.4% rate of overturn.

Medical necessity disputes had the highest rate of overturn, at 52.2%. These disputes, too, were concentrated on relatively few services, including surgery for obesity, breast alterations, varicose vein removal, bone density and sleep studies, and scar treatment. Studdert and Gresenz suggest that more contractual detail could help eliminate some of these appeals, as well. However, they also note that many medical necessity disputes highlight the need for more frankness about health care that is or is not regarded as medically necessary, and more debate in society about the role of health insurance.

The authors say that numerous services that are frequent objects of medical necessity disputes are difficult to place in either the treatment category (i.e., interventions meant to prevent, cure, or ameliorate impairments), or the enhancement category (i.e., services that merely improve conditions that are part of normal human functioning). The authors conclude that open discussion about what involves medical necessity should help to avoid inappropriate denials. It would allow greater oversight of disputes that have the greatest potential for harm to enrollees and perhaps set up different standards of review for different services.

Speech-language pathology and audiology services must be viewed as being in the “treatment category” as opposed to the “enhancement category” noted in the previous paragraph if services are to be deemed medically necessary. Often these services are regarded as a quality of life issue, though, and not as medical care. Clinicians are charged with making the argument that treating an individual’s speech-language, hearing, or swallowing disorder improves health status, and is therefore, medically necessary.

Why Speech-Language Pathology and Audiology Services Meet the Definition of Medical Necessity

Speech-language pathology and audiology services are medically necessary to treat speech-language, swallowing, hearing, and balance disorders. Many of these disorders have a neurological basis, and result from specific injury and illness, such as head injury, Parkinson's disease, stroke, exposure to loud noises in the workplace, and cerebral palsy. (Of course, not all services are medically necessary, such as accent reduction services). Determining medical necessity takes into consideration whether a service is essential and appropriate to the diagnosis and/or treatment of an illness or injury. According to *Stedman's Medical Dictionary, 24th Edition*, illness is defined as "disease," which is further defined as a "disorder of body functions." Loss of hearing, impaired speech and language, and swallowing difficulties all reflect a loss of body functions. Therefore, services to treat such impairments must be regarded as meeting the definition of medical necessity.

Speech-language pathology and audiology services are provided within acceptable professional standards, according to the American Speech-Language-Hearing Association's Preferred Practice Patterns.

The American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) recognized the medically necessary nature of speech-language pathology and audiology services in the following statement:

The AAO-HNS recognizes that speech/language delay is a known sequela of congenital or acquired hearing loss, whether conductive or sensory-neural. In children with speech/language delay, speech therapy is a medically necessary therapy, and should be a covered service for reimbursement by third-party payers.

Documentation Needed To Establish Medical Necessity

The following basic elements of coverage and medical review guidelines are contained in national Medicare policy manuals. This information helps to define "reasonable and necessary care" for speech-language pathologists and Medicare claims reviewers, and can be used as guidelines in providing documentation for medical necessity

Claims for speech-language pathology and audiology services should be supported by providing the following basic elements of coverage:

Reasonable: provided with appropriate amount, frequency and duration, and accepted standards of practice;

Necessary: appropriate treatment for the patient's diagnosis and condition;

Specific: targeted to particular treatment goals;

Effective: expectation for improvement within a reasonable time;

Skilled: requires the knowledge, skills and judgment of a speech-language pathologist, that is, complex and sophisticated.

Relevant documentation for establishing medical necessity may include:

1) **medical history** ; pertinent medical history that influences the speech-language or audiology treatment, brief description of functional status of patient prior to the onset of condition requiring speech-language pathologist, and relevant prior speech-language treatment.

2) **speech, language, and related disorder;** the diagnosis established by the speech-language pathologist, such as expressive aphasia or dysarthria.

3) **date of onset;** date of onset of speech, language and related disorder diagnosis.

4) **physician referral**

5) **initial assessment and date;** the procedure used by the speech-language pathologist to diagnose speech, language, and related disorders, and the date the initial assessment is completed by the billing provider.

6) **plan of treatment and date established**

7) **progress notes;** updated patient status reports concerning the patient's current functional communication abilities/limitation.

How Payers Determine Medical Necessity

Health plans may determine medical necessity by reviewing assigned procedure codes from the *Physicians' Current Procedural Terminology, 4th Edition* (CPT codes) and diagnostic codes from the *International Classification of Diseases, 9th Edition, Clinical Modification* (ICD-9-CM). Medical policies often define ICD-9-CM codes that support medical necessity for many provided services. Software packages are available that compare the CPT code to the ICD-9-CM code to determine medical necessity (Appeals Made Easy, 2001). Many private health plans also incorporate the Centers for Medicare and Medicaid Services (CMS) Correct Coding Initiative (CCI) edits into their systems. This is a system that detects when procedure codes have been inappropriately performed on the same day. Speech-language pathology and audiology services are well-represented in both CPT and ICD-9-CM coding systems. The establishment of speech-language pathology and audiology-related codes within these two major medical coding systems indicates the medical nature of speech, language, hearing, and swallowing disorders.

A more in-depth look at how payers determine medical necessity is found in the 1999 report to the California HealthCare Foundation titled *Decreasing Variation in Medical Necessity Decision Making*. Authors Singer and Bergthold et al., point out basic steps in a medical necessity decision-making process. Both health plans and medical groups (i.e., independent practice associations, single specialty medical groups) were surveyed, and both were found to follow the same process. The steps are divided into three time phases including 1) steps prior to a request for authorization; 2) steps during the decision process, and 3) steps after the decision is communicated to physician and consumer.

Steps Prior to Authorization

- A. Contracts between the purchaser and the plan define covered benefits, and include definitions of terms such as medical necessity.
- B. Coverage policies or guidelines are developed by health plans and specify what types of treatment are optimal for given conditions, and how the plan will cover the treatment for these conditions. Coverage guidelines may be based on evidence-based practice guidelines as outlined by national or professional medical societies or the plan's own experience, or a combination of both.
- C. Coverage guidelines are distributed to physicians and consumers. Physician education is provided when needed.
- D. Procedures are divided into groups needing pre-authorization and those not needing pre-authorization (seldom denied, or have low volume or cost).
- E. Request for authorization is submitted.

Steps During the Decision

- A. Clerical personnel check the eligibility of the member and determine if the entire category of service is a covered benefit (e.g. vision care). Disputed cases are referred to a nurse or medical director.
- B. If the member's eligibility is confirmed, and the service appears to be covered, a clinician (usually a nurse) reviews the request against coverage guidelines. The nurse can approve the request, but cannot deny authorization, per NCQA accreditation (National Committee on Quality Assurance). Most plans require a physician to make any denial of medically necessary services. In practice, nurses often do the background research for the decision process, and refer the decision to the medical director for final signature and review.
- C. A medical director may apply his or her own experience and expertise to make the decision, or may refer the case to a medical policy committee, to external physicians, or

other organization personnel. The authors of the report indicate that at this point, there is no common process. The way a medical director makes a decision varies. Medical directors may be required, at least in California, to consult committees, national databases, and outside sources to make a final determination. **The contractual definition of what constitutes a medically necessary service is not the primary driving force in making a decision, according to the authors. Rather, coverage policies and guidelines are more important influences over payment decisions.**

D. A medical director might verbally deny the requested service but recommend an alternate level of care, type of treatment or provider. This “diversion” would not generally be considered a denial.

Steps After the Decision

A. The decision to approve or deny is communicated to the provider and consumer, usually by letter.

B. If the provider or consumer disagrees with the decision, an internal appeals process may begin.

C. Consumers in California can request an independent review by the Department of Corporations (DOC) if they have used the plans internal appeals process, or if they have an urgent case. The Medicare and Medicaid programs have formal appeal processes, as well. A DOC staff attorney reviews the request, collects relevant documentation from the plan and consumer, and may ask a physician consultant to review. If the plan is found to be in compliance, a letter is sent to the consumer. If the DOC concludes that the plan has violated pertinent requirements, the DOC sends a demand letter to the plan, and can refer the case to its enforcement division if the plan does not agree to reverse its decision.

The DOC rarely included information on how it defined medical necessity, but would provide quotes from the consultant review. There were no stipulations that scientific evidence or literature should be used to support the consultant’s opinions. The DOC never defined medical necessity, though it would quote the consultant’s definition, which varied. Sometimes the consultant used the health plan definition of medical necessity, in other instances he/she used criteria but did not cite any source, referred to anonymous colleagues’ opinions, or referenced a journal article. The presence of “pain” and “functional impairment” were criteria most often used in more than a third of DOC requests for assistance appeals. The importance of “psychological impact” was also noted.

These are the basic steps payers appear to follow in determining medical necessity in California. They appear to be similar to steps other plans in other states follow, as reported over the years by ASHA members. A significant finding was that definitions of medical necessity in contract language were not likely to be helpful in decision making.

Related Legal Issues

There is variation in the way courts interpret medical necessity, according to Singer and Bergthold. The way in which courts handle appeal cases is inconsistent and variable, providing little guidance to consumers or other stakeholders about how to resolve their disputes. The authors found that many medical necessity disputes never reach a judgment on the merits because they are dismissed on procedural grounds. There is little judicial precedent or useful interpretation of medical necessity criteria or decision making from the courts. ASHA could find no case law regarding either speech-language pathology or audiology and medical necessity.

Medical Necessity and Disabilities

Health plans may define medically necessary services in a way that leads to denial of services needed by special populations, including children and adults with special health care needs and developmental disabilities. In a report from the National Center for Education in Maternal and Child Health, supported by the National Policy Center for Children with Special Health Care Needs and the Joseph P. Kennedy, Jr. Foundation (National Maternal and Child Health Clearinghouse, 1999), a strategy is outlined for defining medical necessity that promotes high-quality care for children and adults with special health care needs. The definition can be incorporated into legislation, regulation, and contracts. Criteria for evaluating definitions of medical necessity include:

- 1) The definition should incorporate appropriate outcomes within a developmental framework.
- 2) The definition should address the information needed in the decision-making process, and who will participate in that process.
- 3) The definition should refer to specific standards.
- 4) The definition should support flexibility in the sites of service delivery.

The report provides specific wording for defining medical necessity which can be found at the end of this document.

Summary

Speech-language pathologists and audiologists must document how the services they provide are medically necessary in order to be reimbursed by health plans. However, research indicates that contractual definitions of medical necessity lack specificity of meaning and do not aid decision makers in determining what to cover or not cover (Singer et al., 1999). Coverage policies and guidelines, utilization review procedures, and organization structure are much more important as influences over coverage decisions. While clinicians must continue to document the medical necessity of speech-language, hearing, balance, and swallowing services, one should also continue to be a proponent of coverage policies and evidence-based practice guidelines.

Specifications for Defining Medical Necessity

1. A covered service or item is medically necessary if it will do, or is reasonably expected to do, one or more of the following:
 - Arrive at a correct medical diagnosis¹
 - Prevent the onset of an illness, condition, injury, or disability (in the individual or in covered relatives, as appropriate)²
 - Reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury, or disability
 - Assist the individual to achieve or maintain sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities
2. The MCO or insurer must determine medical necessity on the basis of health information provided by the following persons: the individual (as appropriate to his or her age and communicative abilities), the individual's family, the primary care physician, and consultants with appropriate specialty training, as well as other providers, programs, multidisciplinary teams, educational institutions, or agencies that have evaluated the individual.
3. The determination of medical necessity must be made on an individual basis and must consider
 - The functional capacity of the person and those capacities that are appropriate for persons of the same age or developmental level
 - Available research findings, health care practice guidelines, and standards issued by professionally recognized organizations or government agencies
4. Final determinations will be made by a physician in concert with the following persons: the individual's primary care physician; a consultant with experience appropriate to the individual's age, disability, or chronic condition; and the individual and/or family.
5. Medically necessary services must be delivered in a setting (e.g., an individual's home, school, child care center, workplace, or community-based agency) that is appropriate to the specific health needs of the individual.

Source: National Policy Center for Children with Special Health Care Needs and the Joseph P. Kennedy, Jr. Foundation. Vienna, VA: National Maternal and Child Health Clearinghouse.

¹Unspecified or undiagnosed conditions are common in this population; hence, additional or special diagnostic procedures or tests are frequently needed to reach a diagnosis that will assist in determining an appropriate care plan.

²Knowledge about the role of genetics in chronic disease and disability is growing rapidly. For example, diagnosis of fragile X syndrome in a child requires pedigree analysis and laboratory studies not only to permit accurate diagnoses, but also to ensure that genetic counseling is provided to help individuals and families make informed choices on reproductive issues.

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