WYO MEDICAID
DIVISION OF HEALTHCARE FINANCING

PROVIDER AND BENEFITS MANAGEMENT UNIT
WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Medical Necessity and Authorizations of Medical Necessity

September 1, 2018

Acknowledgment

The presentation is a compilation of information found in a number of recent reports on documentation standardization, as well as content and recommendations from Wyoming State staff. The presentation relies primarily on information from a training manual produced by Mary Thornton & Associates, Inc. and the Colorado Behavioral Healthcare Council (2011), Colorado Training and Reference Manual for Behavioral Health Services. It was retrieved from http://www.cbhc.org/news/wp-content/uploads/2011/05/Colorado-Training-and-Reference-Manual-for-Clinicians.pdf. General content has been integrated into the presentation.

The presentation was supplemented with information from other sources including Ohio State Medicaid Program, Washington State Medicaid Program, the Centers for Medicare & Medicaid Services, A Cerlerian Group Company, House of New Hope, and WebPT.

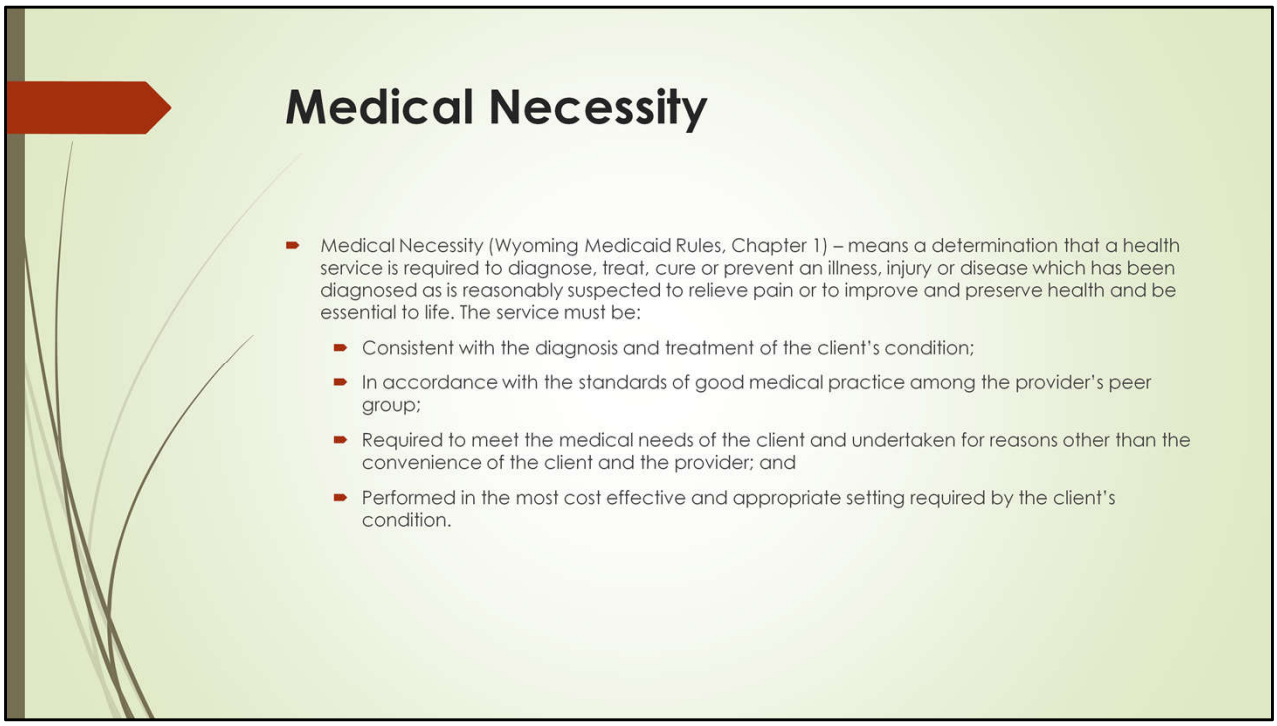
Objectives

- To provide an understanding of medical necessity and rehabilitative services.
- To provide the process for authorization of medical necessity.

Documentation

- Provides clear evidence of the continuum of care between providers.
- Provides a pathway and the client's response to treatment.
- Supports billing for services rendered.
- Acts as a legal record of care given.
- Shows medical necessity.

Years ago, documentation was not submitted to Medicare or other payers. The chances of a medical record becoming a legal document in a malpractice case was minimal. Most client records were only seen by the provider and their staff. No standards existed for client records/documentation. These times have changed significantly. Documentation is not only required but critical for evidence of care for reviews, audits and malpractice. It is also an integral part of the continuity of care with other providers.



The medical record has become the vital determining factor when assessing what is medically reasonable and necessary.

Medical Necessity Check

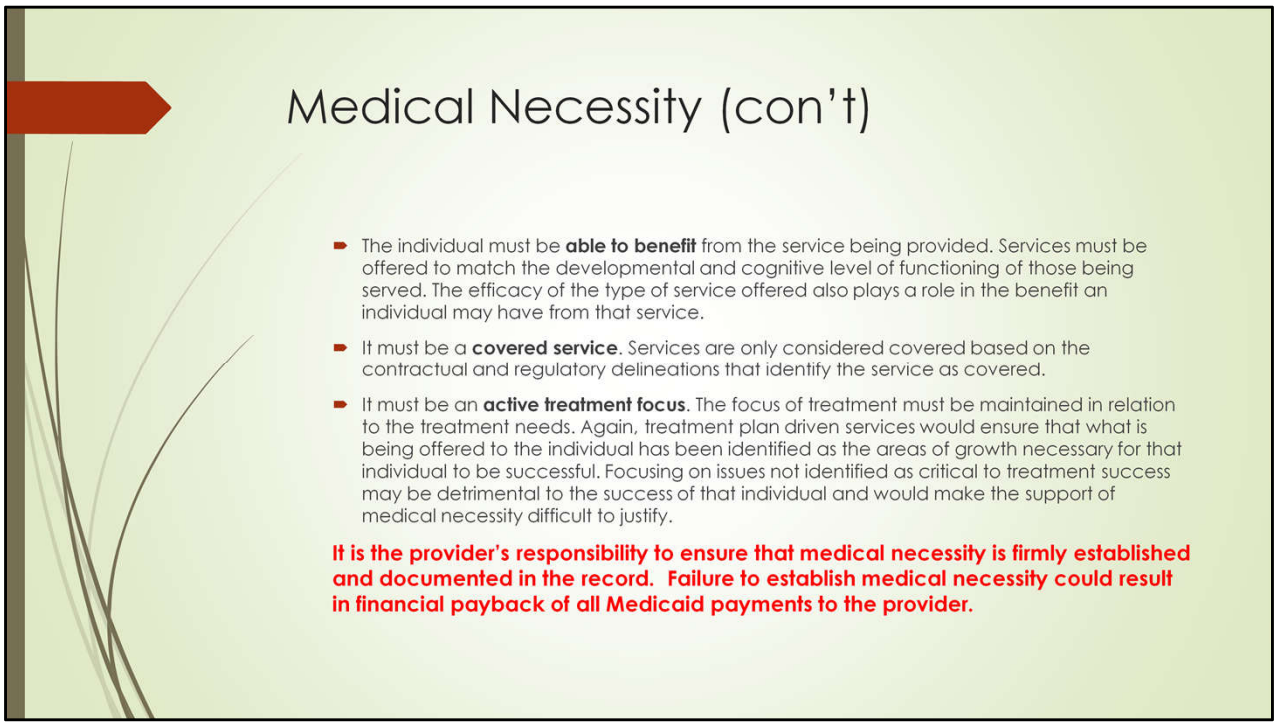
1. Does the record show a patient complaint that is consistent with an injury or condition? If a complaint is treated due to provider philosophy or technique or as part of a routine, then the care might not be considered medically necessary.
2. Are there objectives findings which explain the subjective complaint? Is treating the condition within the provider's scope of practice?
3. Is the selected case management and treatment appropriate for the diagnosis and phase of the condition? For example, care for the same diagnosis might vary between two patients based on gender, age, comorbidities, etc. Are there specific measurable goals?
4. Is there documented progress based on a care plan? The plan should include specific measurable goals. Medical necessity is not presented if patient complaints and objective findings remain the same over long periods. Improvement must be noted over time.

The four elements of medical necessity
1. Complaint
2. Explanation
3. Appropriate Treatment and
4. Progress

These can be applied to each and every procedure code billed on a claim. If all four elements are met, the service is likely to be deemed medically necessary.

Medical Necessity

- There are seven key elements that demonstrate medical necessity for services:
  - It treats a **mental health condition/illness or functional deficits** that are the result of the mental illness. These would not include issues such as normal developmental milestones or other issues unrelated to a mental illness.
  - It has been **ordered or prescribed**. This speaks to the importance of the treatment plan; the treatment plan would support the specified interventions necessary to treat the identified mental health issues.
  - The service should be **generally accepted as effective** for the mental illness being treated. Ensuring the use of current practices, particularly Evidence Based Practices which have research support behind them, is essential. Unproven or controversial approaches introduce risk into the treatment process and should be avoided.
  - The individual must **participate** in treatment. If an individual is not active in treatment or not following through on treatment recommendations, it is difficult to justify continued medical necessity since the impact of treatment interventions cannot be assessed.



One of the biggest problems providers face when audited is the many services are deemed not medically necessary and are routinely denied. Much of the proof falls back on the medical record. Here are some specific situations as they relate to audits:

Unnecessary diagnostic testing. The need for any diagnostic testing must be substantiated in the documentation. The rationale for ordering the test should be based on the provider's inability to establish a diagnosis to a reasonable degree of clinical certainty without the test results.

Unnecessary services. It is inappropriate to bill for procedures for parts of the body that are not associated with the patient's complaint, presenting problem or those found through objective measures. Be aware of individual payer policies of what they consider necessary.

Unjustified frequency of treatment. This is an issue when there is little or no documented clinical assessment of the patient's progress that would require the billing for such services. Essential and required information should be in the daily notes. If progress has not been noticed, there should be a referral for further testing and evaluation.

Routine Services. Another issue is billing for services which are performed on a routine basis as opposed to clearly establishing and supporting medical necessity per third-party billing requirements. When these types of services do not meet coverage guidelines, they are easily identified when evaluation provider claims.

Restorative (Rehabilitative) Services

- Restorative (Rehabilitative) Services – Services that help patient's get back or improve skills and functioning for daily living that have been lost or impaired because the client was sick, hurt or suddenly disabled.
- Federal Medicaid Law defines rehabilitative services as: "Any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to his best possible functional level" [42 CFR §440.130].
- Rehabilitative Services means to restore ability.
  - An ability was once present, but was lost; or, was present and not exercised, and ability is restored through rehabilitative services.
  - Similar to other rehabilitative therapies.

Medicaid rehabilitative service providers are required to:

- Specify the type, frequency and duration of service in written treatment (rehabilitative) plan with a key focus on ensuring that all services are being directed toward specific and measureable rehabilitation goals which are developed with the client and their family/guardian.
- Avoid billing Medicaid for provision of services that are "Intrinsic elements" of another federal, state or local program other than Medicaid.
- Support each patient encounter and each item of service reported on the Medicaid claim form

Note: Rehabilitative services should not automatically be a part of an agency's day programming and are considered an individualized service based on each client's unique treatment needs.

Rehabilitative (Restorative) Services

Examples of exclusions to rehabilitative option services include:

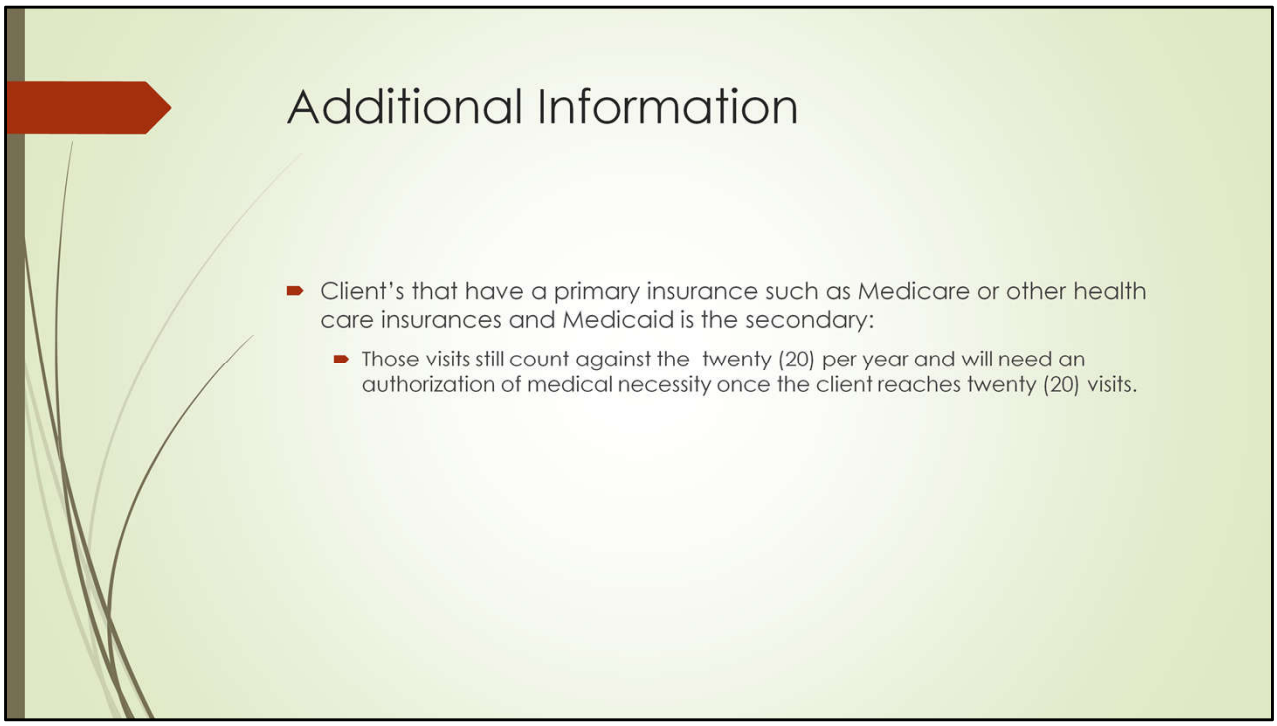
- Socialization & Recreational events with no component of active treatments
- Academic education
- Job training/vocational services
- "Attendance" in a group, psychological rehabilitation, individual rehabilitative services, or individual treatment program is not in and of itself a treatment plan goal.

Authorization of Medical Necessity

- An Authorization of Medical Necessity is required for Medicaid clients age 21 and over whom have dates of service in excess of twenty (20) per calendar year.
- Link to submit an authorization of Medical Necessity is http://www.qualishealth.org/healthcare-professionals/wyoming-medicaid
- A comprehensive Qualis review is completed. Documentation needed includes:
  - Treatment plan/Plan of care initially and every 90 days (to show progress/lack of progress/goal progression)
  - Initial Clinical Assessment/Intake and/or updated clinical assessment/intake
  - Last 5 progress notes for each requested code. Each service should demonstrate: patient current function abilities, interventions provided by measureable goals & outcomes
  - Progress notes should identify the date, length of time, (start and end times in standard or military time) and location of service
  - Any additional documentation to support continuation of medically necessary behavioral health services

Denials and Appeals Process

- If the initial request for authorization for medical necessity is denied or reduced, a request for reconsideration can be submitted through Qualis Health, including any additional clinical information that supports the request for services.
- Should the reconsideration request uphold the original denial or reduction in services an appeal can be made to the state by sending a written appeal via email to the Behavioral Health Program Manager, Brenda Stout (Brenda.Stout1@wyo.gov
  - The appeal should include an explanation of the reason for the disagreement with the decision and the reference number from Qualis Health's system



Note: If Medicare pays the claim and Medicaid is only paying co-insurance and/or the deductible, those claims don't count towards the threshold.

Contact info and additional resources

- To initiate a review go to Qualis Health Provider Portal at https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
- Need assistance? Call (800) 783-8606
- Mailing Address
  Medicaid Services Department
  PO Box 33400
  Seattle, WA 98133
- Available webinar and PowerPoints are available at http://www.qualishealth.org/healthcare-professionals/wyoming-medicaid/provider-education or additional resources at http://www.qualishealth.org/healthcare-professionals/wyoming-medicaid/provider-resources

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