AN EVALUATION

Prior Authorization for Therapy and Other Services

Department of Health and Family Services

01-13

July 2001

2001-2002 Joint Legislative Audit Committee Members

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July 26, 2001

Senator Gary R. George and
Representative Joseph K. Leibham, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator George and Representative Leibham:

As requested by the Joint Legislative Audit Committee, we have completed an evaluation of the Department of Health and Family Services' (DHFS's) prior authorization process for occupational, physical, and speech therapy services provided under the Medical Assistance program. Administrative code states that prior authorization is intended to safeguard against unnecessary or inappropriate care. In 1999, approximately 6,300 individuals received therapy services that required prior authorization; these services cost $11.2 million.

From 1995 through June 2000, the average processing time for therapy prior authorization requests increased by 6.7 percent (1.1 working days), despite a decrease in the number of requests submitted and an increase in the number of staff processing requests. Longer processing times resulted primarily from increases in the percentage of incomplete requests returned to providers. In 1995, 43.9 percent of requests were returned at least once; in 1999, the rate of return was 49.5 percent.

We also examined denial rates for therapy prior authorization requests. We found that since 1997, denial rates have been substantially higher for school-age children than for other age groups. Unlike other age groups, school-age children can obtain services without prior authorization through the School-Based Services program. The Legislature created this program in 1995 to capture Medical Assistance funds for special education services. In 1999, 62 percent of Medical Assistance expenditures for therapy services for school-age children were paid to school-based providers. Community-based therapy providers and some parents believe that the growth of the program has made it more difficult to obtain approval for therapy services outside of school and that DHFS staff are inclined to deny community-based services to children also receiving school-based services. However, we found that denial rates for community-based therapy were slightly lower for children receiving therapy through the School-Based Services program than they were for children who were not receiving therapy through that program.

We appreciate the courtesy and cooperation extended to us by DHFS and the Department of Public Instruction. DHFS's response is the appendix.

Respectfully submitted,

Janice Mueller
State Auditor

JM/PS/ao

Summary

Under the federal Medical Assistance program, which funds health care services for low-income and disabled individuals, services such as occupational, physical, and speech/language therapies provided outside of a hospital are considered optional and can be covered at a state's discretion. These therapy services are typically provided in a patient's home, at a provider's clinic, or by school districts. Before funding these services, Wisconsin requires them to be approved by the Department of Health and Family Services (DHFS), which administers the Medical Assistance program. DHFS requires providers of medical services to submit prior authorization requests to justify the medical need for therapy services. According to s. HFS 107.02 (3)(b), Wis. Adm. Code, reasons for the prior authorization process include safeguarding against unnecessary or inappropriate care and services, preventing excess payments, and determining if less-expensive alternative care is possible.

Providers, parents, and advocates believe that approval for therapy services has become increasingly difficult to obtain and that DHFS has changed the criteria and procedures it uses to review prior authorization requests. In particular, they assert that it has become more difficult to obtain approval for therapy services for school-age children (those ages 3 to 21). They believe it is more difficult to obtain community-based services because the State has a financial incentive to provide services in schools through the School-Based Services program, which is intended to capture Medical Assistance funding for special education costs.

In response to these concerns, and at the request of the Joint Legislative Audit Committee, we examined prior authorization for therapy services, including:

- trends in the number of approvals, denials, and modifications of requests for prior authorization;
- the criteria DHFS uses to reach decisions on prior authorization requests;
- the time required to reach decisions on prior authorization requests; and
- the period for which prior authorization approvals are valid.

We also examined the possible expansion of the prior authorization process for certain types of prescription drugs.

Section HFS 107.02 (3)(e), Wis. Adm. Code, establishes several criteria for determining whether to approve or deny a request for prior authorization. These criteria include the appropriateness, cost, and medical necessity of the service; the extent to which less-expensive alternatives are available; and limitations imposed by federal and state statutes and rules.

Most requests for prior authorization are processed by the State's fiscal agent for the Medical Assistance program, Electronic Data Systems. There are three primary phases of the prior authorization process: clerical review, clinical review, and final action. The fiscal agent is responsible for the first phase, during which requests submitted by providers are checked for completeness and clerical accuracy. Requests with missing or inaccurate clerical information, such as incorrect Medical Assistance identification numbers, are returned to providers for correction before moving further in the process. The fiscal agent is also responsible for the second phase, during which reviewers evaluate whether the medical necessity of the service is justified by the clinical information provided. As with the clerical review, requests can be returned to providers for additional information.

The final step in the process, in which a request is either approved, approved with modifications, or denied, is also typically conducted by the fiscal agent. If the request is approved, the provider is notified that treatment costs are reimbursable under Medical Assistance. Requests that are denied or modified to reduce the frequency of the treatment are forwarded to DHFS, which employs its own clinical reviewers to make final determinations in consultation with the Department's chief medical officers.

We found that DHFS does not determine whether it is meeting administrative code guidelines for the timeliness of its prior authorization request processing. Section HFS 107.02 (3), Wis. Adm. Code, requires a determination to be made on 95 percent of all prior authorization requests within 10 working days of the date on which all necessary information is received, and on 100 percent of requests within 20 working days of that date. These standards apply to all services for which prior authorization is required. We found that if these standards had been applied only to prior authorization requests for therapy services, rather than to all services, DHFS would not have met timeliness standards for any of the three therapy types since 1996 and would have met no standards for occupational therapy since 1995, the first year we reviewed.

We also determined the total processing time for requests; that is, the number of working days between an initial submission to the fiscal

agent and the date at which a final decision is made. On average, processing time increased by 6.7 percent, or 1.1 working days, between 1995 and 2000. In 1995, average processing time for all therapy types was 16.4 days; in 2000, it was 17.5 days.The increase was greatest for physical therapy, but processing time for speech/language therapy also increased. In contrast, processing time decreased by 7.9 percent, or 1.8 working days, for occupational therapy. However, it should be noted that processing time for occupational therapy was the longest of the three types in each year we examined.

During the same period that processing time increased, the number of DHFS and fiscal agent reviewers also increased, and the volume of prior authorization requests for therapy services decreased. The decline in the number of requests has two principal causes. First, total Medical Assistance enrollment declined by 7.7 percent between 1995 and 2000. Second, the implementation of managed care programs for Medical Assistance recipients resulted in greater numbers of recipients being served by health maintenance organizations (HMOs), which are not required to seek prior authorization from the State to provide therapy services. The reduced number of requests and increased number of staff reviewing requests resulted in the number of prior authorization requests per reviewer declining from 5,143 in 1995 to 2,627 in 1999.

DHFS officials indicate that additional staff were assigned following independent consultants' reports in 1996 and 1997 that recommended more thorough reviews of requests. These more thorough reviews have resulted in an increase in the rate at which requests are returned for additional information. In 1995, 43.9 percent of requests were returned at least once for additional information; in 1999, the rate of return was 49.5 percent. During this same period, processing time for requests that were returned at least once increased by 3.3 percent, or from 15.2 to 15.7 working days.

Requests are returned primarily because of clerical errors, such as failing to include a dated physician's signature on the request, and clinical errors, such as failing to provide information on the coordination of treatment with other health care providers. Approximately two-thirds of the reasons coded on returns we reviewed were clerical in nature.

DHFS has undertaken several initiatives to improve its review process and reduce processing time for prior authorization requests for therapy services. However, we believe additional efforts are needed to educate providers and improve request processing. Several provider groups with which we spoke indicated that they have asked DHFS for a clear definition of "medical necessity," which is the principal criterion used in approving requests for services. DHFS developed a draft document outlining its interpretation of the administrative code definition of medical necessity in December 1998, but a final version has not been

issued. We have included a recommendation for DHFS to provide more specific guidance to providers on this matter.

Denial rates for prior authorization requests increased from 1995 through 1997 and then decreased in each subsequent year. However, denial rates for school-age Medical Assistance recipients have increased over time and are higher than those for children under three and adults over 21. Despite increased denial rates, over 96 percent of prior authorization requests for therapy services in 1999 resulted in some level of service being granted to the recipient.

DHFS officials attribute increased denial rates for school-age children to the Department's efforts to improve the prior authorization review process. DHFS determines whether a recipient is receiving duplicative services through a school district or other provider as part of its efforts to comply with administrative code requirements to safeguard against unnecessary or inappropriate care and services.

When a prior authorization request is denied, DHFS sends a letter to the Medical Assistance recipient indicating the reason for denial and also informs the provider. However, the information given is typically insufficient for a recipient or a provider to understand why the request was denied. We have included a recommendation for DHFS to provide more specific explanations of request denials, to help recipients make more informed decisions about whether to appeal a denial and to assist providers in submitting more complete requests.

When services are denied, Medical Assistance recipients may appeal decisions to the Department of Administration's Division of Hearings and Appeals. Administrative law judges employed by the Division ruled on the merits of 266 therapy cases between 1998 and 2000. Denials were upheld in 43.2 percent of the cases. They were upheld in part and overruled in part in 28.6 percent of cases, and overruled in 28.2 percent.

The School-Based Services program was established by 1995 Wisconsin Act 27 as a funding program intended to capture Medical Assistance funds for some federally mandated special education costs incurred by school districts. Federal special education law requires school districts to provide and pay for medical services that an independent review team determines to be necessary for a child's education.

Funding provided by the School-Based Services program has grown substantially. In 1999, the last year for which comprehensive data are available, 158 of Wisconsin's 426 school districts (37 percent of all districts), 8 of 12 Cooperative Educational Service Agencies (CESAs), and 1 of 5 Children with Disabilities Education Boards run by counties received $15.3 million in Medical Assistance reimbursement for costs they incurred to serve 19,811 children. This amount represents 1.5 percent of statewide special education costs.

Some providers and advocates believe a complex funding arrangement that allows the State to retain a portion of the federal reimbursement also provides an incentive to deliver services through school districts rather than community-based providers. However, we found that community-based therapy denial rates for children receiving therapy through the School-Based Services program were actually slightly lower in both 1998 and 1999 than those for children who were not receiving therapy funded through the program. If, as some providers believe, DHFS wanted to maximize the financial benefits of School-Based Services, then community-based services for children served by the program would be denied more often than services for children not served by the program.

Some parents and providers also believe that the increased use of school districts to provide therapy services results in too little therapy being provided during the summer months. Medical Assistance therapy costs for school-age children declined substantially during the summer months of 1998 and 1999 when schools were not in session, decreasing from a monthly average of $1.2 million during the school year to almost $600,000 during the summer.

School districts are not required to provide special education services year-round unless mandated by a child's individual education plan (IEP). Several parents, providers, and interest group representatives with whom we spoke indicated that this creates an economic disincentive for schools to determine that summer therapy services are needed, because schools would then be financially obligated to provide the services. Moreover, they believe that because prior authorization is not required for services provided during the school year through the School-Based Services program, the use of the IEP in determining the need for therapy services during the summer months creates a different standard for determining whether care should be provided.

Because of the increase in the amount of therapy services funded by the School-Based Services program and the decline in the amount of therapy services provided during the summer months, we have included options the Legislature may wish to consider to increase the amount of therapy provided during the summer months. It should be noted that these options could lead to significant increases in program costs.

Finally, we reviewed DHFS's prior authorization practices for prescription drugs, which represent the largest single category of provider expenditures for non-institutional care in the Medical Assistance program. DHFS uses the prior authorization process to help control drug costs, which rose by 75.8 percent between fiscal years 1995-96 and 1999-2000, or from $185.4 million to $325.9 million. In general, DHFS has chosen to require prior authorization for drugs that are manufactured by companies not participating in a federal drug rebate

program, that have generic versions available, or that have lower-cost alternatives.

DHFS plans to expand the use of prior authorization in the next two years for certain ulcer treatment drugs, cholesterol-lowering drugs, and non-sedating antihistamines for which generic versions have recently become or will soon become available. DHFS estimates that this will result in total savings of $34.0 million in the next biennium. Some advocates and others have raised concerns about requiring prior authorization for antidepressants as generic versions of some drugs in this category become available. DHFS officials indicate they do not plan to add this category of drugs to the prior authorization list; instead, they plan to educate and encourage physicians to prescribe generic versions of antidepressants when appropriate.

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The federal Medical Assistance program, which funds health care services for low-income individuals, mandates coverage for inpatient and outpatient hospital services, nursing home care, and prescription drugs. However, certain therapy services that are provided outside of hospitals, such as occupational, physical, and speech/language therapies, are considered optional under the program and are covered at a state's discretion. These therapy services are typically provided in patients' homes, at providers' clinics, or by school districts, and they are supported by both federal Medical Assistance funding and state general purpose revenue (GPR). In most cases, therapy services require prior authorization by the Department of Health and Family Services (DHFS), which administers Wisconsin's Medical Assistance program, if costs are to be reimbursed by the program.

Administrative code states that prior authorization is intended to safeguard against unnecessary or inappropriate care.

According to s. HFS 107.02 (3)(b), Wis. Adm. Code, reasons for the prior authorization process include safeguarding against unnecessary or inappropriate care and services, preventing excess payments, and determining if less-expensive alternative care is possible. Providers submit prior authorization requests, which are reviewed by DHFS staff or its fiscal agent for the program. Following the review, requests may be approved or modified, or providers and patients may be notified that the requested services are not reimbursable under Medical Assistance. In 1999, 665 providers submitted at least one prior authorization request for therapy services.

Providers, patients and their families, and advocates believe that DHFS has recently changed the criteria and procedures it uses to review prior authorization requests. In particular, they assert that requests for therapy services for school-age children are being denied more frequently because the State has a financial incentive to provide services for children through the School-Based Services program, which is intended to maximize Medical Assistance funding for special education costs incurred by school districts.

Providers and advocates have asserted:

- that an increasing percentage of requests for the provision of therapy services to children are being denied, or are being modified by DHFS to provide care for a shorter period or less frequently than had been requested;

- that the time required for processing prior authorization requests is increasing;

- that requests are being returned to providers more frequently for additional information; and

- that DHFS is using unclear and inconsistent criteria in deciding whether to approve or deny services.

In response to these concerns, and at the request of the Joint Legislative Audit Committee, we examined prior authorization for therapy services, including:

- trends in the number of approvals, denials, and modifications of requests for prior authorization;

- the criteria DHFS uses to reach decisions on prior authorization requests;

- the time required to reach decisions on prior authorization requests; and

- the period for which prior authorization approvals are valid.

We also examined the possible expansion of the prior authorization process for certain types of prescription drugs.

In conducting our review, we analyzed all prior authorization requests for therapy services that were submitted from January 1995 through June 2000 and which included adequate information for a comprehensive analysis. This totaled approximately 77,000 requests, or 91.6 percent of all therapy requests submitted over this period. We also interviewed officials and staff of DHFS and the Department of Public Instruction and spoke with representatives of therapy associations, therapy providers, parents of children requesting therapy services, and school administrators.

Prior Authorization Requirements

DHFS has the authority under s. HFS 107.02 (3), Wis. Adm. Code, to require prior authorization for any service covered by Medical Assistance. However, prior authorization is currently required for only certain goods and services, such as:

- occupational, physical, and speech/language therapy services provided outside of a hospital or an educational agency such as a school district;

- transportation in specialized medical vehicles;
- durable medical equipment, which includes items such as hearing aids, wheelchairs, and prostheses;
- disposable medical supplies, such as diapers, above standard quantity limits;
- personal care and home health services;
- dental and orthodontic services;
- psychotherapy;
- alcohol and other drug treatment;
- certain medical services, including chiropractic care and organ transplants; and
- certain drugs, such as those that have less-expensive alternatives.

In 1999, goods and services requiring prior authorization represented 3.6 percent of the goods and procedures reimbursable under Medical Assistance, excluding medications.

Some therapy services do not require prior authorization.

Providers of therapy services are not required to submit prior authorization requests in four instances: when services are provided in an inpatient or outpatient hospital setting; when they are provided by a health maintenance organization (HMO), which may have its own internal referral or authorization practices; when they are provided by a local educational agency; or during the first 35 treatment days after a patient experiences a new "spell of illness," defined in administrative code as a loss of skills resulting from a new disease, injury, or medical condition or from an increase in the severity of a preexisting condition.

For those services that require prior authorization, s. HFS 107.02 (3), Wis. Adm. Code, establishes the following criteria for approving or denying a request:

- the appropriateness, cost, and medical necessity of the service;
- the frequency with which the service is furnished;
- the quality and timeliness of the service;

- the extent to which less-expensive alternative services are available;
- the effective and appropriate use of available services;
- the mis-utilization practices of providers and recipients;
- the limitations imposed by pertinent federal or state statutes, rules, regulations, or interpretations, including Medicare or private insurance guidelines;
- the need to ensure closer professional scrutiny when the quality of care has been unacceptable;
- flagrant or continuing disregard of established state and federal policies, standards, fees, or procedures; and
- the professional acceptability of unproven or experimental care, as determined by consultants to DHFS.

Program Expenditures

In FY 1999-2000, therapy expenditures represented less than 1 percent of Medical Assistance provider expenditures.

The amount of Medical Assistance expenditures associated with services that require prior authorization cannot be precisely determined, but it represents a small percentage of total program expenditures. In fiscal year (FY) 1999-2000, the State's largest Medical Assistance expenditures were for care that does not require prior authorization. Expenditures for nursing homes, HMOs, and hospitals were $1,671.7 million, or 64.8 percent of the total provider expenditures shown in Table 1. Moreover, only a small number of prescribed medications, which represented the third-largest category of FY 1999-2000 expenditures, require prior authorization. In contrast, expenditures for occupational, physical, and speech/language therapy services, which typically require prior authorization, were $16.2 million, or 0.6 percent of total Medical Assistance provider expenditures.

Table 1

Medical Assistance Provider Expenditures
FY 1999-2000
(in millions)

Category of Expenditure	Amount	Percentage of Total[1]
Nursing homes and institutions	$1,017.7	39.4%
HMOs	354.3	13.7
Drugs	325.9	12.6
Hospitals	299.7	11.6
Home care	137.1	5.3
Medicare[2]	130.0	5.0
Miscellaneous non-institutional care[3]	103.5	4.0
Physicians and clinics	57.9	2.3
County-matched services[4]	36.9	1.4
School-based services	35.9	1.4
Outpatient mental health	34.5	1.3
Durable medical equipment and disposable supplies	31.6	1.2
Therapy services	16.2	0.6
Total	$2,581.2	99.8%

[1] Total does not equal 100.0 percent because of rounding.
[2] Includes payment of premiums, deductibles, and copayments for low-income elderly and disabled Medicare recipients.
[3] Includes laboratory and x-ray charges; dental and vision care; chiropractic care; early and periodic screening, diagnostic, and treatment services; family planning services; prenatal care coordination; federally qualified health care centers treating medically underserved populations; ambulance and specialized medical vehicle transport; and other miscellaneous non-institutional care.
[4] Costs for additional services some counties choose to provide beyond those covered under state law. Counties provide the funds needed to match federal revenue.

As shown in Table 2, expenditures for therapy services decreased from $21.1 million in 1995 to $17.6 million in 1999, or by 16.6 percent. This decrease is due, in part, to the expansion of Medical Assistance coverage through HMOs, which are paid a flat monthly fee per patient regardless of which services are needed. Therapy expenditures requiring prior authorization also declined during the same period, but at a rate of 20.7 percent. In addition, the percentage of therapy expenditures requiring prior authorization decreased from 67.2 percent of total expenditures for therapy in 1995 to 63.8 percent in 1999.

Table 2

Medical Assistance Therapy Expenditures
1995 through June 2000

Year	Amount	Amount Requiring Prior Authorization	Percentage Requiring Prior Authorization
1995	$21,053,980	$14,155,793	67.2%
1996	23,596,673	15,205,685	64.4
1997	21,981,806	14,443,599	65.7
1998	18,983,906	11,564,019	60.9
1999	17,605,168	11,223,043	63.8
2000*	8,333,809	5,284,884	63.4

* Represents data through June 2000.

Most midwestern states provide therapy services to all Medical Assistance recipients.

Although occupational, physical, and speech/language therapy services are optional under federal regulations, Wisconsin provides these services to Medical Assistance recipients, as do six other midwestern states. However, as shown in Table 3, Indiana and Ohio cover therapy services only for Medical Assistance recipients classified as "categorically needy" because they do not have sufficient income to pay for health care services. Illinois, Iowa, Michigan, Minnesota, and Wisconsin offer these therapy services to all Medical Assistance recipients, including disabled and elderly persons with moderate incomes who qualify for the program when their health care costs would otherwise deplete all of their financial assets.

Table 3

Provision of Medical Assistance Therapy Services in Midwestern States

State	Provided to All Recipients	Provided Only to Categorically Needy Recipients
Illinois	X	
Indiana		X
Iowa	X	
Michigan	X	
Minnesota	X	
Ohio		X
Wisconsin	X	

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Like therapy expenditures, the number of prior authorization requests for therapy services has decreased over the past five years. However, both the number of staff reviewing requests and the time required to process requests have increased. The increase in processing time results primarily from requests being more thoroughly reviewed by DHFS or its fiscal agent and more frequently returned to providers because of incomplete or inaccurate information. To address concerns raised about the more thorough review process, DHFS has undertaken efforts to assist providers in writing complete and accurate requests, as well as efforts to reduce processing time.

Submission and Review Procedures

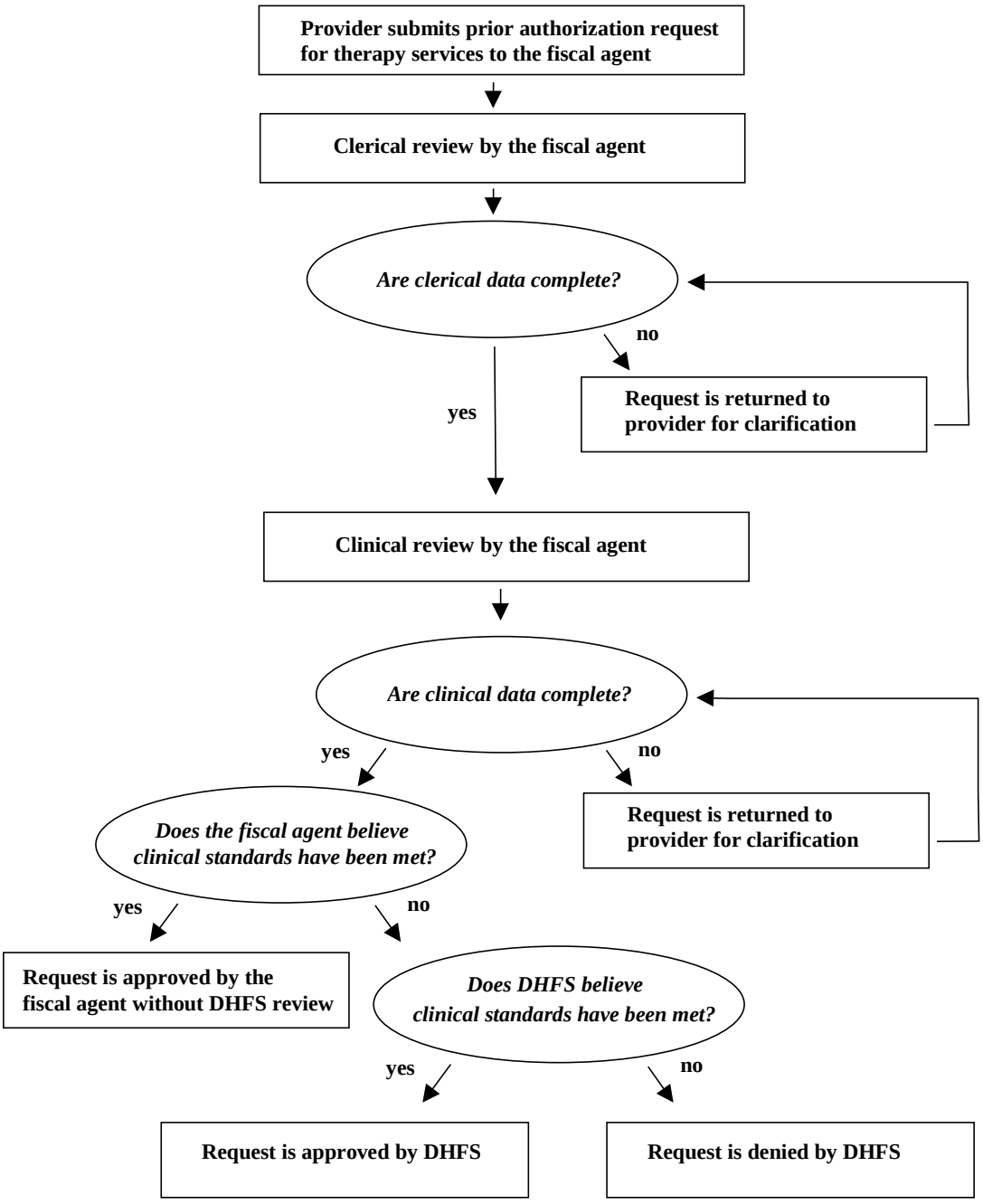
Prior authorization review is part of the fiscal agent's contract.

Since 1977, Electronic Data Systems has acted as the State's fiscal agent for the Medical Assistance program. In this role, the fiscal agent is responsible for processing payment claims and reviewing prior authorization requests. The current contract, in effect until December 2004, is structured to pay the fiscal agent a base fee for many services, including prior authorization review, with additional funds for reporting and data processing. The fiscal agent is not paid more if individual prior authorization requests require additional review. In FY 1999-2000, the fiscal agent was paid $40.5 million for all contract services, including $16.9 million for base fee services.

There are three primary phases of the prior authorization review process, which is shown in Figure 1: clerical review, clinical review, and final action. The fiscal agent performs the clerical review, receiving all requests submitted by providers and reviewing them for completeness and clerical accuracy. Requests that are incomplete or contain inaccurate information are returned to providers for clarification. The most common reasons for returning requests during the clerical review process are that Medical Assistance identification numbers or physicians' signatures are missing. Providers typically supply all missing or incorrect information when they resubmit requests. However, in some cases requests are returned several times before the information is complete and correct.

Figure 1

Prior Authorization Review Process



The second phase of the review process is a clinical review conducted by therapy consultants that the fiscal agent hires on a contractual basis. This step entails reviewing information such as the patient's current medical status, plans for treatment, coordination of treatment with any other health care providers, and goals to be achieved during the course of therapy. During this review, the fiscal agent may return the request to the provider for additional information or clarification. For example, a clinical reviewer may request that the provider supply additional information on the patient's current motor skills to determine if therapy is necessary. As with clerical review, requests may be returned to providers several times until sufficient information is available to make a determination.

The final phase is the decision to approve, approve with modifications, or deny reimbursement for the requested services. If the fiscal agent reviewer recommends approval, the provider is notified that services are reimbursable under Medical Assistance guidelines. If the fiscal agent reviewer recommends denial or modification, the request is forwarded to DHFS reviewers, who make a final determination in consultation with the Department's chief medical officers. If a request is denied or modified, the Medical Assistance recipient is notified directly with a letter.

Meeting Established Processing Time Standards

In addition to therapies, several other Medical Assistance services, including certain medications, durable medical equipment, and transportation in specialized medical vehicles, require prior authorization. Timeliness standards for processing prior authorization requests have been established in s. HFS 107.02 (3)(a), Wis. Adm. Code, which requires that determinations be made on 95 percent of all prior authorization requests within 10 working days of the date on which all necessary information is received, and on 100 percent of requests within 20 working days of that date. These standards apply to all goods and services for which prior authorization is required, rather than to individual categories of services. However, some requests, such as those for certain medications, are handled by an electronic approval system and can be processed almost instantly, while others, such as requests for therapy services, can take significantly longer.

DHFS does not measure whether it is meeting timeliness requirements for processing prior authorization requests.

DHFS does not determine the extent to which it is complying with these timeliness requirements. However, we reviewed the extent to which DHFS would have met established timeliness standards had they been applied only to prior authorization requests for therapy, rather than to all services. We found that if these standards had been applied only to prior authorization requests for therapy, DHFS would not have met timeliness standards for any of the three therapy types since 1996. Table 4 presents information on the percentage of requests processed within time limits set forth in administrative code.

Table 4

Percentage of Requests Processed
Within Time Limits Established in Administrative Code*
1995 through June 2000

	Occupational		Physical		Speech/Language	
Year	Within 10 days	Within 20 days	Within 10 days	Within 20 days	Within 10 days	Within 20 days
1995	91.8%	99.0%	95.7%	98.0%	98.0%	100.0%
1996	85.0	98.0	95.8	99.8	97.6	99.3
1997	86.9	97.8	87.9	97.5	94.0	99.0
1998	78.3	91.5	86.3	96.9	85.0	98.2
1999	82.3	95.9	92.4	99.1	85.7	99.2
2000*	81.5	94.8	91.9	99.7	88.3	99.3
Overall Standard	*95.0%*	*100.0%*	*95.0%*	*100.0%*	*95.0%*	*100.0%*

* Represents data through June 2000.

Assessing Changes in Processing Times

Average processing time increased by 6.7 percent between 1995 and June 2000.

To better understand the time DHFS and the fiscal agent require to process requests, we analyzed the number of working days between the initial submission of a prior authorization request and date at which a final decision was made. As shown in Table 5, the average number of working days required to process a prior authorization request increased by 6.7 percent between 1995 and 2000. The increase was 19.7 percent for physical therapy and 21.8 percent for speech/language therapy. Processing time decreased by 7.9 percent for occupational therapy, but it should be noted that processing time for occupational therapy has consistently been one to two weeks longer than for other therapy types. DHFS staff indicate this is because occupational therapy requests tend to be more complex and varied and can involve a wider range of therapeutic activities than other types of therapy requests.

Table 5

Average Total Processing Time for Prior Authorization Requests
1995 through June 2000
(in working days)

Year	Occupational	Physical	Speech/Language	All Therapies
1995	22.8	13.7	12.4	16.4
1996	24.8	14.2	12.5	17.1
1997	22.3	16.3	13.4	17.2
1998	26.9	18.3	14.8	19.9
1999	24.7	14.9	14.9	17.8
2000*	21.0	16.4	15.1	17.5
Percentage Change, 1995-2000	-7.9%	19.7%	21.8%	6.7%

* Represents data through June 2000.

In analyzing the data, we found that average processing times are skewed by some cases that take substantially longer to process. In fact, as shown in Table 6, more than half of the prior authorization requests were processed within 10 working days in both 1995 and 1999. In addition, over two-thirds of requests in both 1995 and 1999 were processed within 20 working days—but the percentage of requests processed within that time period decreased. While the majority of requests are still being processed within 20 days, that percentage is declining.

Table 6

Distribution of Total Processing Times
1995 and 1999
(in working days)

Total Processing Time	Number in 1995	Percentage of 1995 Total	Number in 1999	Percentage of 1999 Total
1 to 10 days	9,298	58.3%	7,068	51.7%
11 to 20 days	3,280	20.6	2,894	21.2
21 to 30 days	1,563	9.8	1,785	13.1
31 to 40 days	763	4.8	802	5.9
41 to 50 days	364	2.3	423	3.1
51 to 60 days	208	1.3	252	1.8
61 or more days	468	2.9	436	3.2
Total	15,944	100.0%	13,660	100.0%

Processing time by DHFS and the fiscal agent has generally increased and is longest for occupational therapy.

We could not determine an average number of working days prior authorization requests spent with providers, because processing time not spent with DHFS or the fiscal agent consists of time spent with the provider as well as time spent in transit. However, we were able to determine the number of days prior authorization requests spent with DHFS or the fiscal agent. As shown in Table 7, the time requests spent with DHFS or the fiscal agent increased by 9.7 percent between 1995 and June 2000. The increase was greatest for physical therapy. For occupational therapy, the number of days increased to its highest point in 1998 and then decreased in each of the following two years; however, processing time for occupational therapy requests remained the longest among the three therapy types.

Providers and patient advocates believe that delays in beginning a course of therapy or interruptions in a patient's therapy can be harmful to the patient and can increase costs. For example, providers assert that patients who have demonstrated progress may regress if therapy is interrupted when a request for additional therapy is not approved on a timely basis. Under such circumstances, providers believe it is possible that additional costs may be incurred in making up for progress lost while services are interrupted.

Table 7

Average DHFS/Fiscal Agent Processing Time for Prior Authorization Requests
1995 through June 2000
(in working days)

Year	Occupational	Physical	Speech/Language	All Therapies
1995	14.6	9.7	9.8	11.4
1996	16.0	9.9	9.4	11.7
1997	14.4	11.5	9.9	11.9
1998	16.9	12.9	10.8	13.6
1999	15.3	10.3	11.0	12.0
2000*	14.4	11.9	11.3	12.5
Percentage Change, 1995-2000	-1.4%	22.7%	15.3%	9.7%

* Represents data through June 2000.

Explaining Changes in Processing Times

The number of therapy requests declined by 14.3 percent between 1995 and 1999.

The increase in overall processing time for requests has occurred despite a decline in the number of requests submitted and an increase in the number of staff who process requests. As shown in Table 8, total prior authorization requests submitted for therapy services decreased from 15,944 in 1995 to 13,660 in 1999, or by 14.3 percent. The largest decline occurred between 1995 and 1996, when total requests fell by 1,431, or 9.0 percent. Among the three types of therapy, the largest decrease occurred for occupational therapy. Physical therapy requests decreased the least over this period.

DHFS staff attribute the submission of fewer requests to two main factors. First, total Medical Assistance enrollment declined by 7.7 percent between 1995 and 2000. Second, the statewide implementation of managed care programs for Medical Assistance recipients in 1995 has reduced the need for prior authorization. In 2000, 40.6 percent of Medical Assistance recipients were enrolled in HMOs, which are not required to seek DHFS's approval before providing therapy services to their members.

Table 8

Number of Prior Authorization Requests for Therapy Services
1995-1999

Year	Type of Therapy: Occupational	Physical	Speech/Language	Total	Percentage Change
1995	5,332	6,473	4,139	15,944	
1996	4,635	5,699	4,179	14,513	-9.0%
1997	4,200	5,862	4,091	14,153	-2.5
1998	3,940	5,732	3,538	13,210	-6.7
1999	4,069	6,110	3,481	13,660	3.4
Percentage Change, 1995-1999	-23.7%	-5.6%	-15.9%	-14.3%	

Since 1995, the number of therapy requests reviewed by each staff person has declined substantially.

In addition, we found that during the same period in which the number of prior authorization requests decreased, the number of full-time equivalent (FTE) staff reviewing requests increased from 3.1 to 5.2, or by 67.8 percent. As a result, the number of requests reviewed by each staff person declined substantially. As shown in Table 9, the number of requests per reviewer dropped from 5,143 in 1995 to 2,627 in 1999.

DHFS officials indicate that additional staff were assigned to review therapy requests following two independent consultants' studies in 1996 and 1997. One of the consultants recommended additional staffing to increase the time available to complete thorough reviews of requests.

The additional staff and the submission of fewer requests have allowed DHFS to review prior authorization requests more closely. This increased scrutiny has led to an increase in the percentage of requests that are returned for additional information. In 1999, 49.5 percent of requests were returned to providers for additional information and, as shown in Table 10, 50.5 percent were processed without returns. In 1995, 43.9 percent of requests were returned for additional information, and 56.1 percent were processed without returns. The percentage of requests processed without returns for additional information is lowest for occupational therapy and highest for speech/language therapy.

Table 9

Number of Staff Reviewing Prior Authorization Requests
1995-1999

Year	DHFS Staff*	Fiscal Agent Staff**	Total Staff	Number of Requests Submitted	Number of Requests per Staff Person
1995	2.0	1.1	3.1	15,944	5,143
1996	2.0	1.4	3.4	14,513	4,269
1997	2.0	1.9	3.9	14,153	3,629
1998	3.0	3.1	6.1	13,210	2,166
1999	2.5	2.7	5.2	13,660	2,627

* In addition to time spent processing requests, includes time spent on other functions, including corresponding with recipients and providers, revising fiscal agent guidelines, and preparing cases for administrative hearing.

** Includes only those hours spent reviewing prior authorization requests. Does not include vacation or other leave time.

Table 10

Percentage of Requests Processed Without Returns
1995-1999

Year	Occupational Therapy	Physical Therapy	Speech/Language Therapy	All Therapies
1995	46.1%	56.8%	67.9%	56.1%
1996	34.3	51.0	63.7	49.3
1997	38.4	51.9	60.1	50.3
1998	35.9	47.6	59.1	47.2
1999	38.6	54.5	57.4	50.5

The increase in the rate at which requests are returned to providers appears to be the primary factor increasing processing times. As shown in Table 11, we found that the average processing time for requests that were never returned decreased by 1.2 percent from 1995 to 1999, while

it increased by 3.3 percent for requests that were returned at least once. This indicates that additional time is not being taken with all requests, only those that reviewers believe are lacking adequate documentation or have other problems.

Table 11

Processing Time for Requests With and Without Returns
1995 and 1999

	Number of Requests in 1995	Average Working Days to Process	Number of Requests in 1999	Average Working Days to Process	Percentage Change in Average Processing Time
Never returned	8,950	8.4	6,897	8.3	-1.2%
Returned at least once	6,994	15.2	6,763	15.7	3.3

To better understand why prior authorization requests are returned, we examined the codes used by reviewers to indicate the reasons for returns. As noted, requests may be returned for either clerical reasons, such as a missing provider identification number, or clinical reasons, such as incomplete descriptions of treatment plans.

Approximately two-thirds of all return codes cited have related to clerical errors or omissions made by providers.

The majority of return codes for requests were related to clerical errors or omissions. As shown in Table 12, approximately two-thirds of codes cited in returns involved providers failing to submit correct and complete clerical information. However, the percentage of return codes related to clerical errors is decreasing, while the percentage of codes related to clinical errors is increasing. This is likely the result of the more thorough reviews by DHFS and fiscal agent staff.

Finally, we reviewed individual reasons coded in returns of prior authorization requests. As shown in Table 13, insufficient clinical information was cited as a reason for return in 28.5 percent of requests submitted from 1995 through June 2000. The next four most common reasons were all clerical in nature.

Table 12

Percentage of Return Codes Related to Clerical or Clinical Errors
1995 through June 2000

Year	Percentage of Return Codes Related to Clerical Information	Percentage of Return Codes Related to Clinical Information
1995	70.7%	29.3%
1996	68.4	31.6
1997	66.5	33.5
1998	66.1	33.9
1999	66.3	33.7
2000*	65.8	34.2

* Represents data through June 2000.

Table 13

Frequency of Top Five Reasons for Returns
1995 through June 2000*

Reason for Return	Type of Reason	Total Reasons for Returns	Percentage of Total
Insufficient clinical information to verify need for service	Clinical	18,398	28.5%
Missing or outdated physician's signature	Clerical	14,695	22.8
Failure to indicate patient's primary diagnosis code	Clerical	3,637	5.7
Inconsistent provider and Medical Assistance numbers	Clerical	2,112	3.3
Failure to include physician's prescription order for treatment	Clerical	1,728	2.7
Subtotal		40,570	63.0
All other reasons		23,900	37.0
Total		64,470	100.0%

* Represents data through June 2000.

Efforts to Improve Processing of Prior Authorization Requests

DHFS has undertaken several initiatives to improve its review process and reduce processing times in the future. However, service providers have questioned why greater efforts were not made sooner, given that DHFS officials have been aware of providers' need for additional guidance in writing prior authorization requests since 1996.

Studies of the prior authorization process that were funded by DHFS have found fault with both the data submitted by providers and the review process used to assess requests. A 1996 review of an undocumented number of speech therapy requests by an independent speech/language pathologist concluded that providers often submitted incomplete documentation and did not have a "clear understanding of the prior authorization review process." Another outside consultant reviewed 30 randomly selected 1997 occupational therapy requests and identified a few poorly written requests but concluded that providers were hindered by confusing forms and inconsistent reviewer practices. For example, some requests were returned for additional information that was actually provided in the original submission, and some reviewers asked for data unrelated to what is required by administrative code or DHFS guidelines. DHFS has since undertaken several efforts to improve its prior authorization review process.

A checklist is now used by reviewers to ensure that all clerical errors are noted at one time.

First, in September 1997, DHFS implemented a checklist to be used in reviewing each request for therapy services. Reviewers are instructed to note all clerical errors in one review before sending a request back to the provider. Previously, a reviewer might have returned the request upon discovery of the first clerical error, which could result in numerous returns before all the required information was provided.

Second, since 1998, DHFS has increased its efforts to educate providers regarding prior authorization procedures for therapy services. DHFS staff have made 16 presentations to explain the prior authorization process to providers, and they have met formally with four providers to review past prior authorization requests. In addition, DHFS staff have made 18 presentations to schools, social service agencies, the media, and advocacy groups for the disabled. However, some providers have expressed frustration with what they believe is the Department's inability or unwillingness to provide clear examples of "good" or "acceptable" prior authorization submissions during its presentations.

Third, to reduce the amount of time that is spent in transit as requests move between DHFS or the fiscal agent and providers, providers have been allowed to submit requests by fax since November 2000. DHFS will respond in the same manner unless the provider requests paper documentation. DHFS officials expect this to significantly reduce overall processing times.

New detailed instructions are being developed for completing prior authorization requests.

Finally, in response to provider concerns, DHFS is designing a new request form for prior authorization of therapy services and developing more comprehensive instructions. The new form is intended to make it easier for providers to write complete, structured requests and for DHFS reviewers to find all necessary information.

The new request form and accompanying instructions were piloted with five providers from February 1 through March 31, 2001. We spoke with four of these providers; the fifth was no longer in business at the time of our fieldwork. Three of the providers were satisfied that the new materials will help them submit more accurate and complete requests more easily. The fourth provider, which primarily serves children under three years of age, believes the new form's requirements for documenting coordination among all therapy providers are unnecessary for serving younger children. DHFS anticipates using the new form and instructions for all providers later this year.

Although DHFS has made several efforts to educate providers and to improve request processing, the large percentage of requests that continue to be returned to providers suggests that additional efforts are needed. Several provider groups indicate that they have asked DHFS to provide them with a clear definition of "medical necessity," because meeting this standard is the main criterion for approving a request for services. DHFS developed a draft document, known as a provider update, outlining its interpretation of the administrative code definition of medical necessity and shared it with several provider representatives in December 1998. However, a final version of this document has not been issued. To assist providers in developing a better understanding of how DHFS interprets the definition of medical necessity, *we recommend the Department of Health and Family Services issue specific guidance regarding how the concept of medical necessity is applied in its evaluations of prior authorization requests and make this information available to providers by November 1, 2001*.

In addition, DHFS may wish to focus its future educational efforts on providers submitting the largest number of prior authorization requests. We found that in 1999, just over half of all returns—51.7 percent—were generated by 20 providers. In most cases, these 20 providers were among those who submitted the greatest number of prior authorization requests. Focusing educational efforts on the largest providers will likely have the greatest effect on reducing return rates for prior authorization requests, as well as on improving the overall speed with which requests are processed.

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In addition to their concerns about increases in processing time, providers have raised concerns about the extent to which requests are denied or modified. They are particularly concerned about requests to provide services to school-age children, because they believe that these requests are being treated differently than those for other age groups. Although our analysis confirmed several of the providers' assertions, the cause of these changes—and whether they are beneficial or detrimental to the program—is less clear.

Trends in Decisions on Prior Authorization Requests

The majority of prior authorization requests for therapy services are for the treatment of individuals over the age of 21. As shown in Table 14, 51.4 percent of the 77,354 prior authorization requests received between 1995 and June 2000 were for individuals 22 and older. Another 25.5 percent were for individuals from 3 to 21, who are classified as school-age children entitled to receive special education services under state and federal law and are therefore likely to receive therapy services through schools or other local educational agencies without prior authorization. The remainder of requests, 23.1 percent, were for individuals less than three years old.

Reviewers of requests can take one of three actions: approval, approval with modification, or denial of the request. Approved requests may include a reduction in the total duration for which the therapy is authorized to be provided. For example, if a provider requests therapy services be provided to a patient twice per week for 26 weeks and reviewers reduce the duration to 12 weeks, DHFS and the fiscal agent consider the request to have been approved, and no record of the modification is made.

However, if reviewers approve less-frequent therapy than had been requested, even if it is approved for the requested duration, the request is considered a modification. For example, if a provider requests therapy services be provided to a patient twice per week for 26 weeks and reviewers authorize 26 weeks of therapy but only once per week, the request is recorded as a modification. Finally, if requests are denied, no services are approved and no reimbursement is provided through the Medical Assistance program.

Table 14

Distribution of Prior Authorization Requests by Age Group
1995 through June 2000

	Under 3 years		3-21		22 and Over		Total	
Year	Number of Requests	% of Total	Number of Requests	% of Total	Number of Requests	% of Total	Number of Requests	% of Total
1995	2,927	18.4%	3,640	22.8%	9,377	58.8%	15,944	100.0%
1996	3,082	21.2	3,796	26.2	7,635	52.6	14,513	100.0
1997	3,110	22.0	3,874	27.4	7,169	50.6	14,153	100.0
1998	3,407	25.8	3,465	26.2	6,338	48.0	13,210	100.0
1999	3,590	26.3	3,476	25.4	6,594	48.3	13,660	100.0
2000*	1,756	29.9	1,488	25.3	2,630	44.8	5,874	100.0
Total	17,872	23.1%	19,739	25.5%	39,743	51.4%	77,354	100.0%

* Represents data through June 2000.

Denial of Prior Authorization Requests

Denial rates for the 3-21 age group are higher than those for older or younger recipients.

As shown in Table 15, the overall rate at which prior authorization requests were denied increased from 1995 through 1997 and then decreased in each subsequent year through 1999. Denial rates for those under three years old were the most stable over time. In addition, the denial rate for this group has consistently been the lowest of the three age groups we reviewed. In contrast, denials for individuals in the 3 to 21 age group have increased over time, have been the highest of the three age groups since 1996, and were the most variable over time.

Although denial rates have increased somewhat over time and vary among age groups, it should be noted that in 1999 and the first half of 2000, over 96 percent of requests for therapy services resulted in some level of service being granted to the recipient. Denial rates in some earlier years were higher, but for all age groups as a whole denials have not exceeded 6.2 percent in any of the years we examined.

Table 15

Percentage of Prior Authorization Requests Denied, by Age Group
1995 through June 2000

Year	Under 3 Years	3-21	22 and Over	All Ages
1995	0.1%	1.6%	3.5%	2.5%
1996	0.1	5.0	4.7	4.2
1997	0.1	11.7	5.3	6.2
1998	0.1	10.6	4.5	5.1
1999	0.1	8.8	3.1	3.8
2000*	0.2	9.5	3.0	3.8

* Represents data through June 2000.

Denial rates were substantially lower for children under three than for other age groups.

We also found that denial rates for children under three years of age were substantially lower than those for other age groups. DHFS staff indicate that they take a less-stringent approach in approving therapy requests for children under the age of three because the developmental needs of young children are difficult to determine, and early intervention is believed to mitigate future therapy costs. This group is typically served through the Department's Birth to Three program, which is mandated to provide early intervention services for children under the federal Individuals with Disabilities Education Act.

DHFS officials attribute the increased denial rates for those from 3 to 21 to the Department's efforts to improve the program. Section HFS 107.02 (3), Wis. Adm. Code, indicates that one of the reasons for prior authorization is to safeguard against unnecessary or inappropriate care and services, which DHFS officials indicate includes determining whether the requested services would duplicate those being received from another provider. DHFS has enhanced its review of prior authorization requests to better determine when similar services are being provided in other settings, such as through a school district.

To provide more information on why requests are denied, we reviewed the reasons that are coded by DHFS and fiscal agent staff for denial. As shown in Table 16, from 1995 through 1999, the single most common reason for denial of requests—"service(s) do not meet Medical Assistance guidelines"—accounted for 53.4 percent of the reasons that requests were denied. In general, this denial code indicates that the provider did not adequately establish the medical necessity of the proposed service as required by state and federal law. It should be noted that two of the top five reason codes cited in denial—"services were

provided before prior authorization was obtained" and the required patient evaluation information was not submitted within required time limits—represent 15.9 percent of all reasons DHFS denied services and are failures on the part of providers to comply with program policies and procedures.

Table 16

Top Five Reason Codes Cited in Request Denials
1995-1999

Reason for Denial	Frequency of Code	Percentage of All Codes
Service(s) do not meet Medical Assistance guidelines	1,780	53.4%
Insufficient documentation to support the request	321	9.6
Services were provided before prior authorization was obtained	268	8.0
The required patient evaluation was received more than two weeks after evaluation was conducted	264	7.9
Skills of a therapist are not required to maintain the recipient's progress	72	2.2
Subtotal	2,705	81.1
All other codes	632	18.9
Total for all codes	3,337	100.0%

A Medical Assistance recipient who believes that the denial of services was not justified may appeal the decision, and the case will be heard by an administrative law judge in the Department of Administration's Division of Hearings and Appeals. We examined the outcome of appealed cases to determine whether the decisions of DHFS to deny services were generally upheld. From 1998 through 2000, administrative law judges ruled on the merits of prior authorization denials for therapy services in 266 instances. Of these denials:

- 115 (43.2 percent) were upheld;
- 76 (28.6 percent) were upheld in part and overruled in part; and
- 75 (28.2 percent) were overturned.

It should be noted that these data may not provide a good picture of the Department's overall performance, because the number of cases appealed represents a small percentage of the total denied and because cases that are pursued are presumably appealed because of factors suggesting DHFS reviewers made an error.

Current denial correspondence is not specific or clear regarding reasons for denial.

When a request is denied, DHFS sends a letter directly to the Medical Assistance recipient indicating the reason for denial and also notifies the provider by returning of the request form with the reason for denial indicated. As noted, the reason code indicated in more than half of the denials is that the service requested does not meet Medical Assistance guidelines. However, this reason—which is provided with no other detail—is typically insufficient for a recipient or a provider to understand why the request was denied. Without more detailed and case-specific explanations of the reason for denial, it is difficult for a provider to avoid submitting similar requests in the future.

Currently, DHFS staff provide written, case-specific explanations for denials only if Medical Assistance recipients appeal denials and hearings are scheduled with administrative law judges. Given that letters are already sent to recipients each time service is denied, it would be beneficial if these letters always included an explicit statement of the reasons for denial. Although writing case-specific letters would require additional staff time, it might also reduce future costs by, for example, educating recipients and providers about Medical Assistance requirements so that future prior authorization requests contain appropriate and adequate information and will have to be returned less often. Additional information could help recipients to make more informed decisions about whether to seek an appeal. Therefore, *we recommend the Department of Health and Family Services include more specific explanations of why prior authorization requests have been denied in each denial letter that is sent to a Medical Assistance recipient and in correspondence to the provider*.

Modification of Prior Authorization Requests

Requests for service are modified more frequently for the 3-21 age group than for other age groups.

As noted, while providers make specific requests regarding treatment frequency for clients, DHFS staff have the discretion to make changes to the requested frequency. As shown in Table 17, rates of modification follow a similar pattern to rates of denial. Overall, modification rates increased from 1995 through 1997 and then decreased in each subsequent year. Modification rates for those under three years old were again lowest among the three age groups. In contrast, modification rates for the 3 to 21 age group have generally increased over time. As with increased denial rates for individuals from 3 to 21, DHFS staff attribute these trends to shorter recommended courses and intensities of therapy, as well as the need to coordinate treatment with other providers such as local educational agencies.

Table 17

Percentage of Prior Authorization Requests Modified, by Age Group
1995 through June 2000

Year	Under 3 Years	3-21	22 and Over	All Ages
1995	2.5%	4.2%	4.0%	3.8%
1996	4.0	5.6	7.8	6.4
1997	2.5	5.8	9.2	6.8
1998	2.6	7.4	8.7	6.7
1999	2.0	7.0	6.4	5.3
2000*	1.4	7.0	5.3	4.5

* Represents data through June 2000.

We were unable to determine directly the extent to which DHFS had reduced the requested duration of services because, as noted, when services are approved but their duration is shortened, the requests are considered to have been approved and are not counted as modifications. Providers believe both that the duration of requested services is being shortened and that this may hamper the effectiveness of therapy by unnecessarily interrupting services if further requests are not approved in a timely manner.

Therapy requests for the 3-21 age group are more likely to be approved for shorter periods.

Although we could not determine directly the frequency with which periods of service were reduced during the prior authorization process, we were able to measure changes in the periods for which prior authorizations were valid. Overall, we found that the authorized time period for services increased through 1997 and has generally decreased since that time. As shown in Table 18, at 14.4 percent, the decline in the number of authorized days was greatest for those from 3 to 21. In fact, except for 1995, the number of days prior authorization approvals have been valid has been lowest for the 3 to 21 age group. These trends were consistent among the three therapy types.

Table 18

Number of Calendar Days for Which Prior Authorizations Are Valid
1995 through June 2000

Year	Under 3 Years	3-21	22 and Over	All Ages
1995	174.2	154.0	141.5	150.6
1996	164.7	148.6	223.2	191.0
1997	157.8	138.9	232.4	190.4
1998	150.1	126.6	206.6	170.9
1999	148.0	126.5	169.6	153.1
2000*	152.2	131.9	176.2	157.9
Percentage Change, 1995-2000	-12.6%	-14.4%	24.5%	4.9%

* Represents data through June 2000.

DHFS officials attribute the shorter length of approved treatment time for those from 3 to 21 to recommended standards of practice in providing therapy services to children. Because children are still growing and developing, and changes in their abilities may occur at an uneven pace, professional therapy associations recommend that children's therapy goals be more specific and of shorter duration. Shorter courses of treatment allow for more frequent evaluation of a child's current status and abilities, according to DHFS staff.

The number of requests submitted per person has increased over time and is higher for children than adults.

A logical consequence of a decrease in the authorized duration of therapy services is an increase in the number of requests per recipient. We found that, overall, the average number of requests submitted per recipient per year has increased since 1996. As shown in Table 19, the increase from 1995 through 1999 was the greatest for those from 3 to 21. The number of requests per recipient 22 or older actually decreased slightly over this period.

Table 19

Average Number of Prior Authorizations Submitted per Person, by Age Group
1995-1999

Year	Under 3 Years	3-21	22 and Over	All Ages
1995	2.44	2.12	1.80	1.96
1996	2.48	2.22	1.71	1.96
1997	2.53	2.32	1.67	1.97
1998	2.60	2.37	1.64	1.99
1999	2.77	2.45	1.70	2.07
Percentage Change, 1995-1999	13.5%	15.6%	-5.6%	5.6%

The number of providers submitting prior authorization requests increased between 1995 and 1999.

As with shortened treatment periods, providers and advocates believe that an increased number of requests submitted per person has a negative effect on patients. As noted, providers are concerned that requiring providers to submit a larger number of requests may result in gaps in service delivery, which they believe can adversely affect patients' progress. In addition, they believe that placing additional administrative burdens on providers may result in some choosing not to serve Medical Assistance clients. However, as shown in Table 20, the number of providers submitting at least one request per year increased by 11.6 percent between 1995 and 1999. This increase occurred during the same period that some Medical Assistance clients began to be served through HMOs, which, as noted, are not required to obtain the State's approval before providing services. Therefore, it does not appear that providers have become more reluctant to serve Medical Assistance clients.

Table 20

Number of Therapy Providers Submitting at Least One Prior Authorization Request
1995-1999

Year	Number of Providers	Percentage Change
1995	596	
1996	594	-0.3%
1997	590	-0.7
1998	603	2.2
1999	665	10.3
Percentage Change, 1995-1999		11.6%

Providers assert that trends in the Department's decisions on prior authorization requests for therapy services substantiate concerns they have expressed and create the potential for gaps and delays in providing service, especially to school-age children. In contrast, DHFS officials maintain that the changes are simply the result of good management and that they justify enhanced review of prior authorization requests for therapy services. In an attempt to provide a more complete context for this debate, we reviewed the School-Based Services program, through which therapy services provided to school-age children are funded by Medical Assistance.

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While very young children and adults requiring therapy services are typically served by private providers in their communities, school-age children are often served in their schools by school therapists. The majority of Medical Assistance funding for these services is provided by the School-Based Services program, which partially reimburses schools for these costs. Community-based therapy providers believe the State has encouraged the provision of care through the School-Based Services program because this approach saves state GPR. Parents have questioned whether the program results in substantially fewer children being served during the summer months, when most schools do not provide services. To address these concerns, we compared rates of denial for children who both requested community-based therapy and were receiving School-Based Services therapy with those for children not in the School-Based Services program.

History of the School-Based Services Program

The School-Based Services program allows schools to capture federal Medical Assistance funds for special education services.

The School-Based Services program was established as a funding program intended to capture Medical Assistance funds for some federally mandated special education costs incurred by educational agencies such as school districts. The 1998 federal Medicare Catastrophic Coverage Act requires Medical Assistance funds to be used before any other federal funding source for medical costs related to special education of disabled school children. Wisconsin's School-Based Services program was established by 1995 Wisconsin Act 27 to give educational agencies easier access to Medical Assistance funding to meet their special education costs. While all public school children requiring special education services receive them at no charge, only low-income children qualifying for Medical Assistance are eligible to have their special education costs paid for by the School-Based Services program.

Federal special education law requires schools to provide and pay for medical services determined by an independent review team to be necessary for a child's education and documented in his or her Individual Education Plan (IEP). The School-Based Services program allows educational agencies to become Medical Assistance providers and to claim partial reimbursement for therapy, nursing, special transportation, and other medical service costs that are identified as necessary for a special education student to receive a public education.

Expansion of School-Based Services

Both the use of School-Based Services funding and the number of children served by the program have increased substantially since 1995.

The School-Based Services program has grown substantially. As shown in Table 21, the number of children served, the number of educational agencies receiving funding, and total expenditures have all risen substantially since the program was created in July 1995. In 1999, the last year for which comprehensive data are available, 158 of Wisconsin's 426 school districts (37 percent of all districts), 8 of 12 Cooperative Educational Service Agencies (CESAs), and 1 of 5 Children with Disabilities Education Boards run by counties received $15.3 million in School-Based Services funds to serve 19,811 children.

Table 21

School-Based Services Program Service and Funding Levels
1995-1999

Year	Number of Children Served	Number of Educational Agencies Served*	Federal Medical Assistance Reimbursement to Educational Agencies
1995	199	7	$ 33,013
1996	2,935	46	1,244,801
1997	11,789	82	6,428,939
1998	17,320	154	13,609,155
1999	19,811	167	15,300,562

* Includes school districts, CESAs, and Children with Disabilities Education Boards.

In 1999, School-Based Services funded 1.5 percent of statewide special education costs.

Although it has grown rapidly, School-Based Services funding covers only a fraction of statewide special education costs. In total, 16.3 percent of Wisconsin's 121,205 special education students received services funded through the School-Based Services program in 1999. However, the program funded only 1.5 percent of total statewide special education costs, or $15.3 million.

As shown in Table 22, transportation costs are the single largest program expense and represent 32.0 percent of total School-Based Services program costs. These costs are reimbursable only for children who cannot ride regular buses without aides or special equipment. When combined, speech/language, physical, and occupational therapies account for 54.2 percent of total program costs.

Table 22

School-Based Services Program Costs
1999
(in millions)

Type of Service	Reimbursed Costs	Percentage of Total
Transportation	$ 4.9	32.0%
Speech/language therapy	4.7	30.7
Occupational therapy	1.9	12.4
Nursing	1.8	11.8
Physical therapy	1.7	11.1
Other costs*	0.3	2.0
	$15.3	100.0%

* Includes social worker services, psychologist services, counselor services, development of IEPs, and durable medical equipment.

Funding Issues

When a service is performed by a community-based provider and directly reimbursed through the Medical Assistance program, the provider is paid a set reimbursement for the specific service rendered. As with all Medical Assistance services in Wisconsin, funding consists of approximately 41 percent GPR and 59 percent federal funds. For example, if therapy service was provided for which the maximum reimbursement rate established by Medical Assistance was $400, the provider would be paid a maximum of $400, consisting of $236 in federal funds and $164 in GPR.

The State retains 40 percent of the federal Medical Assistance reimbursement provided to schools.

In contrast, if a school district provided the same service under the complex School-Based Services funding formula, it would be responsible for providing matching funds for the service equal to $164.00 (40 percent of the approved federal reimbursement rate for the service provided). The State would pay the school $141.60 (35.4 percent of the Medical Assistance–approved reimbursement) in federal funds through the program, and the remaining amount of federal reimbursement—equal to $94.40, or 23.6 percent of the total reimbursed—would be retained in the State's General Fund in recognition of the State's support of general local education costs. Table 23 illustrates the distribution of funds for a community-based provider and a school district participating in the School-Based Services program.

Table 23

Example of the Distribution of Medical Assistance Therapy Funding, Based on Provider Type

	Community Providers	School-Based Providers
Federal funds	$236.00	$236.00
Federal funds retained by the State	0.00	(94.40)
GPR funds to the provider	164.00	0.00
Funding provided by educational agency	0.00	258.40
Total funding	$400.00	$400.00

As shown in Table 24, School-Based Services expenditures have grown substantially, from $93,257 in 1995 to $43.2 million in 1999. As a result, the annual amount of federal reimbursement retained in the General Fund over that period increased from $22,009 to $10.2 million.

Table 24

Total School-Based Services Program Costs
1995-1999

Year	Federal Reimbursement Retained in General Fund	Federal Reimbursement Paid to Educational Agencies	Funds Paid by Educational Agencies	Total Program Costs
1995	$ 22,009	$ 33,013	$ 38,235	$ 93,257
1996	829,868	1,244,801	1,441,719	3,516,388
1997	4,285,959	6,428,939	7,445,946	18,160,844
1998	9,072,770	13,609,155	15,762,015	38,443,940
1999	10,200,375	15,300,562	17,720,990	43,221,927

The Legislature's decision to implement the School-Based Services program in a manner that allows the State to retain a portion of the federal funding has allowed both school districts and the State to receive financial benefits from the program. However, some have questioned

whether the State should return a greater percentage of the federal funding to school districts. In April 2000, the federal General Accounting Office reported that 46 states had developed similar programs and that 15 of these states retain a portion of the federal reimbursement for health care services provided. Of these 15 states, 7 retain a greater proportion of funds than Wisconsin does. Among other midwestern states that have school-based Medical Assistance programs, Michigan retains 40 percent; Ohio retains 4 percent; and Illinois retains 10 percent, but only from its largest school districts. Minnesota, on the other hand, retains none of the federal reimbursement for health care services and passes it all to local education agencies. However, it should be noted that Wisconsin funds a substantial portion of local education costs that other states may not.

During the past two years, the Legislature increased the amount of federal reimbursement returned to school districts.

As a result of concerns regarding the State's retention of a portion of the federal reimbursement, the Legislature acted to temporarily increase the portion sent to school districts. 1999 Wisconsin Act 9, the 1999-2001 Biennial Budget Act, directed DHFS to provide school districts with 90 percent of the federal reimbursement received for all School-Based Services expenditures above $16.1 million in both FY 1999-2000 and FY 2000-01. The additional funding is distributed based on the proportion of School-Based Services costs reimbursed to each participating school district in the prior fiscal year. In September 2000, DHFS distributed a total of $3.8 million in additional funding to 167 local education agencies for costs incurred during the 1999-2000 school year.

Concerns Regarding Service

Providers and advocates believe that because the State retains a portion of the federal reimbursement for School-Based Services, it has an incentive to ensure services are provided by local educational agencies rather than by private providers. We compared rates of denial for children who both requested community-based therapy and were receiving School-Based Services therapy with those for children not in the School-Based Services program, and we found that the data do not support these assertions.

Community therapy denial rates for children receiving school-based services were lower than denial rates for children not receiving school-based services.

If, as providers believe, DHFS wanted to maximize the financial benefits of the School-Based Services program, then community-based services for children in schools participating in the program would be denied more often than services for children who are not served by the program. However, as shown in Table 25, the community-based therapy denial rates for children participating in the program were actually lower than those for children who were not receiving school-based therapy services in both 1998 and 1999, the two most recently completed years for which data are available.

Table 25

Denial Rates for Children's Community-Based Therapy Services
1998 and 1999

Year	Denial Rate for Children Also Receiving Therapy Through School-Based Services	Denial Rate for Children Not Receiving Therapy Through School-Based Services
1998	10.4%	10.9%
1999	8.4	9.4

Since the creation of the School-Based Services program, school districts have accounted for an increasing percentage of the Medical Assistance–funded therapy services provided to disabled children. As shown in Table 26, the amount spent for therapy services provided through the School-Based Services program to disabled children by local education agencies has increased substantially, growing from 0.3 percent of all therapy costs in 1995 to 62.0 percent in 1999.

Table 26

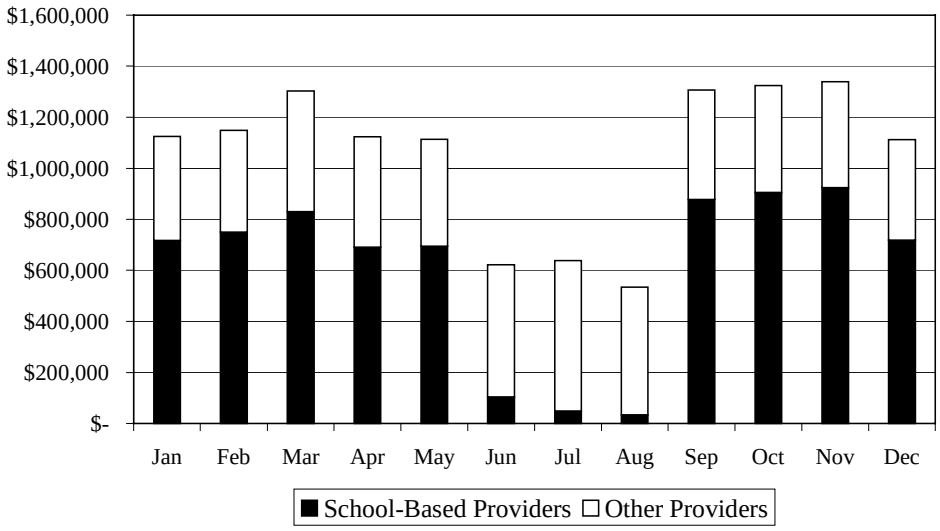
Reimbursement for Therapy Services
1995-1999

Year	School-Based Provider Expenditures	Community Provider Expenditures	Total Expenditures	School-Based Provider Expenditures as a Percentage of Total Expenditures
1995	$ 20,000	$6,700,000	$ 6,720,000	0.3%
1996	800,000	7,400,000	8,200,000	9.8
1997	3,500,000	6,700,000	10,200,000	34.3
1998	6,400,000	5,700,000	12,100,000	52.9
1999	8,300,000	5,100,000	13,400,000	62.0

Some parents and providers believe the increased percentage of total Medical Assistance–funded therapy services provided by school districts results in inadequate service during the summer months. As shown in Figure 2, during 1998 and 1999, average monthly therapy costs for the 3 to 21 age group declined substantially during the summer. While total therapy expenditures averaged $598,060 during the months of June, July, and August, they averaged $1,210,629 during the other nine months of the year, when school is in session. The lower expenditures reflect a decline in services provided by school districts. Even though monthly community provider expenditures rose during the summer, these increases did not compensate for the decreased School-Based Services expenditures.

Figure 2

Average Monthly Therapy Expenditures for Individuals Ages 3-21
1998 and 1999



School districts are not required to provide special education services year-round unless mandated by a pupil's IEP, and only 108 of the 158 districts participating in the School-Based Services program provide Medical Assistance therapy services during the summer. Federal and state special education laws are intended to offer disabled children the same access to education that non-disabled children have. Because few non-disabled children attend school during the summer, it is not unexpected that few disabled children will receive services during the summer.

School districts are required to pay for summer services if they are required in a child's IEP.

However, it appears that the funding mechanism may discourage some school districts from offering these services. Under federal law, schools are obligated to pay for therapy during summer months if the IEP team recognizes the need for such services. However, under state law, IEP teams are not required to consider the need for summer therapy services; instead, the need is typically considered only if a member of the team, such as the child's parent, specifically requests that this be evaluated.

If the IEP does not indicate that a child requires summer therapy services, a parent may request services be provided in the community instead. Therefore, DHFS officials believe that the decrease in services during summer months does not necessarily indicate that needed services are not being provided, only that some therapy services are not necessary during months when children are not in school. Some community therapy providers, on the other hand, believe that additional services are needed during the summer but are not always provided in the community because of the obstacles imposed by the prior authorization process. In addition, some believe that the real problem rests with school districts, which some assert have not always met their legal obligation to provide therapy services to students during the summer months.

The practice of using IEPs in determining the medical necessity of therapy services has been questioned.

In determining whether summer services are medically necessary, DHFS and fiscal agent reviewers examine the child's IEP to determine which services have been provided during the school year and whether the IEP indicates these services are necessary during the summer. Several parents, providers, and interest group representatives assert that this process is flawed because there is an economic disincentive for schools to include summer therapy in IEPs when school districts are obligated to fund these services. Moreover, they believe that because prior authorization is not required for services provided during the school year through the School-Based Services program, the use of the IEP in determining the need for therapy services during the summer months creates a different, inappropriate standard for determining whether care should be provided. They assert that the IEP is an educational planning document, and its use in determining the medical necessity of treatment is inappropriate.

As noted previously, DHFS has drafted a document interpreting its definition of medical necessity. The document also contains a discussion of the difference between services considered medically necessary for children to receive a public education and those considered medically necessary for anyone regardless of age. Our recommendation that DHFS issue specific guidance in this area is intended to help providers and Medical Assistance recipients to better understand the distinctions DHFS draws between medical necessity in educational and non-educational settings.

Some providers noted that since implementation of the School-Based Services program, the denial rate for children's therapy services has increased. In 1995—the year before implementation of School-Based Services—DHFS denied 1.6 percent of all authorization requests from community-based therapists to provide services to those ages 3 to 21. Since then, the denial rate has ranged from a low of 5.0 percent in 1996 to a high of 11.7 percent in 1997.

Providers also expressed concerns about the timeliness of DHFS reviews of requests for therapy during summer months and about whether DHFS considers requests for services during summer months differently than those during the school year. Based on the assumption that requests submitted between April 1 and June 30 represent summer service requests, and requests submitted in other months represent school-year service requests, we reviewed all prior authorization requests for the 3 to 21 age group submitted by community-based therapy providers from 1995 through 1999.

We found similar processing times and denial rates for summer and school-year requests, but differences in the amount of therapy approved. Between 1995 and 1999, the average processing time for summer requests increased from 10.6 days to 14.7 days; over the same period, the processing time for school-year requests increased from 12.1 days to 14.4 days. However, we found the denial rate averaged 8.1 percent for summer requests, slightly higher than the 6.6 percent denial rate for school-year requests. In addition, as shown in Table 27, we found that the authorized treatment duration for summer service was shorter than that for school year service. However, because DHFS does not document the amount of therapy services each provider requests, we were not able to determine whether these differences reflect more limited requests by providers in summer or decisions by DHFS and fiscal agent staff to approve shorter service periods.

We also reviewed a sample of cases in which denials of summer therapy services were appealed. We found that it is unclear whether administrative law judges generally uphold these denials. Neither DHFS nor the Division of Hearings and Appeals keeps separate records on appeal decisions for summer therapies; however, DHFS staff provided us with 13 summer therapy appeal cases decided between 1997 and 2000. In 8 of the 13 cases, the Department's denial was upheld in full, in 2 cases the denial was upheld in part and overruled in part, and in 3 cases the denial was overruled in full.

Table 27

Therapy Prior Authorizations for Individuals Ages 3-21
Average Time Approved (in calendar days)

Year	Period Authorized for Summer Request	Period Authorized for School-Year Request
1995	132.1	159.5
1996	119.8	152.4
1997	117.3	140.6
1998	106.5	128.0
1999	112.7	124.6

Given the growth in the School-Based Services program as the primary mechanism for providing therapy services to school-age children, and the decline in therapy services provided during summer months, the Legislature might wish to consider:

- whether it should require DHFS to discontinue the use of IEPs as a source of information in determining whether to approve requests for therapy services and to develop other criteria for assessing the medical necessity of the requested services; or

- whether it should require DHFS to assume that any continuation of IEP-mandated therapy is medically necessary.

Implementation of these options may result in increased Medical Assistance costs. In particular, DHFS officials note that some IEP-mandated services do not meet the standard of medical necessity outside of the educational setting. Should these services be automatically approved because they are included in an IEP, officials believe program costs could increase significantly. In addition, some believe that requiring DHFS to authorize IEP-mandated therapy during the summer may discourage school districts from meeting their obligation to provide therapy services during the summer when needed.

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Prior Authorization for Prescription Drugs

In FY 1999-2000, prescription drugs represented 12.6 percent of total provider expenditures.

Nearly all medications prescribed by a physician are covered by the Medical Assistance program. However, DHFS requires prior authorization for certain drugs as a means of controlling costs, and it plans to expand the use of prior authorization to further control drug cost increases. Prescription drug costs are the largest single category of expenditures for non-institutional care in the Medical Assistance program. They represented 12.6 percent of total provider expenditures in FY 1999-2000, making controls in this area important to controlling the overall cost of the Medical Assistance program.

Prescription Drug Expenditures

DHFS estimates that less than 1 percent of drugs require prior authorization.

As shown in Table 28, total prescription drug expenditures in the Medical Assistance program have increased from $185.4 million in FY 1995-96 to $325.9 million in FY 1999-2000, or by 75.8 percent. DHFS does not track the cost of drugs requiring prior authorization separately from the cost of other drugs; therefore, we were unable to determine the percentage of total drug expenditures related to drugs requiring prior authorization. DHFS staff estimate that less than 1 percent of drugs require prior authorization but believe the percentage of total expenditures represented by those drugs is substantially higher.

Table 28

Prescription Drug Expenditures for the Medical Assistance Program
FY 1995-96 through FY 1999-2000
(in millions)

Fiscal Year	Total Expenditures	Percentage Change
1995-96	$185.4	
1996-97	204.8	10.5%
1997-98	224.9	9.8
1998-99	259.3	15.3
1999-2000	325.9	25.7
Percentage Change, 1995-96 to 1999-2000		75.8%

Federal Prescription Drug Regulations Under Medical Assistance

Federal regulations regarding state Medical Assistance programs' coverage of drugs have changed over time. The Omnibus Budget Reconciliation Act of 1990 prohibited states from developing formularies (lists of drugs to be covered by a private or public health insurance program) and instead required that states cover any drug considered to be medically necessary and produced by a manufacturer that had entered into a rebate agreement with the federal government. The Omnibus Budget Reconciliation Act of 1993 relaxed that restriction and allowed states to develop formularies; however, states were required to develop a prior authorization process to allow coverage of any drug deemed medically necessary. In addition, each state's governor was required to appoint a board to determine which drugs would be included in the formulary.

DHFS uses the prior authorization process to help control prescription drug costs.

Because of the requirement that any drug deemed medically necessary be covered—either by being included in the formulary or through the prior authorization process—DHFS staff report that a formulary would have to be quite expansive, or the prior authorization process for drugs greatly expanded, for a formulary to be implemented successfully. Therefore, DHFS has chosen instead to use the prior authorization process to help control drug costs.

Drugs Requiring Prior Authorization

Under s. HFS 107.10 (2), Wis. Adm. Code, the following drugs require prior authorization before their cost will be covered by Medical Assistance:

- all stimulant drugs placed on Schedules II, III, and IV by the federal Controlled Substances Act, which regulates the use and distribution of certain drugs because of their potential for abuse (the only exception to this classification under Wisconsin's Medical Assistance program is methylphenidate [Ritalin]);

- medically necessary, specially formulated nutritional supplements and replacement products, including products used for the treatment of severe health conditions such as metabolic disorders;

- any drug produced by a manufacturer that has not entered into a rebate agreement with the federal government, if the prescribing provider demonstrates to DHFS that no other drug sold by a manufacturer that has signed a rebate agreement is medically appropriate and cost-effective in treating the recipient's condition;

- drugs identified by DHFS that are sometimes used to treat fertility or impotence, when used to treat conditions not related to fertility or impotence; and

- at the discretion of DHFS, drugs that have been demonstrated to entail substantial cost or utilization problems for the Medical Assistance program, including antibiotics that cost $100 or more per day.

In exercising its discretion to require prior authorization, DHFS has generally chosen to require prior authorization for drugs:

- that are manufactured by companies not participating in a drug rebate program; or

- that have generic versions available at lower cost, or that are expensive and have other alternatives DHFS requires physicians to try before prescribing the more expensive drugs.

Department Strategies to Control Drug Costs

DHFS requires prior authorization for some expensive drugs that have cheaper generic alternatives.

Because the cost of prescription drugs has increased by 75.8 percent in the past five fiscal years, DHFS has developed strategies to contain cost increases. In doing so, DHFS has focused on particular classes of drugs for which significant cost savings may be achieved. DHFS has interpreted administrative code related to drugs that "entail substantial cost or utilization problems for the Medical Assistance program" to allow it to require prior authorization for these high-cost medications.

As noted, DHFS often requires prior authorization for brand-name drugs that have less-expensive generic equivalents. For example, two ulcer treatment medications, Pepcid and Axid, have been placed on the prior authorization list because less-expensive generic versions of these drugs are available. The same has been done with Vasotec and Lisinopril, two blood pressure medications for which generic versions are available. As shown in Table 29, DHFS estimates that the addition of several other drugs to the prior authorization list over the next two fiscal years will result in savings of approximately $34.0 million.

Table 29

DHFS-Estimated Savings on Drugs
for Which Prior Authorization Is Planned
FY 2001-02 and FY 2002-03
(in millions)

Drug Category	Therapeutic Action	Estimated FY 2001-02 Savings	Estimated FY 2002-03 Savings
Proton pump inhibitors	Treatment of ulcers	$8.0	$14.0
Anti-hyperlipidemics	Lowering of cholesterol	3.0	7.0
Non-sedating antihistamines	Treatment of allergies	-	2.0
Total		$11.0	$23.0

Some have raised concerns regarding particular classes of drugs that might become subject to prior authorization. In particular, mental health advocates are concerned that several commonly prescribed antidepressants known as SSRIs (selective serotonin reuptake inhibitors, such as Prozac) might become subject to prior authorization as the patents on some of these drugs expire in late 2001. At present, DHFS officials indicate that they are not considering the use of prior authorization for this category of drugs, but instead plan to educate and encourage physicians to prescribe generic antidepressants when appropriate.

As part of the 2001-2003 biennial budget deliberations, the Legislature has considered options to limit the authority of DHFS to expand the number and type of drugs for which prior authorization can be required without legislative consideration. Most recently, the Legislature has debated a provision in Assembly Substitute Amendment 1 to 2001 Senate Bill 55, the 2001-2003 Biennial Budget Bill, for the establishment of a prescription drug benefit program for senior citizens that includes a proposal to prohibit prior authorization for additional types of prescription drugs. Continued debate on the number and types of drugs for which prior authorization can be required seems likely.

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State of Wisconsin
Department of Health and Family Services

Scott McCallum, Governor
Phyllis J. Dubé, Secretary

July 23, 2001

Janice Mueller
State Auditor
Legislative Audit Bureau
22. E. Mifflin Street, Suite 500
Madison, WI 53703

Dear Ms. Mueller:

Thank you for the opportunity to comment on the Legislative Audit Bureau's evaluation of Wisconsin Medicaid's prior authorization (PA) requests and decisions, school-based services, and PA for prescription drugs.

The report contains only two recommendations to the Department, and we concur with both. The first recommendation is to provide additional clarification to providers on "medical necessity." The current definition and standards of medical necessity are contained in code and are applied on a case-specific basis. We will prepare a Medicaid Provider Update to describe the various aspects of this rule and provide examples of services that would be considered medically necessary. However, since individual circumstances determine whether a service is or is not medically necessary, it is not reasonable to expect any one definition of medical necessity to address every possible issue or question. That is a primary reason why we utilize health care professionals licensed in the individual service category to adjudicate PA requests.

The second recommendation is to provide more detailed reasons for the denial of PA in the letter to Medicaid recipients. The report points out that creating a case-specific denial letter will require additional staff, resources, and system changes, and would increase the time required to process PA requests. With current resources we will change our letter and will investigate ways of including a more specific rationale for the decision. In addition, since the provider receives detailed information on the denied PA request form, we will also encourage recipients to discuss the denial with their provider.

The report also makes two alternative suggestions to the Legislature, with which we disagree. First, discontinuing use of the individual education plan (IEP) as a source of information in determining therapy services will harm children. The IEP establishes the plan and related services a student needs to benefit from public education, including the frequency and duration of each service. Once the IEP is developed, the school is required to provide the services that are identified in it. Of the information submitted by therapy providers, the IEP is often the most well-documented and comprehensive assessment of a child's needs and treatment goals. If Medicaid did not use the IEP, it would need to create an alternative form on which the provider

would need to identify the other services the child was receiving. Using the IEP makes it easier for the provider and the family to provide this important information.

Second, requiring services provided during the school year to be covered by Medicaid over the summer even if the community provider could not demonstrate medical necessity would require either 100% state funding or put the state at risk of a disallowance of federal funds. While federal regulations permit use of the IEP for Medicaid school-based services payments, all services authorized in an IEP do not meet the standard of medical necessity to be eligible for federal funding for Medicaid benefits outside of the school setting. In addition, as the report notes this suggestion would result in a significant increase in Medicaid expenditures, for which additional state funding would be required through legislation.

We also wish to note the following:

- The administrative code requires that determinations be made on 95 percent of PA requests within ten working days of the date on which all necessary information is received. This standard applies to all goods and services for which PA is required. The Department complies with this requirement. The administrative code also requires that determinations be made on 100 percent of PA requests within 20 working days of the date on which all necessary information is received. Over the last five years 98 percent of all therapy PAs were processed within the 20 day limit. While we could assure compliance with the code by denying PA requests rather than by continuing to work with the provider to approve or modify the request, we have opted not to do this. Finally, the Department does monitor the time required to process PAs, and has penalized the fiscal agent for failing to meet their contractual obligations on timeliness.

- As the report notes, the average processing time is skewed by some cases that take substantially longer to process. For this reason, the median processing time for PAs is a more accurate depiction of the experience of most providers. For example, in 2000 the average processing time was 17.5 days for a therapy PA, while the median processing time was 11 days. Thus, 50 percent of PAs were processed in 11 days or less.

- We recognize the need for continuous provider training and ongoing technical assistance to providers. As the report indicates, "Since 1995, approximately two-thirds of all return codes cited have related to clerical errors or omissions made by the providers." For example, to reduce their error rate two large therapy providers requested information and assistance from the Department to improve the quality of their PA submissions. The outcome for these providers has been highly successful. We are willing, and have offered, to provide this assistance to other providers and we hope that they will accept this invitation.

The report appears to link Medicaid to the reduction in therapy services during the summer months. Therapy services covered as a Medicaid benefit actually increase over the summer months for medically necessary services provided by non-school providers in the community. In

contrast, school-based payments for therapies provided in the school experience a dramatic drop over the summer months. This occurs because some schools do not identify the need in the child's IEP for therapy services to continue over the summer. Since Medicaid is merely a payment source for school-based services, if there is a concern that school-based therapy services should be continued over the summer we suggest that the Legislature request additional information from the Department of Public Instruction. If the school district were to identify summer therapy services in the child's IEP, Medicaid school-based services payment for 60% of the cost would be paid.

As the report notes, the need for summer services is typically considered only if a member of the team, such as the child's parent, specifically requests that this be evaluated. With the availability of federal Medicaid payments for a broader range of therapies through school-based services, we would encourage all families to work with their school to identify the therapy services that should be continued over the summer in their child's IEP.

In closing, please note that:

- Less than 4 percent of all goods and services covered by Wisconsin Medicaid require PA.
- Since 1995, Medicaid has reviewed almost 1 million PA requests and has processed over 99 percent of these requests within the timelines established in administrative code.
- From 1995 to 1999, Medicaid reimbursement for children's therapy services has increased from $6.7 million to $13.4 million, and the number of certified Medicaid community providers has increased by 11.6 percent
- Over 96 percent of all PA therapy requests in 1999 resulted in some level of service being authorized.
- Wisconsin Medicaid's coverage of therapy services is significantly broader than many other state Medicaid programs and virtually all private insurance plans.

Thank you, again, for the opportunity to comment and for the time and effort of your staff during the audit. We are very pleased that the report would suggest that our program is well-managed and that medically necessary services are authorized in a fair and consistent manner.

Sincerely,

Phyllis J. Dubé
Secretary