The Letter of Medical Necessity as Genre: Who Creates It and Who Controls It

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Abstract - In this study, we analyze a small corpus of Letters of Medical Necessity and responses to those letters through the lens of Rhetorical Genre Theory. When all parties share an understanding of the relation between action and purpose, texts have a high probability of fulfilling their social purposes. However, as Carolyn Miller points out, there can be situations in which both parties in a communicative transaction believe a given genre exists, when, in fact, different understandings of the rhetorical situation undermine the success of that genre. Our analysis suggests that writers and evaluators often have differing understandings of the letter of medical necessity genre. We further find that writers of these letters, themselves, often have differing concepts of the letters' content and form. Thus, we suggest that those writing letters of medical necessity should engage in conversations about the needed content and form, and that providers and evaluators foster dialogue about the genre's key features.

Index Terms - Medical communication, genre theory, healthcare, medical equipment.

INTRODUCTION

Over the course of the last year, we have conducted a study that uses rhetorical theory—specifically, Rhetorical Genre Theory—as a means of gaining insight into the documents health providers write in order to secure insurance coverage for biomedically engineered rehabilitation equipment. This process usually includes a letter of medical necessity (what we will refer to as a claim), written by a rehabilitation team (whom we will refer to collectively as the provider) on behalf of a patient, and the letter of denial written by representatives of insurance companies (whom we will refer to as the insurance representative).

Our interest in this project stemmed from the work that author 1 does in linguistics, especially Discourse Studies, and author 2 does in Pediatric Rehabilitation. In his clinical work, author 2 often has occasion to interact with insurance companies to secure funding for medical equipment for his patients. The process of identifying a need for durable medical equipment for a pediatric patient with a chronic medical condition, such as cerebral palsy, requires several steps and is quite time-consuming for all involved. If at the end of this lengthy process, the claim is denied, frustrations for all involved are palpable.

The letter of medical necessity is needed to justify funding for rehabilitation equipment, but also for other medical interventions such as a medication or surgery. However, Research and Development for rehabilitation equipment differs from that for new medications or surgical techniques, and this may impact how a letter of medical necessity should be conceived. The journey from the conception of an idea to patient use for rehabilitation devices spans a wider diversity of disciplines than the one for traditional medical interventions. As a result, those making the judgments of medical necessity lack the knowledge of those in engineering disciplines who are instrumental in the development of this equipment; likewise, many of those who work to develop and produce biomedically engineered devices may not be fully aware of, and certainly are not involved with, the complex communications that determine whether their devices are deemed necessary for the medical treatment of patients.

In this pilot study we examine a corpus of these claims where the claim was denied, as well as the information about the denials issued by the insurance companies. In order to apply Rhetorical Genre Theory to medical communications revolving around payment for goods, one must appreciate the outsized role that the term "medical necessity" plays in these deliberations.

MEDICAL NECESSITY

In a paper reviewing the history of this term, Bergthold traces the concept of medical necessity to the 1940s with the rise of private insurance. According to Bergthold, that was a time when "insurers accepted the decisions of physicians about what was medically necessary without much question" [1, p. 181]. By the 1960s, however, "insurance companies began to question the value of services for which payment was requested, and they began to insert more and more specific definitions of

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medical necessity into insurance contracts" and by the 1970's the "private insurance sector began to develop a broader base for decision making about medical necessity . . . by requiring physicians to justify their previously unchallenged decisions" [1, p. 182]. Bergthold notes that "[a]fter all the arguments have been made to fix the old term, there are more compelling reasons to delete it and substitute new language, with new criteria" [1, p. 188]. Over twenty years ago, Bergthold argued the ambiguity of the term medical necessity created more problems than it solves, yet the term remains at the center of claims for coverage to this day.

In a recent article analyzing the use of this term since the implementation of the Affordable Care Act (ACA) in United States of America, Skinner explains that in the current insurance environment, neither the ACA nor Health and Human Services (HHS) "engages the question of medical necessity . . . with vigor or precision" [2, p. 3]. Rather than lamenting this fact, however, Skinner argues that in addition to being "daunting," to attempt to stipulate exactly what this term should mean would "evoke accusations that the HHS was intruding on doctor-patient relations . . ." because, as Skinner sees it, the concept of medical necessity "resists abstraction and must be determined instead through assessments of specific patients who are located in particular contexts as opposed to universally applicable benefits, which constitute general guidelines for plans" [2, p. 3].

While the medicolegal and ethical implications of understanding medical necessity are not explored in this paper, such work informs and impacts the work of this study. As we explore in the pilot, the information that is codified in claims and denials related to medical necessity are at the crux of the decisions being made and yet, at times, the parties involved are not approaching medical necessity in the same manner.

Genre Theory

To pivot from Medicine to Discourse Studies, we must first present a brief overview of genre theory. Unlike Literary Genre Theory, Rhetorical Genre Theory is a relatively recent phenomenon. In 1984, one of the most impactful early works in this field, Carolyn Miller's "Genre As Social Action," replaced the literary view of genre as a "kind of taxonomy," with what Miller refers to as "a rhetorically sound definition of genre" [3, p. 151]. According to Miller, one may attempt to characterize a given text by examining its subject matter or content (what Miller refers to as its "substance"), its formal characteristics (what Miller refers to as its "syntactics"), and/or its rhetorical purposes (what Miller refers to as its "pragmatics") [3, p. 152]. For Miller, the purposes for which a specific text is used, what she refers to as "rhetorical action," provide the key to understanding its genre characteristics. That isn't to say, however, that one can separate action from the other elements in the rhetorical situation, as Miller makes clear below:

> A classifying principle based in rhetorical action seems most clearly to reflect rhetorical practice (especially since, as I will suggest later, action encompasses both substance and form). And if genre represents action, it must involve situation and motive, because human action, whether symbolic or otherwise, is interpretable only against a context of situation and through the attributing of motives [3, p. 152].

The "context of situation and motive" are encapsulated in the concept that Miller refers to as Rhetorical Situation. This is a term that Miller adapts from Lloyd Bitzer, but unlike Bitzer, who sees a rhetorical situation as one in which some use of language can solve a problem that one "finds" in his/her world, Miller argues that a rhetorical situation is one that not only allows for language to be used in solving a problem but is also one in which language must be used to "negotiate" what is, and what is not, a problem that lends itself to solution via rhetorical action. For example, if a rhetor working in the United States during 1950's wanted to solve "the problem" of a ban on gay marriage by means of persuasion using language, she would face a set of cultural constraints that prevent this situation from being viewed as one that could be solved by language---given the wide-spread acceptance of the definition of marriage as a union between a man and a woman.

Since there is no agreed upon rhetorical problem in this situation, there is no "genre" for solving this problem. It is only after a problem is identified as rhetorical that rhetors can use language to solve that problem. And once that rhetorical situation begins to be repeated, the linguistic action used in attempts to solve the problems in those recurring situations is known as a genre.

Of course, it isn't actually possible for a particular situation to be repeated since every situation that humans encounter is unique. This is not to say, however, that humans don't "see" situations as recurring; they do, as Miller explains in saying:

> Recurrence is implied by our understanding of situations as somehow "comparable," "similar," or "analogous" to other situations, but, as Robert A. Stebbins notes, "objective situations are unique"—they cannot recur [4, p. 154]. What recurs cannot be a material configuration of objects, events, and people, nor can it be a subjective configuration, a "perception," for these, too, are unique from moment to moment and person to person. Recurrence is an intersubjective phenomenon, a social occurrence, and cannot be understood on materialist terms [3, p. 156].

In other words, humans agree that one event represents a reoccurrence of another because of our ability as language users to generalize from one unique event (what Bitzer and other genre theorists refer to as a token) to create a type—the process that Miller discusses as "typification." According to Miller, "[a] new type is formed from typifications already on hand . . . If a new typification proves continually useful for mastering states of affairs, it enters the stock of knowledge and its application becomes routine" [3, p. 157].

As is often the case with powerful concepts, this one can seem too trivial to need mentioning. Why do we need such elaborate theory to account for the fact that humans "recognize" a vast array of rhetorical situations that call for rhetorical actions, rhetorical situations such as a friendly email, a thank you letter, a job application, an elevator greeting, or an introduction of one friend to another? While virtually every literate speaker knows immediately what type of rhetorical action is called for in the above examples, this list is fairly unspecialized. Now consider the Legal Discourse community. While the layman could recognize that "the party of the first part" is a phrase that would belong in that community, he would be at a loss to produce appropriate legal communications. Rhetorical Genre Theory is particularly helpful in understanding such communities and, in particular, the crucial role that their use of language plays in forming those communities.

One of the leading rhetorical genre theorist, John Swales, clarified the relationship between genre theory and communities further when he proposed: "A genre comprises a class of communicative events, the members of which share some set of communicative purposes. These purposes are recognized by the expert members of the parent discourse community, and thereby constitute the rationale for the genre" [5, p. 58]. Swales' communicative events are akin to Bitzer's text tokens/events in that they require an understanding of the exigence for the event, the audience the event is directed to, and the various constraints of this rhetorical situation.

Clearly, a rhetorical situation is one that has an exigence, in that it presents a problem or issue that needs to be solved or resolved in some way. What might we say about the concept of audience? In many rhetorical situations, no specialized audience is required. Almost anyone can serve as audience for a text message, a best man's wedding reception speech, or a thank-you letter. However, as we move to consider specialized discourse communities, we find that, just as specialized knowledge is required to recognize an exigence and to perform the text token, specialized knowledge is required of those who are being called upon to take some action that would remove or change the exigence. Though an attorney may act on behalf of a layperson, she is directing that act to an audience with the required specialized knowledge, namely another attorney or judge.

We move now to the constraints found in various rhetorical situations. There are two sets of countervailing constraints in any rhetorical situation. To understand how these work, it may help to think of the action taking place in the use of a particular genre as something of a play with a protagonist and an antagonist. If the rhetor, whom we can think of as the protagonist, can see an exigence, i.e. a problem that needs a solution, it is useful to ask why this problem has not already been solved? Two primary reasons present themselves: 1) the problem has not been "recognized" as something that needs to be (and can be) solved via language use; 2) there are opposing forces, i.e. antagonists, that, until this point, have prevented the problem from being solved; these constraints may be imposed by the belief systems of a society, by laws and customs of a society, and/or by the high costs—in terms of money, time, effort, face-saving, etc. The rhetor uses all the devices of rhetoric available to her--logic (logos), ethics (ethos), and emotion (pathos)—to bring about a solution. In a sense, she uses positive "constraints"—the forces of the protagonist—to overcome the negative forces "constraints" of the antagonist.

In a very real sense, however, the rhetor's first, and most important, task is to perform an action that brings about the "recognition" that the problem can, and should, be solved. In large part, this may involve working against constraints that have been built into the very language we use, as we saw with the example of a person wishing to address the issue of gay marriage in the United States during the 1950's.

With these brief forays into the history of the concept of medical necessity and into a theory of how such terms come to define what types of rhetorical actions one sees as possible, we turn to the pilot study of letters of medical necessity and insurance company denials.

THE STUDY

As a first step in our work, we analyzed 11 claims requesting durable equipment for pediatric rehabilitation patients, all of which were denied, as well as the texts in which those denials were announced. All documentation for a single patient was given a letter designation which can be found in brackets whenever these documents are referenced below. These data were collected from a durable medical equipment vendor with patient identifiers redacted. The analysis of this data was deemed to be non-human subjects research by the Human Subjects Research Institutional Review Board of the University of Virginia. We analyzed these data using a combination of Rhetorical Genre Theory and Grounded Research. Once again, we find the work of Carolyn Miller helpful; she offers the concepts of *Substance* (what we will refer to as "content") and *Syntactics* (what we will refer to as "form"). Our primary analysis focused on the substance of these letters of medical necessity and the statements of denial provided by insurance companies. Our preliminary analysis of these letters has focused on those characteristics that suggest a mismatch between the concepts of what the content and/or form of these documents should be between authors of the documents and the insurance representatives, at times, and between the various authors of these documents themselves, at other times.

I. The Letter of Medical Necessity

In Grounded Research, one examines data to determine what patterns emerge from close analysis of those data. Obviously, with our limited set of data, any patterns we discern are both preliminary and perhaps not generalizable. This work serves to provide a starting point for pattern recognition that will need confirmation and refinement as more data become available. With that caveat, we discerned two patterns that warrant further examination. The first pattern is a struggle between writers and evaluators of these letters as they attempt to "negotiate" what will be meant by medical necessity. The second pattern suggests a lack of understanding, on the part of the letter writers, of just what the letter of medical necessity comprises.

a. Content of Letters of Medical Necessity

Table 1 shows the categories of content found in the letters of medical necessity; these categories were created as a result of our Grounded Research analysis. Per the Table, there are several items of content often found in the performance of this genre. However, even more interesting than the areas of content agreement are those instances of potential disagreement where a type of content is only found in 1 or 2 of the examples. For example, only 1 provider included information on the patient's goals for his progress; only 2 providers include information on the preferences of the patient or parent/guardian. We find inclusion of these items of content rather unexpected, and we wonder why the providers include them. Is this a case in which this provider is unsure of exactly what is appropriate in this genre? Perhaps, but not necessarily. For example, only 1 person in this sampling provides research literature support for the requested equipment. Does this mean that such content is inappropriate in samples of this genre? Surely not, since one of the criteria for establishing medical necessity is supporting research. However, in these examples it seems likely that little research is offered because there is a lack of research funding to study the outcomes for use of the types of durable medical equipment being requested. This fact, in turn, may account for another category that we do find amply represented here: Provider's Opinion Concerning Supporting Facts. As we examine the entries we have placed in this category, we find logical and anecdotal arguments for the efficacy of the equipment being requested. Because empirical research is lacking, providers offer these arguments as the next best thing.

TABLE 1: CATEGORIES OF CLAIMS' CONTENT.

Category	Frequency
Provider's Concern for Patient's Wellbeing	8
Provider's Opinion Concerning Supporting Facts	8
Provider's Opinion of Requested Equipment's Role in Patient's Therapy	6
Provider's Goals for Patient's Treatment	5
Additional Context	4
Provider's Opinion on Ethics of Patient Care	2
Patient's Attitude, Work Ethic, Support System	2
Patient/Parent Preferences	2
Supporting Research	1
Patient's Rehabilitation Plan	1
List of Patient Goals	1

i. Negotiations of Genre Between Providers and Insurance Representatives

A relatively large number of samples reference the overall wellbeing of the patient; there are also two examples in which providers mention patients' attitudes, work ethics, and/or support systems and two other examples in which providers mention their opinions about the ethics of treating patients. One might see these latter two categories as outliers because of their infrequency. However, like the references to the patient's wellbeing (in the first category), they seem to suggest that providers think the insurance representative should view the issue of medical necessity holistically and in broad terms.

Such a view seems reminiscent of early definitions of medical necessity that were often so broad and vague as to include anything a physician thought helpful to a patient. Clearly, in an age of limited resources and capitalistic medicine, such vague references to the overall wellbeing of patients prove problematic. As we shall see in our discussion of denials below, appeals to overall wellbeing are not persuasive to insurance representatives, who show no willingness to move beyond the strict treatment parameters for diseases and conditions. Yet, providers persist in attending to the patient in a holistic fashion that takes into account such seemingly non-quantifiable variables as the patient's attitude and support system. Are providers simply unaware of what will matter to an insurance representative, or is there some other explanation for this phenomenon? We contend that providers can't help but to include such information because they see it as highly pertinent to the claim and, moreover, they are attempting to use language to influence the insurance representatives' understandings of medical necessity.

Rather than misunderstanding the claim genre, providers may, in fact, be "recognizing" as rhetorical a situation that others presume to be non-rhetorical. In other words, they may be attempting to perform the claim genre in such a fashion as to effect changes in the very constraining definitions of medical necessity employed by insurance representatives. As shown in Table 2, insurance representatives often appeal to formalized language of medical necessity to "rule" these rhetorical appeals "out of bounds," that is, to pronounce these as non-rhetorical situations.

ii. Differing Understandings of Genre Among Providers

At what point do we move from labeling a provider's text as an attempt to negotiate a new meaning of medical necessity with an insurance representative to labeling it as a failure to understand the proper content for that genre? Clearly, there will be cases that resist easy classification. However, that should not prevent us from identifying other cases that seem obviously problematic, given the basic understanding of the provider's role and the insurance representative's role. For example, we find the following statements of patient/parent preferences problematic:

Patient/Parent Preferences/Goals

- He [patient] would like to return to his prior level of function before his spinal injury. [A]
- [Patient's] parents prefer to have just one device that both brothers can us [sic.] to avoid extra equipment that can clutter the home environment. [E]
- …patient's brother [*redacted*] is also expected to use this standing frame. [E]

While everyone involved hopes patient *A* can return to his prior level of function, that goal itself does not speak to the issue of whether the requested device is medically necessary to assist in his recovery. In examining the next two points, the providers err in failing to recognize that almost every insurance policy is applicable to a single patient and, in fact, planning for someone who is not the patient to use the device could be construed as insurance fraud. Moreover, one of the clear criterion insurance representatives apply in their evaluative process is the concept of "convenience"; medical necessity is a term coined to separate those things that are needed for a patient's care from those that would be good to have. Both of these claims concerning patient *E* seem clearly aimed at providing convenience for the family rather than addressing a medical need for the patient.

Provider's Opinion of Cost Effectiveness of Treatment

- [Patient] should be provided Go Wing Arm device that will allow her to keep working because it is more cost effective to keep [patient] working and a productive member of society in comparison to not supporting her needs and requiring her to be dependent on caregivers. [C]
- [Patient] should get a standing frame that he and his brother can use because a clutter free environment is important to helping the boys move freely in their home without the risk of injury during transfers and use of their power mobility devices. [E]

Here the provider seems to understand that cost effectiveness is a criterion that insurance representatives constantly apply: if a less expensive wheelchair than the one requested can meet the "needs" of a patient, the insurance representative isn't likely to approve the expensive chair. It is in the purview of a provider to consider such issues of cost. However, the first example moves to larger issues of "societal costs" in the formulation of what constitutes the less expensive treatment is something that the insurance representatives aren't authorized to do and, thus, is not a proper part of the content of a letter of medical necessity. Also, while the information about patient *E* may be seen as introduction of a matter of convenience—to live without clutter—the way it is framed here makes it seem that the provider is attempting to deal with issues of "potential cost" that lie outside the current medical needs in this particular case. The fact that another injury may take place that might result in additional costs to the insurer would not be something the insurance representative is authorized to consider in evaluating this claim.

Additional (Extraneous) Information

- … mom reports [patient's] wheelchair has been unstable since they took it on the airplane to Disney World over a year ago. . . [I]

The detail offered about patient *I* above seems problematic in a genre intended to deal with issues of medical necessity in an objective fashion. On the one hand, narrating the "story" of the Disney World trip could be seen as an attempt to appeal to emotions—what bad luck that this accident occurred on what was supposed to be a happy event; on the other hand, it could introduce unconscious negative biases in that a family that can afford these outings might also be able to afford a new wheelchair. Neither of these biases has any place in a letter of medical necessity.

b. Form of Letters of Medical Necessity

We could spend quite a bit of time discussing the various lexical and syntactic choices in these letters that define medical discourse. Given our limited space here, we confine our analysis to formal characteristics that suggest failures on the part of writers to understand and use this discourse. These issues included informal language and problems with modification and transitivity.

i. Formal vs. Informal Language

Lexical choices can help identify a discourse as medical. For example, one often finds such language as "secondary to" used in something of the fashion that a layperson might use "caused by," or "ambulation" used for what a layperson might call "walking," or "transfers" to refer to movement from one thing such as a wheelchair to another thing such as a bed. Such lexical choices contribute to the formal nature of medical discourse. However, when such formal, and clearly medical, terms as those mentioned above are found in documents using extremely informal language, the effect is to undercut the authority of the writers. Such is the case in each of the passages below (inappropriate language is italicized):

- to avoid extra equipment that can *clutter* the home environment. [E]
- and he would not *stay put* with the use of just a booster seat. [D]
- [Patient] needs Bath Chair because her [sic.] *has seen better days*, has had a lot of usage and her back is not high enough (her head goes above the top of the back.'[J]

We should note that any one of these choices in isolation would likely cause little difficulty for the writer, but in each case, there is a way to speak more formally. For example, rather than using "clutter," one could say that extra equipment would limit the open space needed to maneuver a wheel chair. The issue is a bit more troubling when one speaks of bath chair as having "seen better days." In fact, most equipment that is not brand new "has seen better days," so the language is not very exacting: how old is it, or, what damage has it sustained?

ii. Dangling Modification and Transitivity

The dangling modifier seems one of those prescriptive rules that has little to do with a sentence's meaning. Textbooks tell us that a sentence with a dangling modifier such as, "Walking down the street, the building's design impressed me" "says" that the building was "walking." Such examples do not serve us well because we all know that buildings cannot walk; no one misreads the meaning of this sentence. However, there are very real cases in which dangling modifiers hinder communication. Such is the case with some of the examples in our sampling. Consider this passage from sample D:

> By stretching for a prolonged period of time, ROM [range of motion] is proven to improve. By helping patient to improve his ROM [range of motion], his risk of development [sic.] painful joint contractures is avoided. [D]

Here we assume that it is the patient who is stretching, but we aren't sure of the exact situation. Is the patient stretching his own legs, is a machine assisting with the stretching, or what? In addition to the problem caused by the dangling modifier, we have a problem having to do with what linguists call transitivity, a term that helps identify agency in a given a situation. When a small child reports of his favorite toy—"it broke"—he avoids assigning any agency in the sentence, there is no reference to the person doing the "breaking." As we see here, one way to avoid agency is to move from a transitive structure such as X broke Y to an intransitive structure such as Y broke. Another way is to change an active structure into a passive structure: X broke Y becomes Y was broken (with the agent deleted). That is what happens in the structure above; we don't know what/who has proved that this stretching (whatever kind it is) causes improvements in range of motion (ROM). Though we aren't sure exactly what the writer meant to say, a much clearer claim would be the following: "The studies cited below show that by using this machine for 30 minutes each day to stretch their limbs, patients improve their ROM." The second part of this passage is equally problematic. The dangling modifier ("By helping patient to improve his ROM") fails to make clear who or what is "helping patient improve his ROM." Once we have clarified the first part of the passage, then we can revise the second part to make it clear what is being asserted:

> The studies cited below show that by using this machine for 30 minutes each day to stretch their limbs, patients improve their ROM, thereby lowering the risks that they will experience painful joint contractures.

Readers may have noted that the revised sentence assumes there are studies that the writer can point to in this sentence "the studies cited below." What if there are no such studies? In such cases, the prose is more difficult to construct; however, writers should resist the temptation to hide the lack of agency, i.e. the fact that they know of no such studies, by means of obfuscating sentence structures. Readers may not have knowledge of rhetorical names for such structures—dangling modifiers, agent-less sentences—but, as native and sophisticated users of the language, they know when such obfuscation is being used.

II. Insurance Company Denials

It is important to note that insurance companies almost never provide reasoning for those claims they grant and that there is usually not much more reasoning provided for claims that are denied. Thus, we must use deduction and inference to decide what successful claims should include. While it would be useful to analyze the form of denials, we will limit our analysis here to their content.

Content of Denials

What we can see in the denial statements in our sampling is a strong tendency to fall back onto medical necessity. In Table 2, we see that 9 of the 11 denials mentioned the issue of medical necessity. Once the claim is made that a treatment isn't medically necessary, the insurance representative either lets the claim stand unsupported or refers the patient/provider to some statutory explanation of medical necessity. These denials read as pronouncements delivered "ex cathedra," even though the obligatory information about how an appeal may be made is included.

TABLE 2: CATEGORIES OF DENIALS' CONTENT.

Category	Frequency
Not Medically Necessary	10
No Supporting Research	2
Experimental Treatment	1
Less Costly Treatment Available	2
Treatment Deemed for Convenience	5
Policy Doesn't Cover Requested Item	1
IR Doesn't Accept Provider's Prognosis for Patient	1
Other	1

Two denials deviated from the boilerplate response offered in the majority of cases. The first (labeled in Table 2 as "Other") states:

> We cannot approve your request for the group 3 Quantum power wheelchair and accessories, Group 3 power wheelchairs are only approved if the mobility limitation is due to a progressive neurological condition, myopathy, or congenital skeletal deformity. You do not have a medical condition under one of these diagnoses. You have problems walking due to pain, trouble breathing and arthritis. Therefore, this request is not approved. A group 2 power wheelchair would be considered. Therefore. [sic.] your request is denied. [K]

In the case of K, the insurance representative mentions "conditions" are covered, but since no conditional label has been attached to this patient, the fact that a medical authority attests to the patient's inability to walk "due to pain, trouble breathing and arthritis" is not a sufficient cause for approval of the device. This response would seem to support Skinner's fear of stipulative definitions of medical necessity, because, as he put it, the concept: "resists abstraction and must be determined instead through assessments of specific patients who are located in particular contexts as opposed to universally applicable benefits, which constitute general guidelines for plans." [2, pp. 3].

Another potentially anomalous element in a denial occurs in the denial of patient *A*'s claim.

> **The claim:** [Patient] is unable to achieve a standing position at this time . . . [Patient] has personal rehab goals for ambulation and improved independence with transfers and overall increased function in bilateral lower extremities. He would like to return to his prior level of function before his spinal cord injury. He will participate in 2-3 days of physical therapy each week upon discharge from inpatient therapy, and will benefit from additional standing at home between therapy sessions to continue progressing motor control of bilateral lower extremities, core control, and endurance for upright activity. [A]

When the insurance representative denies the request, the denial includes a noun phrase description (in italics below) that assumes the patient will not regain use of his lower extremities:

> **The denial**: However, a stander is considered not "medically necessary" under our guidelines because medical studies do not definitely show that these types of devices are of help to *people who are paralyzed.*

This example would seem somewhat like the situation we describe above in an era when the language used to define marriage (as between a man and woman) rendered it impossible to talk (or write) about any other possibilities. Here we may have a classic case of failure to agree on a Rhetorical Situation that would allow for the use of language to affect an outcome.

CONCLUSION

We conclude by referring to the subtitle of our paper which asks: Who Creates It, and Who Controls It? In order to answer this question, we return to John Swales' concept that genres play a key role in the formation of discourse communities. In discussing Swales' work, we noted that members of a discourse community, both those who create genres and those who read/hear them, recognize the purposes that a given text token is used to perform.

Given this concept of genre as it relates to discourse community, our study raises the question of whether providers and insurance representatives share the same understanding of the letter of medical necessity genre; indeed, it further problematizes the question of whether various providers share an understanding of this genre. Thus, the question in our subtitle is real rather than rhetorical. One must be sure that a discourse community exists in order to know who "owns" the genres used by that community.

This pilot study was limited by the small volume of the corpus of claims. However, our purpose was not to find generalizable results, but rather to apply and test the feasibility of using an approach based on genre theory to increase understanding of a complex form of communication in the healthcare landscape. Also, our work is limited indirectly by the limitations of rehabilitation equipment research. There are very few studies of medical outcomes on such equipment because of a lack of funding, highly customizable equipment, and the scarcity of patients that need the most complex equipment.

We intend further study of these communications by interviewing both providers who write these letters and insurance representatives who are charged with evaluating them. Future study designs will require further refinement of the application of Grounded Research with Genre Theory as well as an increased volume of claims to improve the generalizability of results. We will share our findings to both letter writers and insurance representatives; to date there has been little communication between the members of these two groups.

Another point of potential research development is to consider the biomedical engineer as a stakeholder in this complex process. We are not capturing input from engineers, who may differently describe how a device could be medically necessary based on their technical experience. That input could help providers decide when equipment is medically necessary and write more convincing letters when it is. While not every claim for a piece of equipment can be successful, our sense is that the number of unsuccessful letters at this time suggests a communication failure that can, and should, be remedied.

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