HSS 1,5,7

CERTIFICATE

STATE OF WISCONSIN)
)SS
DEPT. OF HEALTH & SOCIAL SERVICES)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Donald E. Percy, Secretary of the Department of Health and Social Services and custodian of the official records of said department do hereby certify that the annexed rules repealing and recreating selected sections of the Medicaid Administrative Rule, HSS 2, were duly approved and adopted by this department on August 17, 1979.

I further certify that said copy has been compared by me with the original on file in this department and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the department at the State Office Building, 1 W. Wilson Street, Madison, this 17th day of August, 1979.

SEAL:

D. E. P.

Donald E. Percy, Secretary
Department of Health and Social Services

ORDER OF THE

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

REPEALING AND RECREATING RULES

Relating to rules concerning revisions of selected sections of the Medicaid Administrative Rule, HSS 2.

Pursuant to authority vested in the Department of Health and Social Services by section 227.014(2), Wis. Stats., and section 49.45(10), the Department of Health and Social Services hereby repeals and recreates rules as follows:

Sections HSS 1.03(67) - (77) and (154) - (157) are repealed and recreated below:

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Home Health/Personal Care

(67) Administrator, Home Health Agency. "Administrator, home health agency," means a person who:

(a) Is a licensed physician; or

(b) Is a registered nurse; or

(c) Has training and experience in health service administration and at least one year of supervisory or administrative experience in home health care or related health programs.

(68) Branch Office. "Branch office" means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.

(69) Bylaws or Equivalent. "Bylaws or equivalent" means a set of rules adopted by a home health agency for governing the agency's operation.

(70) Home Health Agency. "Home health agency" means a public agency or private organization, or a subdivision of such an agency or organization which is primarily engaged in providing skilled nursing services and other therapeutic services to a recipient at the recipient's place of residence.

(71) Home Health Aide. "Home health aide" means an individual employed by or under contract with a certified home health agency to provide home health aide (including personal care) services under the supervision of a registered nurse.

(72) Parent Home Health Agency. "Parent home health agency" means the agency that develops and maintains administrative controls of subunits or branch offices or both.

(73) Personal Care Services. "Personal care services" means those services enumerated in section 7.11 when provided by a provider meeting the requirements of section 5.16.

(74) Personal Care Worker. "Personal care worker" means an individual employed by a certified home health agency or other agency approved by the department pursuant to section 5.16, to provide personal care services under the supervision of a registered nurse.

(75) Primary Home Health Agency. "Primary home health agency" means the agency that is responsible for the service rendered to patients and for implementation of the plan of treatment.

(76) Proprietary Agency. "Proprietary agency" means a private profit-making agency licensed by the state.

(77) Social Work Assistant. "Social work assistant" means a person who:

(a) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least one year of social work experience in a health care setting; or

(b) Has two years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.

(78) Subdivision. "Subdivision" means a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the conditions of participation for home health agencies. A subdivision which has subunits or branches or both is regarded as a parent agency.

(79) Subunit. "Subunit" means a semi-autonomous organization, which serves patients in a geographic area different from that of the distance between it and the parent agency. The subunit by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision, and services on a daily basis with the parent agency and must, therefore, independently meet the conditions of participation for home health agencies.

Section 1.03(88) through (101) is repealed and recreated below:

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Mental Health Services

(88) Active Treatment. "Active treatment" means implementation and administration of a professionally developed and supervised individual plan of care, which plan shall be developed and implemented no later than 14 days after admission to the facility. Active treatment must be reasonably expected to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan of care shall be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

(89) AODA Treatment Services. "AODA treatment services" means those services provided by a provider certified pursuant to sections 5.22 or 5.23 of this rule, to inform, motivate, guide and assist alcoholics and drug abusers, and those persons affected by problems related to the abuse of alcohol or drugs. Examples of AODA services include but are not limited to client evaluation, orientation and motivation, treatment planning, consultation and referral, client education, individual counseling, group counseling, and crisis intervention.

(90) Board. "Board" means a community mental health board established under s.51.42, Wis. Stats., a developmental disabilities board established under s.51.437, Wis. Stats., or a community human services board established under s.46.23, Wis. Stats.

(91) Day Treatment. "Day treatment" means a non-residential program that provides case management, medical care, psychotherapy, other therapies and follow-up, to alleviate problems related to mental illness or emotional disturbances. Such services are delivered in a medically supervised setting and are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day. Day treatment may also provide structural rehabilitative activities including training in basic living skills, interpersonal skills, and problem solving skills.

(92) Differential Diagnostic Examination. "Differential diagnostic examination" means an examination and assessment of the person's emotional and social functioning which shall include one or more of the following: neurologic studies, psychological tests and psycho-social assessments of the recipient's functioning.

(93) Inmate. "Inmate of a public institution" means a person who has resided for a full calendar month in an institution that is the responsibility of a governmental unit, or over which a governmental unit exercises administrative control, to participate in the living arrangement and to receive treatment or services provided there which are appropriate to the person's requirements.

(94) Inpatient Psychiatric Facility. "Inpatient psychiatric facility" means an inpatient facility which meets the requirements of section 5.21.

(95) Institution for mental diseases. "Institution for mental diseases" means a mental hospital, a psychiatric facility, and a skilled nursing or intermediate care facility that primarily cares for mental patients.

(96) Outpatient Facility. "Outpatient facility" means a facility licensed or approved by the department under section 632.89, Wis. Stats.

(97) Prescription. "Prescription" means an order by a physician for treatment for a particular person. The order shall be in writing and shall include the date of the order, the name and address of the physician, the physician's medical assistance provider number, the name and address of the recipient, the recipient's medical assistance eligibility number, the nature of the recommended treatment based on the diagnostic exam in the case of psychotherapy, and the physician's signature.

(98) Psychiatric Facility. "Psychiatric facility" means a psychiatric program as defined in HSS 107.13(1)(b).

(99) Psychiatric Hospital. "Psychiatric hospital" means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

(100) Psychotherapy. "Psychotherapy" means treatment of an individual with mental illness or medically significant emotional or social dysfunctions by psychological or interpersonal means. The treatment is a planned and structured program which is based on information from a differential diagnostic examination and which is directed at the accomplishment of specified goals. The treatment goals may include removing, modifying, or retarding existing symptoms, mediating disturbed patterns of behavior, and promoting positive personal growth and development by enhancing the ability to adapt and cope with internal and external stresses.

(101) Psychotherapy Provider. "Psychotherapy provider" means a person certified by the department to participate in the medical assistance program with the following minimum qualifications:

(a) A licensed physician who has completed a residency in psychiatry; or

(b) A licensed psychologist who is listed or eligible to be listed in the National Register of Health Services Providers in Psychology; or

(c) An outpatient facility operated by a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats.; or

(d) An outpatient facility operated by a provider hospital which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. or which is accredited by JCAH, Accreditation Program for Psychiatric Facilities; or

(e) At the discretion of the department, an outpatient facility under contract to a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable), Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and which has made substantial effort to comply with the requirements for accreditation by JCAH Accreditation Program for Psychiatric Facilities; or

(f) Clinics certified under rules promulgated by the department to govern section 632.89, Wis. Stats.

Section HSS 5.14 is repealed.

5.14 Requirements for Certification of Christian Science Sanitoria.

Section HSS 5.16 is repealed and recreated below:

5.16 Requirements for Certification of Home Health Agencies. Home health agencies are required to meet the conditions of participation enumerated in this section. (NOTE: The following rules are a codification of 42 CFR 405.1201 through 42 CFR 405.1230. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the federal regulations shall hold).

(1) Compliance with federal, state, and local laws. An agency shall be eligible for certification by the department if it meets the standards in this section. In addition, a proprietary organization which is not exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954 shall be licensed as a home health agency pursuant to section 141.15, Wis. Stats.

(2) Organization, services, administration. Organization, services provided, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be clearly set forth in writing and shall be readily identifiable. Administrative and supervisory functions shall not be delegated to another agency or organization. All services not provided directly shall be monitored and controlled by the primary agency, including services provided through subunits of the parent agency. If an agency has subunits, appropriate administrative records shall be maintained for each subunit.

(a) Services provided.

1. Part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech, or occupational therapy), or home health aide or personal care services, shall be made available on a visiting basis, in a place of residence used as a patient's home. A public or nonprofit home health agency shall provide at least one of the qualifying services directly through agency employees but may provide the second qualifying service and and additional services under arrangements with another agency or organization, except for personal care services which shall be provided directly by the agency, whenever the service is offered. A proprietary home health agency shall provide all services directly, through agency employees.

2. In those areas where personal care services are not available, the department may, at its discretion, certify a county social service or human service agency to provide personal care services, stipulated by contract.

3. If a social service agency is certified to provide personal care services at the effective date of this rule, it may be certified for a period of no longer than two years, unless it can otherwise meet the requirements of this rule for home health agencies. If it can, at or before the end of the two years, meet the requirements of a home health agency, it may be certified as a home health agency and may be discontinued as an approved social service agency.

(b) Governing body. A governing body (or designated persons so functioning) shall assume full legal authority and responsibility for the operation of the agency. The governing body shall appoint a qualified administrator, arrange for professional advice, adopt and periodically review written bylaws or an acceptable equivalent, and oversee the management and fiscal affairs of the agency. The name and address of each officer, director, and owner shall be disclosed. If the agency is a corporation, all ownership interests of 10 percent or more (direct and indirect) shall also be disclosed.

(c) Administrator. The administrator, who may also be the supervising physician or registered nurse shall organize and direct the agency's ongoing functions; maintain ongoing liaison among the governing body, the group of professional personnel, and the staff; employ qualified personnel and ensure adequate staff education and evaluations; ensure the accuracy of public information materials and activities; and implement an effective budgeting and accounting system. A qualified person shall be authorized in writing to act in this capacity in the absence of the administrator.

(d) Supervising physician or registered nurse. The skilled nursing and other therapeutic services provided shall be under the supervision and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse). This person or similarly qualified alternate, shall be available at all times during operating hours and shall participate in all activities relevant to the professional services provided, including the developing of qualifications and assignments of personnel.

(e) Personnel policies. Personnel practices and patient care shall be supported by appropriate, written personnel policies. Personnel records shall include job descriptions, qualifications, licensure, performance evaluations, and health examinations, and shall be kept current.

(f) Personnel under hourly or per visit contracts.

1. If personnel under hourly or per visit contracts are utilized by the agency, there shall be a written contract between such personnel and the agency clearly designating:

a. That patients are accepted for care only by the primary home health agency,

b. The services to be provided,

c. The necessity to conform to all applicable agency policies including personnel qualifications,

d. The responsibility for participating in developing plans of treatment,

e. The manner in which services shall be controlled, coordinated, and evaluated by the primary agency.

f. The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation, and

g. The procedures for determining charges and reimbursement, including the provision that only the home health agency shall bill the program and be reimbursed.

(g) Coordination of patient services. All personnel providing services shall maintain liaison with each other to assure that their efforts effectively complement one another and support the objectives outlined in the plan of treatment as explained in subsection 5.16(4). The clinical record or minutes of case conferences shall establish that effective interchange, reporting, and coordinated patient evaluation does occur. A written summary report for each patient shall be sent to the attending physician at least every 60 days.

(h) Services under arrangements. Services provided under arrangements shall be subject to a written contract conforming with the requirements specified in paragraph (f) of this section, and with the requirements of section 1861(w) of the Social Security Act (42 USC 1395x(w)).

(i) Institutional planning. The home health agency, under the direction of the governing body, shall prepare an overall plan and budget which provides for an annual operating budget and a capital expenditure plan.

1. Annual operating budget. There shall be an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense).

2. Capital expenditure plan. The capital expenditure plan shall be in compliance with chapter 150, Wis. Stats. Records relating to the capital expenditure plan shall comply with the requirements of subsection 5.02(2) and (3).

3. Preparation of plan and budget. The overall plan and budget shall be prepared under the direction of the governing body of the home health agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the home health agency.

4. Annual review of plan and budget. The overall plan and budget shall be reviewed and updated at least annually under the direction of the governing body of the home health agency, by the committee referred to in subsection 5.16(2)(i)(3).

(3) Group of professional personnel.

(a) A group of professional personnel, which shall include at least one physician and one registered nurse (preferably a public health nurse), with appropriate representation from other professional disciplines, shall establish and annually review the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group shall be neither an owner nor an employee of the agency.

(b) Advisory and evaluation function. The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program to assist the agency in maintaining liaison with other health care providers in the community, and to assist the agency in its community information program. Its meetings shall be documented by minutes, which shall be dated.

(4) Acceptance of patients, plan of treatment, medical supervision. Patients shall be accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. If personal care services are considered necessary, an evaluation through the use of a functional assessment scale, provided by the department pursuant to sec. 5.16(8)(c)1., shall first be made. Exception: Personal care services provided to disabled individuals who have been determined to be permanently disabled by the Bureau of Social Security Disability Insurance (BSSDI) shall be exempt from this evaluation through the functional assessment scale. However all other plans of treatment and medical supervision requirements shall apply. Care shall follow a written plan of treatment, approved and periodically reviewed by a physician, and care shall continue under the supervision of a physician.

(a) Plan of treatment. The plan of treatment developed in consultation with the agency staff shall cover all pertinent diagnoses, including mental state, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatment, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of treatment which cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel shall participate in developing the plan of treatment.

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(b) Periodic review of plan of treatment. The total plan of treatment shall be reviewed by the attending physician and home health agency personnel as often as the severity of the patient's condition requires, but at least every 60 days. Agency professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of treatment.

(c) Conformance with physician's orders. Drugs and treatments shall be administered by agency staff only as ordered by the physician. The nurse or therapist immediately shall record and sign oral orders and obtain the physician's countersignature. Agency staff shall check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication. Any problems shall be reported promptly to the physician.

(d) When a recipient is receiving either home health aid or personal care services, the agency shall develop an agreement with the county social service agency in the recipient's county of residence. The agreement shall include a plan of coordination with the county social service agency for exchange of information about services provided to recipients in their home (including but not limited to information on providing of home health aid, personal care, and supportive home care to recipients), in order to minimize the duplication of services.

(5) Skilled nursing service. The home health agency shall provide skilled nursing service by or under the supervision of a registered nurse and in accordance with the plan of treatment.

(a) Duties of the registered nurse. The registered nurse shall make the initial evaluation visit, shall regularly reevaluate the patient's nursing needs, shall initiate the plan of treatment and necessary revisions, shall provide those services requiring substantial specialized nursing skill, shall initiate appropriate preventive and rehabilitative nursing procedures, shall prepare clinical and progress notes, shall coordinate services, shall inform the physician and other personnel of changes in the patient's condition and needs, shall counsel the patient and family in meeting nursing and related needs, shall participate in inservice programs, and shall supervise and teach other nursing personnel.

(b) Duties of the licensed practical nurse. The licensed practical nurse shall provide services in accordance with agency policies, shall prepare clinical and progress notes, shall assist the physician or registered nurse in performing specialized procedures, shall prepare equipment and materials for treatments observing aseptic technique as required, and shall assist the patient in learning appropriate self-care techniques.

(6) Therapy services. Any therapy services offered by the home health agency directly or under arrangement shall be given by a qualified therapist or by a qualified assistant under the supervision of a qualified therapist in accordance with the plan of treatment. The qualified therapist shall assist the physician in evaluating level of function, shall help develop the plan of treatment (revising as necessary), shall prepare clinical and progress notes, shall advise and consult with the family and other agency personnel, and shall participate in inservice programs.

(a) Supervision of physical therapist assistant and occupational therapy assistant. Services provided by a qualified physical therapist assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapist assistant or occupational therapy assistant shall perform services planned, delegated, and supervised by the therapist, shall assist in preparing clinical notes and progress reports, and shall participate in educating the patient and family, and in inservice programs.

(b) Supervision of speech therapy services. Speech therapy services shall be provided only by or under supervision of a qualified speech pathologist or audiologist.

(7) Home health aide services. Home health aides shall be selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. Aides shall be carefully trained in methods of assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, procedures for maintaining a clean, healthful, and pleasant environment, changes in patient's condition that should be reported, work of the agency and the health team, ethics, confidentiality, and recordkeeping. They shall be closely supervised to assure their competence in providing care.

(a) Assignment and duties of the home health aide. The home health aide shall be assigned to a particular patient by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate. Duties include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs, and completing appropriate records.

(b) Supervision. The registered nurse, or appropriate professional staff member, if other services are provided, shall make a supervisory visit to the patient's residence at least once every 30 days, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

(8) Personal care services. Personal care workers shall be employed by the home health agency, unless personal care services are provided pursuant to sec. 5.16(2)(a)2. or sec. 5.16(2)(a)3.

(a) Training. Each personal care worker shall be trained in the provision of personal care services. Training shall consist of a minimum of 40 classroom hours, 25 of which shall cover personal and restorative care subjects. The 40 classroom hours shall include the subjects listed in the "Curriculum Guidelines for Training Homemakers in the Provision of Personal Care Services" which may be obtained from the Division of Community Services. Training shall emphasize techniques and aspects of caring for the target populations.

(b) Supervision by Registered Nurse. Each personal care worker shall be supervised by a registered nurse oriented to or experienced in providing nursing care in the home.

(c) Requests for Services. Requests for personal care services may be made by the recipient, the recipient's physician, social service agency personnel or other individuals or organizations acting on behalf of the recipient.

1. Except as specified in sec. 5.16(4), before involvement in a personal care program, the recipient shall undergo an evaluation through the use of the functional assessment scale provided by the department, to determine the medical necessity for personal care and the person's ability to benefit from it.

2. If it is determined that the level of care needed is personal care, a physician's prescription or orders shall be obtained by the registered nurse, and a plan of care shall be developed by the registered nurse, in consultation with the physician.

(d) Other Requirements of the agency. In addition to requirements stated elsewhere in this section, the home health agency shall:

1. Provide the personal care worker with the basic materials and equipment to deliver personal care services;

2. Maintain time sheets documenting, by funding source, the types and duration of services provided by the personal care worker;

4. The home health agency shall maintain a health care record for each recipient receiving personal care services through the agency. The record shall be kept up to date, and shall include all health services provided by the agency. The record shall include:

a. Nursing assessment, medical plan of care, nursing plan of care, personal care worker's assignment, recording of all assignments whether completed or not and general remarks.

b. The record shall be signed by both the personal care worker and the supervising registered nurse.

c. The personal care worker shall record each visit with the recipient on the health care record, including observations made, activities carried out and not carried out.

d. The personal care worker shall report promptly to the registered nurse supervisor any significant changes in the condition of the recipient.

e. A copy of the written agreement with the health agency or registered nurse providing supervision shall be on file at the agency.

5. The agency shall cooperate with other health and social service agencies in the area and with interested community referral groups in an attempt to avoid duplication of services and to provide the best possible coordination of personal care services to area recipients.

6. Requirements of the registered nurse supervisor. The registered nurse providing the health care supervision shall:

a. Review with appropriate personnel the evaluation based upon the rating scale designated pursuant to sec. 5.16(9)(c)1., before any personal care services are provided.

b. Secure from the physician the necessary written orders;

c. Develop a plan of care in consultation with the physician, prepare the assignment in writing, interpret this assignment to the personal care worker, if necessary, and maintain a copy of the physician's plan of care with the home health agency's health record;

d. Develop an appropriate time and services reporting mechanism for the personal care worker and instruct the personal care worker in the use of reporting mechanism;

e. Identify in the plan of care the frequency and anticipated duration of personal care services;

f. Give written instructions, or if necessary a demonstration to the personal care worker, of the services to be performed;

g. Teach or arrange for the teaching of personal care services to family members, if available and appropriate;

h. Confer with the home health agency staff, the personal care worker, the physician, and other involved professionals in regard to the recipient's progress;

i. Judge the competency of the personal care worker to perform the personal care services; and

j. Review the plan of care and perform an evaluation of the patient's condition not less frequently than every 60 days. The evaluation includes at least one visit to the home and a review of the personal care worker's daily written record, and discussion with the physician of any need for changes in type or level of care or discontinuance of care. If a change is necessary, appropriate referrals shall be made.

7. Requirements of the personal care worker. The personal care worker who shall not be a responsible relative as legally defined under section 52.01(1)(a), Wis. Stats., or a child of the client receiving services, shall:

a. Perform tasks assigned by the registered nurse for which appropriate training has been received;

b. Report in writing to the supervising registered nurse on each assignment;

c. Report promptly to the registered nurse any changes in the recipient's condition; and

d. Confer with the registered nurse regarding the recipient's progress.

8. Records. The following records shall be made available by the agency to the approved survey team and other authorized department personnel:

a. Written personnel policies;

b. Written job descriptions for all positions which are part of the personal care services program;

c. Written plan indicating total process for referral through delivery of services and follow-up;

d. Written statement defining scope of personal care services (The statement shall include: target population, service needs of target population, service priorities and hours the services are available.);

e. Record of each personal care worker's 40 hours of training in personal care;

f. Personal care worker's daily time sheets;

g. Health care record;

h. Medical assistance billings;

i. Cost reports; and

j. Contracts with agencies.

(9) Clinical records. A clinical record containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient receiving home health services. In addition to the plan of treatment, the record shall contain appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes (clinical notes shall be written the day service is rendered and shall be incorporated no less often than weekly); copies of summary reports sent to the physician; and a discharge summary.

(10) Evaluation. The home health agency shall have written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), home health agency staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation program shall be appropriate, adequate, effective, and efficient. Results of the evaluations shall be reported to and acted upon by those responsible for the operation of the agency and shall be maintained separately in administrative records.

(a) Policy and administrative review. As part of the evaluation process the policies and administrative practices of the agency shall be reviewed to determine the extent to which they promote appropriate, adequate, effective, and efficient patient care. Mechanisms shall be established in writing for the collection of pertinent data to assist in evaluation. The data to be considered may include but are not limited to: number of patients receiving each service offered, number of patient visits, reasons for discharge, breakdown by diagnosis, sources of referral, number of patients not accepted and reasons, and total staff days for each service offered.

(b) Clinical record review. At least quarterly, appropriate health professionals, representing at least the scope of the program, shall review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct services as well as services under arrangement). There shall be continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of treatment and appropriateness of continuation of care.

(11) Qualifying to provide outpatient physical therapy or speech pathology services. As a provider of services, a home health agency may qualify to provide outpatient physical therapy or speech pathology services if the agency meets the statutory requirements of section 1861(o) of the Social Security Act and complies with other health and safety requirements prescribed by the Secretary of DHEW for home health agencies. The agency shall also comply with applicable health and safety requirements of sections 5.34(3), (4), (5), (7), (9), and (11) pertaining to provision of outpatient physical therapy or speech pathology services.

(12) Home health agencies shall provide or make available part time or intermittent nursing services, home health aide services and medical supplies, equipment and appliances suitable for use in the home.

Section 5.17 is repealed:

5.17 Requirements for Certification of Social Services Agencies Providing Personal Care Services.

Section 5.18 is repealed:

5.18 Requirements for Certification of Christian Science Nurses.

Section 5.22 is repealed and recreated below:

5.22 Requirements for Certification of Psychotherapy Providers.

(1) (The former Wis. Adm. Code chapter PW-MA 25 is repealed and partially recreated in this section for purposes of certification.) Psychotherapy providers are required to be either:

(a) A licensed physician who has completed a residency in psychiatry;

(b) A licensed psychologist who is listed or eligible to be listed in the National Register of Health Services Providers in Psychology; or

(c) An outpatient facility operated by a "board" as defined in chapter one of this rule which is certified under chapter PW-MH 60.65 (and 60.72 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats.; or

(d) An outpatient facility operated by a provider hospital which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. or which is accredited by JCAH, Accreditation Program for Psychiatric Facilities; or

(e) At the discretion of the department, an outpatient facility under contract to a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable), Wis. Adm. Code and section 632.89(1)(a), Wis. Stats and which has made substantial effort to comply with the requirements for accreditation by JCAH, Accreditation Program for Psychiatric Facilities; or

(f) Clinics certified under rules promulgated by the department to govern section 632.89, Wis. Stats.

(2) Staffing requirements for outpatient facilities.

(a) To provide psychotherapy reimbursable under the medical assistance program, personnel employed by an outpatient facility as defined in sec. 5.22(1)(c), (d), (e), or (f) shall be required to meet provider certification standards specified in this subsection and shall be under the supervision of a licensed physician or licensed psychologist who meets the requirements of 5.22(1)(a) or (b). Persons employed by board operated or hospital outpatient psychotherapy facilities shall not be required to be individually certified as providers and may provide psychotherapy services upon the department's issuance of certification to the facility by which they are employed. In this case, the facility shall provide a list naming personnel employed by the facility who shall be performing psychotherapy services for which reimbursement shall be claimed under the medical assistance program. Such listing shall certify the credentials possessed by the named persons which would qualify them for certification under the standards specified in this subsection. A facility, once certified, shall be under a continuing obligation to promptly advise the department in writing of the procurement or termination of employees who shall be, or have been, providing psychotherapy services under the medical assistance program. Persons eligible in this subsection shall be:

1. A person with a masters degree in social work from a graduate school of social work accredited by the Council on Social Work Education, with course work emphasis in case work or clinical social work and who is listed in or eligible to be listed in either the NASW Register of Clinical Social Workers or the National Registry of Health Care Providers in Clinical Social Work; or

2. A person with a masters degree in psychiatric mental health nursing from a graduate school of nursing accredited by the National League for Nursing;

3. A person with any of the following masters degrees and course work emphasis in clinical psychology: counseling and guidance, counseling psychology, clinical psychology, psychology or school psychology, if the person also is listed or eligible to be listed in their National Registry or has met the equivalent of the requirements for registration in the National Registry of Health Care Providers in Clinical Social Work or in the NASW Register of Clinical Social Work; or

4. A licensed psychologist or licensed physician.

5. Providers defined by subparagraphs 1 through 3 shall also have 3,000 hours of supervised experience in clinical practice. Supervised during the 3,000 hour period means a minimum of one hour per week of face-to-face supervision by another person meeting the minimum qualifications to be a provider.

(3) Reimbursement for outpatient psychotherapy services. Outpatient psychotherapy services shall be reimbursed according to medicare profiles or other mechanisms established by the department for the applicable provider and shall be as follows:

(a) For the services of any provider working in a certified outpatient facility, reimbursement shall be to the facility;

(b) For the services of any provider in private practice who is licensed and certified according to Section 5.22(1)(a) or (b), reimbursement shall be to that provider.

(4) Reimbursement for inpatient psychotherapy services. Reimbursement shall be made to providers defined in 5.22(1)(a) and (b) who provide psychotherapy services to a recipient while the recipient is an inpatient in a general, acute care hospital or in a psychiatric facility. Psychotherapy services provided to such inpatients shall be reimbursed according to medicare profiles or other mechanisms established by the department for the applicable provider and shall be as follows:

(a) For the services of a provider who is a licensed physician defined in 5.22(1)(a) or a licensed psychologist defined in 5.22(1)(b) employed by or under contract to an outpatient facility, reimbursement shall be to the facility;

(b) For the services of any provider who is a licensed physician defined in 5.22(1)(a) or a licensed psychologist defined in 5.22(1)(b) in private practice, reimbursement shall be to the physician or psychologist.

Sec. 5.245 is repealed and recreated below:

5.245 Day Treatment or Day Hospital Services

(1) Day treatment or day hospital service providers are required to be either:

(a) A medical program operated by a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.67 (and 60.73 or 61.03 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats.; or

(b) A medical program under contract to a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.67 (and 60.73 or 61.03 if applicable), Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. Hospital programs shall be accredited by JCAH, Accreditation Program for Psychiatric Facilities.

(2) Program personnel and staffing.

(a) A registered nurse and a registered occupational therapist shall be on duty to participate in program planning, program implementation and daily program coordination.

(b) The day treatment program shall be planned for and directed by designated members of the interdisciplinary team including but not limited to a social worker, a psychologist, an occupational therapist and a registered nurse (or other appropriate health care professional, e.g. physician, physician's assistant).

(c) A written patient evaluation involving an assessment of the patient's progress by each member of the multidisciplinary team shall be made once at least every 60 days.

(d) For the purposes of daily program performance, coordination, guidance and evaluation, there shall be:

1. One qualified professional staff (e.g. OTR, MSW, RN, licensed psychologist, MS psychologist) per group; or

2. One certified occupational therapist assistant and one other paraprofessional per group; and

3. Other appropriate staff, including volunteer staff.

(3) Billing and Reimbursement for Day Treatment or Day Hospital Services.

(a) Reimbursement for medical day treatment or day hospital services shall be at 90% of the rate established and approved by the department less any third party recoupments. For programs defined by sec. 5.245(1)(b), the authorizing board shall be responsible for the remainder of the reimbursement.

(b) Billing submitted for medical day treatment or day hospital services shall, with the exception of state-operated facilities, verify that the service has been approved by the board.

Sec. 7.06(3)(g) is repealed and recreated below:

7.06 Physicians Services

(3) Other Limitations

(g) A maximum of one annual physical examination per calendar year per recipient shall be covered.

Sec. 7.07(2)(c)15 is repealed and recreated below:

7.07 Dental Services

(2) Services Requiring Prior Authorization.

(c) The following dental services require prior authorization in order to be reimbursed under the medical assistance program:

15. Orthodontics - The diagnostic work-up is required to be performed and submitted with the prior authorization request. If the request is approved, the recipient is required to be eligible on the date the authorized orthodontic treatment is started. Once started, the service will be reimbursed to completion, regardless of the recipient's eligibility. Orthodontics are covered as required by federal regulation or, if necessary to prevent acute dental problems or irreversible damage to the teeth or supporting structures.

Sec. 7.10 is repealed and recreated below:

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7.10 Drugs

(1) Covered Services. Drugs and drug products covered by the medical assistance program include legend and certain non-legend drugs and supplies prescribed by a physician licensed pursuant to section 448.04, Wis. Stats., by a dentist licensed pursuant to section 447.05, Wis. Stats., or by a podiatrist licensed pursuant to section 448.04, Wis. Stats. The department may determine whether or not drugs judged by the Food and Drug Administration to be "possibly effective" shall be reimbursable under the program.

(2) Services Requiring Prior Authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3.)] The following drugs/supplies require prior authorization:

(a) All CS II stimulant drugs.

(b) Stimulant drugs in CS III and CS IV with the exception of Ritalin, Sanorex, Deaner and including salts and/or derivatives of Phentermine, Chlorphentermine, Fenfluramine, Phendimetrazine, Diethylpropion, Pipradrol Benzphetamine (alone or combination).

(c) Methaqualone.

(d) All high nitrogen food supplement/replacement products; Lytren, Ensure, Polycose, etc.

(e) Debrisan.

(f) Derifil.

(3) Other Limitations.

(a) Dispensing of schedule III, IV and V drugs shall be limited to the original dispensing plus five refills, or six months, whichever comes first.

(b) Dispensing of non-scheduled legend drugs shall be limited to the original dispensing plus eleven refills, or 12 months, whichever comes first.

(c) Generically-written prescriptions are required to be filled with a generic drug included in the Wisconsin drug formulary.

(d) Legend drugs, except drugs dispensed by unit-dose methods, shall be dispensed in amounts not to exceed a 34-day supply.

(e) Provision of drugs and supplies to nursing home recipients shall comply with the department's policy on ancillary costs as specified in section 7.09(3).

(f) To be included as a covered service, an over-the-counter drug shall be: used in the treatment of a diagnosable condition; and a rational part of an accepted medical treatment plan. Only the following generic categories of over-the-counter drugs are covered:

1. Laxatives.
2. Antacids.
3. Analgesics.
4. Insulins.
5. Minerals and vitamins.
6. Antibiotics--Topical.
7. Antidiarrheals.
8. Hemorrhoidal products.
9. Certain cold and allergy products (e.g., nasal sprays, cough syrups, etc.).

10. Asthma products.
11. Contraceptives.
12. Ophthalmic products (e.g., eye washes, artificial tears).

(4) Non-Covered Services. The following are not covered services:

(a) Claims for underpads or chux for nursing home recipients when billed by a pharmacy provider.

(b) Refills of schedule II drugs.

(c) Refills beyond the limitations of subsection 7.10(3).

(d) Personal care items (e.g. non-therapeutic bath oils).

(e) Cosmetics (e.g. non-therapeutic skin lotions, sun screens).

(f) Common medicine chest items (e.g. antiseptics, bandaids).

(g) Personal hygiene items (e.g. tooth paste, cotton balls).

(h) "Patent" medicines.

(i) Uneconomically small package sizes.

(j) Items which are in the inventory of a nursing home regardless of the person's residing in the home.

(k) Over-the-counter drugs not specified in the Drug Index and not included in the categories in subsection (3) above, and legend drugs not included in the Drug Index maintained by the department.

Section 7.11 is repealed and recreated below:

7.11 Nursing, Home Health Care, and Personal Care Services.

(1) Covered Services.

(a) Services provided by an agency certified under sec. 5.16. Services provided by an agency certified under sec. 5.16 which are covered by the medical assistance program are part-time or intermittent nursing, home health aide, and personal care services, medical supplies, equipment and appliances suitable for use in the home, and therapeutic services which the agency is certified to provide, when provided upon prescription of a licensed physician to a recipient confined to a place of residence. Such residence does not include a hospital, skilled nursing facility or intermediate care facility, except that these services and items may be furnished as home health services to a recipient in an intermediate care facility if they are not required to be furnished by the facility as intermediate care services.

(b) Services provided by a nurse.

1. Services provided by a registered nurse in independent practice which are covered by the MA program are part-time or intermittent nursing services, as defined in section 441.11 Wis. Stats., when there is no certified home health agency in the area to provide such services and when such services are prescribed; and

2. Private duty nursing when prescribed by a physician. Licensed practical nurses may provide private duty nursing services if the physician's prescription calls for a level of care which the licensed practical nurse is licensed to provide.

(c) Services provided by personal care workers. Personal care services may include:

1. Activities of daily living (e.g., helping the recipient to bathe, to get in and out of bed, to care for hair and teeth, to exercise and to take medications specifically ordered by a physician which are ordinarily self-administered, and to retrain the recipient in necessary self-help skills);

2. Household services related to keeping a comfortable and healthy environment in the areas of the home used by the recipient (e.g., changing the bed, light cleaning, rearrangements to assure that the recipient can safely reach necessary supplies or medication, laundering essential to the comfort and cleanliness of the recipient); and

3. Seeing to the nutritional needs of the recipient (e.g., purchase of food, assistance in meal preparation, washing utensils).

(2) Services Requiring Prior Authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] Prior authorization shall be required for:

(a) Long-term private duty nursing services provided in a recipient's place of residence require prior authorization of the department.

(b) Personal care services in excess of 30 hours in any 12-month period.

(3) Other Limitations.

(a) All services provided by a certified home health agency or by a nurse shall be provided upon a physician's orders as part of a written plan of care which is reviewed by the physician at least every 60 days. The plan of care shall include diagnosis, specific medical orders, specific types of services required, rehabilitation potential of the recipient and any other appropriate items.

(b) Registered nurses providing part-time or intermittent nursing service shall receive written orders from the recipient's physician to provide the level of care needed. The registered nurse shall contact the district public health nursing consultant in the area to receive orientation to acceptable clinical and administrative record-keeping before any service is provided. The registered nurse shall document the care and services provided and shall make such documentation available to the department upon request.

(c) Private duty nursing services may only be provided when the recipient requires individual and continuous care beyond that available on a part-time or intermittent basis, and when the recipient's physician has prescribed private duty nursing.

(d) Personal care services may be provided only after an evaluation based on a functional assessment scale provided by the department, pursuant to section 5.16(8)(c)1.

(e) Personal care services shall be reported and billed as a separate service on Medicaid claim forms provided by the department.

(f) The registered nurse shall reevaluate the recipient's condition not less frequently than every 60 days. The reevaluation shall include at least one visit to the recipient's home, a review of the personal care worker's daily written record, a review of the plan of care and contact with the physician as necessary. If a change in level of care is necessary, appropriate referrals shall be made.

(g) Persons providing and supervising personal care services shall be adequately trained and oriented to the provision of care in the home. In the case of the personal care worker, this means a minimum of 40 hours of training. In the case of the registered nurse supervisor, this means an orientation session with the public health nurse, except if the registered nurse is a public health nurse or has had experience providing nursing services in a patient's home.

(4) Non-covered services.

(a) Private duty nursing services provided in a nursing home are not covered by the medical assistance program.

(b) Medical social services are not a covered service.

(c) Christian Science nursing services are not covered.

Section 7.12 is repealed:

7.12 Personal Care Services

Sec. 7.13 is repealed and recreated below: AUG 8 1979

7.13 Mental Health Services

(1) (a) Inpatient psychiatric services. Covered services. Inpatient psychiatric care is a covered service when prescribed by a physician, and when provided within a psychiatric unit of a general hospital which meets the requirements of section 5.09, or when provided by a JCAH-accredited psychiatric facility within the limitations enumerated below.

(b) Requirements for coverage of inpatient psychiatric facility services for recipients under 21 years of age.

1. Inpatient psychiatric services for recipients under age 21 must be provided under the direction of a physician; and by a psychiatric facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Hospitals; and before the recipient reaches age 21 or, if the recipient was receiving the services immediately before reaching age 21, before the earlier of the following:

a. The date the recipient no longer requires the services; or

b. The date the recipient reaches age 22.

2. Certification of need for services. A team specified in HSS 107.13(1)(b)3. must certify that:

a. Ambulatory care resources available in the community do not meet the treatment needs of the recipient; and

b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

d. The certification specified in this section and in HSS 107.13(1)(b)3. satisfies the utilization control requirement for physician certification in HSS 107.13(1)(b)7.

3. Team certifying need for services. Certification under HSS 107.13(1)(b)2. must be made by teams specified as follows:

a. For an individual who is recipient when admitted to a facility or program, certification must be made by an independent team that includes a physician; has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and has knowledge of the individual's situation.

b. For an individual who applies for medicaid while in the facility or program, the certification must be made by the team responsible for the plan of care and specified in HSS 107.13(1)(b)6.; and cover any period before application for which claims are made.

c. For emergency admissions, the certification must be made by the team responsible for the plan of care within 14 days after admission.

4. Active treatment. Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care, described in HSS 107.13(1)(b)5. that is:

a. Developed and implemented no later than 14 days after admission; and

b. Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

5. Individual plan of care.

a. "Individual plan of care" means a written plan developed for each recipient in accordance with HSS 107.13(1)(b)9. and 10., to improve his condition to the extent that inpatient care is no longer necessary. The plan of care must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;

2. Be developed by a team of professionals specified under HSS 107.13(1)(b)6. in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge;

3. Specify treatment objectives;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and

5. Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

b. The plan must be reviewed every 30 days by the team specified in HSS 107.13(1)(b)6. to:

1. Determine that services being provided are or were required on an inpatient basis, and

2. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

c. The development and review of the plan of care as specified in this section satisfies the utilization control requirements for:

1. Physician certification; and

2. Establishment and periodic review of the plan of care.

6. Team developing individual plan of care.

a. The individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

b. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:

1. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

2. Assessing the potential resources of the recipient's family;

3. Setting treatment objectives; and

4. Prescribing therapeutic modalities to achieve the plan's objectives.

c. The team must include, as a minimum, either:

1. A Board-eligible or Board-certified psychiatrist;

2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

d. The team must also include one of the following:

1. A psychiatric social worker.

2. A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

3. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals.

4. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

7. Physician certification and recertification of need for inpatient care.

a. A physician must certify and recertify for each applicant or recipient that inpatient services in a mental hospital are or were needed.

b. The certification must be made at the time of admission or, if an individual applies for assistance while in a mental hospital, before the medicaid agency authorizes payment.

c. Recertification must be made at least every 60 days after certification.

8. Medical, psychiatric, and social evaluations.

a. Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each applicant's or recipient's need for care in the hospital; and appropriate professional personnel must make a psychiatric and social evaluation.

b. Each medical evaluation must include diagnoses; summary of present medical findings; medical history; mental and physical functional capacity; prognoses; and a recommendation by a physician concerning admission to the mental hospital; or continued care in the mental hospital for individuals who apply for medicaid while in the mental hospital.

9. Individual written plan of care.

a. Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the individual;

3. Objectives;

4. Any orders for medications; treatments; restorative and rehabilitative services; activities; therapies; social services; diet; and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and

6. Plans for discharge.

7. The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.

b. Before admission to a SNF or before authorization for payment, the attending physician must establish a written plan of care for each applicant or recipient in a SNF. The plan of care must include:

1. Diagnoses, symptoms, complaints and complications indicating the need for admission;

2. A description of the functional level of the individual;

3. Objectives;

4. Any orders for medications; treatments; restorative and rehabilitative services; activities; therapies; social services; diet; and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and

6. Plans for discharge.

7. The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 60 days.

10. Reports of evaluation and plans of care. A written report of each evaluation and plan of care must be entered in the applicant's or recipient's record:

a. At the time of admission; or

b. If the individual is already in the facility, immediately upon completion of the evaluation or plan.

11. Recipients under age 22 residing in JCAH-accredited inpatient psychiatric facilities, and recipients over age 65 residing in an institution for mental diseases are eligible for medicaid benefits for services not provided though that institution and not reimbursed as part of the cost of care of that individual in the institution.

12. Patient's accounts. Each recipient who is a patient in a state, county, or private mental hospital shall have an account established for the maintenance of earned or unearned money payments received (Social Security payments, SSI payments, etc.). The account for patients in state mental health institutes shall be kept in accord with section 46.07, Wis. Stats. The payee for the account may be the recipient, if competent, or a legal representative.

a. Legal representatives who are employees of county departments of social services or the department of health and social services shall not receive payments.

b. If the payee of the resident's account is a relative, friend or other legal representative, the payee shall submit an annual report on the account to the Social Security Administration.

(c) Other Limitations--Inpatient psychiatric services.

1. Diagnostic interviews with immediate family members of the recipient are covered services. Immediate family members means parents, spouse or children, or for a child in a foster home, foster parents. A maximum of five hours of such interviews shall be covered.

2. Psychotherapy is a covered service when provided to inpatients for whom the therapy is prescribed as a component of the plan of care.

(d) Non-Covered Services--Inpatient psychiatric services.

1. Activities which are primarily diversional in nature such as services which act as a social or recreational outlet for the recipient are not covered services.

2. Mild tranquilizers or sedatives provided solely for the purpose of relieving anxiety or insomnia are not covered services for inpatients in a psychiatric facility.

3. Consultation with other providers about the recipient's care is not a covered service.

4. Inpatient psychiatric hospital services are not covered for recipients who are between the ages of 22 and 65.

(2) Outpatient psychotherapy services.

(a) Covered services. Outpatient psychotherapy services are covered services when prescribed by a physician and when provided by a provider who meets the requirements of section 5.22, and when the following conditions are met:

1. The psychotherapy furnished is in accordance with the definition of psychotherapy in chapter one of this rule.

2. A differential diagnostic examination is performed by a certified psychotherapy provider. A physician's prescription is not necessary to perform the examination.

3. Before the actual provision of psychotherapy services, a physician shall prescribe therapy in writing.

4. Psychotherapy is furnished by a:

a. Provider who is a licensed physician or a licensed psychologist defined under subsection 5.22(1)(a) or (b), and who is:

i. Working in an outpatient facility defined under subsection 5.22(1)(c)(d) or (e) which is certified to participate in the medical assistance program, or

ii. Working in private practice; or

b. Provider defined under subsection 5.22(2)(a)(1), (2) or (3) who is:

i. Working in an outpatient facility defined in 5.22 (1)(c)(d) or (e) which is certified to participate in the medical assistance program.

5. Psychotherapy is performed only in the following locations:

a. Office of the provider.

b. Hospital.

c. Outpatient facility.

d. Nursing home.

e. School.

6. The provider who performs psychotherapy must engage in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed under the medical assistance program.

7. Outpatient psychotherapy services for up to 15 hours or $500 per recipient in a 12-month period may be reimbursed without prior authorization. The 12-month period begins on the first date of the actual provision of psychotherapy services. If reimbursement is also made to any provider for alcoholism or other drug abuse treatment services outlined in section 7.13(1)(d) during the same 12-month period for the same recipient, the hours reimbursed for such services will be considered a concurrent part of the amount available for psychotherapy. Likewise, if several psychotherapy providers are treating the same recipient during a 12-month period, all the psychotherapy shall be considered in the $500 or 15 hour total. If a recipient is hospitalized as an inpatient in an acute care general hospital with a diagnosis of, or for a procedure associated with, a psychiatric condition, reimbursement for any inpatient psychotherapy services will not be considered a concurrent part of the amount available for outpatient psychotherapy. The differential diagnostic examination for psychotherapy and the medical evaluation for alcoholism or other drug abuse treatment services shall also be covered as additional items.

(b) Services Requiring Prior Authorization--Outpatient psychotherapy services.

1. Reimbursement beyond 15 hours or $500 of service may be claimed for treatment services furnished after receipt of authorization by the department. Services reimbursed by any third party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified number of hours of outpatient services to be provided to a recipient within the 12 month period.

3. The department shall set limits on the number of hours for which prior authorization is approved. The department shall require periodic progress reports and subsequent prior authorization requests in instances where additional services are requested.

4. Persons who review prior authorization requests for the department shall have the same minimum training required of providers.

5. The prior authorization request shall include the following information:

a. The name, address and medical assistance provider or identifier numbers of the providers conducting the diagnostic examination or medical evaluation and performing psychotherapy or performing AODA services.

b. The physician's original prescription for treatment.

c. When authorization is being requested for psychotherapy services a detailed summary of the differential diagnostic examination, setting forth the severity of the mental illness or medically significant emotional or social dysfunction and the medical necessity for psychotherapy and the expected outcome of treatment.

d. A copy of the treatment plan which shall relate to the findings of the diagnostic examination or medical evaluation and specify behavior and personality changes being sought.

e. A statement of the estimated frequency of treatment sessions, the estimated cost of treatment and the anticipated location of treatment.

6. The provider requesting prior authorization shall be notified in writing of the department's decision. In cases of a denial of the request, the recipient will also be notified in writing of the department's decision.

(c) Other Limitations--Outpatient psychotherapy services.

1. Collateral interviews are limited to members of the recipient's immediate family; parents, spouse or children, or for children in foster care, foster parents.

2. Group sessions. A psychotherapy group session means a session at which there are more than one but not more than ten recipients receiving psychotherapy services together from one or two providers.

3. Emergency psychotherapy. Emergency psychotherapy may be performed by a provider for a recipient without a prescription for treatment or prior authorization when the provider has reason to believe that the recipient may immediately injure himself or herself or any other person. A prescription for the emergency treatment must be obtained within 48 hours of the time the emergency treatment was provided excluding weekends and holidays. Reimbursement for emergency psychotherapy may be made in accordance with section 5.22(3). Subsequent treatment may be provided if section 7.13(1)(c) is followed.

4. Not more than one provider shall be reimbursed for the same treatment session, unless the session involves a couple, a family group or is a group session as described in subsection 7.13(3)(b)(2). Under no circumstances shall more than two providers be reimbursed for the same session.

(d) Non-Covered Services--Outpatient psychotherapy services.

1. Collateral interviews with persons not stipulated in 7.12(2)(c) and consultations are not covered services.

2. Court appearances or evaluations, except as noted in subsection 7.03(10) are not covered services.

3. Psychotherapy is not a covered service for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention.

4. Psychotherapy provided in a person's home.

5. Self-referrals are not covered. For purposes of this section, a self-referral means a provider referring a recipient to an agency in which the provider has a direct financial interest, or to himself or herself acting as a practitioner in private practice.

(3) Alcohol and other drug abuse services.

(a) Outpatient alcohol and drug abuse treatment services are covered when prescribed by a physician and when provided by a provider who meets the requirements of section 5.23, and when the following conditions are met:

1. The treatment services furnished are in accordance with the definition in chapter one of this rule.

2. Before the enrollment in an alcohol or drug abuse treatment program, the recipient shall receive a complete medical evalution. The evaluation shall include diagnosis, summary of present medical findings, medical history, and explicit recommendations by the physician for participation in the alcohol or other drug abuse treatment program. A medical evaluation performed for such purpose within 60 days prior to enrollment shall be valid for reenrollment.

3. The supervising physician or psychologist shall be responsible for development of a treatment plan, which shall relate to behavior and personality changes being sought, and to the expected outcome of treatment.

4. Outpatient alcohol or other drug abuse treatment services for up to $500 or 15 hours in a 12-month period may be reimbursed without prior authorization. The medical evaluation shall be covered as an additional item.

(b) Services Requiring Prior Authorization--Outpatient Alcohol or Other Drug Abuse Treatment Services.

1. Reimbursement beyond 15 hours or $500 of service may be claimed for treatment services furnished after receipt of authorization by the department. Services reimbursed by any third party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified number of hours of outpatient services to be provided to a recipient within the 12 month period.

3. The Department shall set limits on the number of hours for which prior authorization is approved. The Department shall require periodic progress reports and subsequent prior authorization requests in instances where additional services are requested.

4. Persons who review prior authorization requests for the department shall have the same minimum training required of providers.

5. The prior authorization request shall include the following information:

a. The name, address and medical assistance provider or identifier numbers of the providers conducting the medical evaluation and performing AODA services.

b. The physician's original prescription for treatment.

c. A copy of the treatment plan which shall relate to the findings of the medical evaluation and specify behavior and personality changes being sought.

d. A statement of the estimated frequency of treatment sessions, the estimated cost of treatment and the anticipated location of treatment.

6. The provider requesting prior authorization shall be notified in writing of the department's decision. In cases of a denial of the request, the recipient will also be notified in writing of the department's decision.

(c) Non-Covered Services--Alcoholism/Drug Abuse Treatment.

1. Court appearances or evaluations, except as noted in subsection 7.03(10) are not covered services.

2. Collateral interviews and consultations are not covered services.

(4) Day Treatment or Day Hospital Service. Covered Services.

(a) Day treatment or day hospital services are covered services when prescribed by a physician and when provided by a provider who meets the requirements of section 5.245, and when the following conditions are met:

1. The day treatment services are furnished in accordance with the definition of day treatment in chapter one of this rule.

2. Before the involvement in a day treatment program, the recipient shall undergo an evaluation through the use of the functional assessment scale provided by the department, to determine the medical necessity for day treatment and the person's ability to benefit from it.

3. The supervising psychiatrist shall approve a written treatment plan for each recipient and shall review such plan no less frequently than once every 60 days. The treatment plan shall be based on the initial evaluation and shall include individual goals and the treatment modalities to be used to achieve these goals, and the expected outcome of treatment.

4. Reimbursement may be made without prior authorization from the department for up to 120 hours of day treatment service in a 12-month period which begins on the first date day treatment services are provided. Psychotherapy services or occupational therapy services provided as component parts of a person's day treatment package shall not be billed separately, but shall be billed and reimbursed as part of the day treatment program.

5. Day treatment or day hospital services provided to recipients with inpatient status in a hospital shall be limited to 20 hours per inpatient admission, and shall only be available to patients scheduled for discharge, to prepare them for discharge.

6. Reimbursement shall not be made for day treatment services provided in excess of 30 hours of treatment in any week.

7. Day treatment services are covered only for the chronically mentally ill and acutely mentally ill who have a need for day treatment, and an ability to benefit from the service, as measured by the functional assessment scale authorized by the department.

8. Billing for day treatment services shall be submitted by the 51.42 board. Reimbursement shall be at 90% of the rate established by the department. Day treatment services shall be billed as such, and not as psychotherapy, occupational therapy or any other modality.

(b) Services Requiring Prior Authorization--Day Treatment or Day Hospital Services.

1. Prior authorization is required for day treatment services provided beyond 120 hours of service in a 12-month period.

2. Prior authorization is required for all day treatment or day hospital services provided to recipients with inpatient status in a nursing home. Only those patients scheduled for discharge are eligible for day treatment. No more than 40 hours of service will be authorized in a 12-month period.

a. The prior authorization request shall be requested by the provider and shall include:

i. The name, address, and medical assistance number of the recipient.

ii. The name, address, and provider number of the provider of the service and of the billing provider.

iii. The physician's original prescription for treatment.

iv. A copy of the treatment plan and the expected outcome of treatment.

v. A statement of the estimated additional dates of service necessary and total cost.

b. The provider requesting prior authorization and the recipient shall be notified in writing of the department's decision.

(c) Non-Covered Services--Day Treatment or Day Hospital Services.

1. Day treatment services which are primarily recreation-oriented and which are provided in a non-medically supervised setting such as 24-hour day camps, or other social service programs are not covered services.

2. Consultation with other providers or service agency staff regarding the care or progress of a recipient are not covered services.

3. Preventive or education programs provided as an outreach service; and/or casefinding are not covered services.

4. Aftercare programs, provided independently or operated by or under contract to community mental health agencies under 51.42 or 51.437 are not covered services.

5. Court appearances or evaluations, except as noted in subsection 7.03(10), are not covered services.

6. Day treatment is not covered for recipients with a primary diagnosis of mental retardation.

Sec. 7.14 is repealed and recreated below:

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7.14 Podiatry Services

(1) Covered Services. Podiatry services covered by medical assistance include those medically necessary services for the diagnosis and treatment of the feet, within the limitations described below, when provided by a certified podiatrist.

(2) Other Limitations.

(a) Podiatric services pertaining to the cleaning, trimming, and cutting of toenails (often referred to as palliative or maintenance care, or debridement) will be reimbursed on a once per 31 day period if the recipient is under the active care of a physician, and when the recipient's condition is one of the following:

1. Diabetes mellitus;
2. Arteriosclerosis obliterans evidenced by claudication
3. Peripheral neuropathies involving the feet, which are associated with:
    a. malnutrition or vitamin deficiency
    b. carcinoma
    c. diabetes mellitus;
    d. drugs and toxins;
    e. multiple sclerosis;
    f. uremia

The cutting, cleaning, and trimming of toenails, corns, callouses, and bunions on multiple digits, will be reimbursed at one fee for each service which includes either one or both appendages.

(b) Initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring non-covered care.

(c) Physical medicine is a covered service but is limited to ultrasound and diathermy only for the following diagnoses:

1. symptomatic osteoarthritis
2. tendonitis
3. bursitis

(d) On a podiatrist's claim for a nursing home visit (for the cutting, cleaning, trimming of toenails, corns, callouses, and bunions), the program will reimburse at the nursing home visit procedure code rate for only one of the patients seen on that day of service. All other claims for patients seen at the nursing home on the same day of service will be reimbursed up to the multiple nursing home visit rate. The podiatrist shall identify on the claim form the single patient for whom the nursing home single patient rate may be allowed, and the patient(s) for whom the multiple nursing home visit rate is applicable.

(e) For multiple surgical procedures performed on the same day the podiatrist will be reimbursed as follows:

1. first procedure at 100%;
2. second procedure at 50%;
3. third procedure at 25%;
4. fourth procedure at 12.5%.

Additional surgical procedures performed on the same foot within 120 days of the original surgery will be paid at 50%. Post-operative care, office calls and dressings are considered part of the surgical fee.

(f) The administration of antibiotics is limited to LA, AP, or penicillin for the purpose of treating cellulitis or an acute "itis" associated with foot disease.

(g) Debridement of mycotic conditions and mycotic nails are a covered service per utilization guidelines established by the Department of Health and Social Services.

(h) The application of unna boots is allowed once per two weeks.

(3) Non-Covered Services. The following are non-covered services (in addition to section 7.03):

(a) Procedures which do not relate to the diagnosis or treatment of the ankle and foot are not covered.

(b) Palliative or maintenance care, except as enumerated in subsection (2) above.

(c) Orthopedic shoes and supportive devices such as arch supports, shoe inlays, and pads.

(d) Services directed toward the care and correction of "flat feet".

(e) Treatment of subluxation of the foot.

Sec. 7.24 is repealed and recreated below: AUG 8 1979

7.24 Medical Supplies and Equipment

(1) Covered Services. The following are covered within the limitations of this section, when prescribed by a physician or other person eligible to prescribe such services [NOTE: These items may not be billed by hospitals or nursing homes, but only by certified providers of the special service.]:

(a) Medical supplies and devices.

(b) Basic and necessary durable medical equipment (e.g., standard wheelchairs, walkers, canes, crutches, hospital beds, bed rails, and mattresses, oxygen equipment and cylinders, braces, casts, home dialysis equipment).

(c) Corrective shoes, with the following frequency rates:

1. Three pair per/year (from original date of service) for children up to 15 years of age; and

2. Two pair per/year for recipients over 15 years of age. These frequencies apply to shoes which are or are not attached to an orthotic brace.

(d) Hearing aids.

(e) Prosthetic and orthotic devices, when provided by either an orthotist or a prosthetist certified as a provider.

(2) Services Requiring Prior Authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3.)] The following services require prior authorization:

(a) Purchase of wheelchairs and prosthetic and orthotic appliances which are not included on the department-approved price tables. Rental of such items requires prior authorization for the second and succeeding months of rental use, except that if rental cost exceeds a dollar amount established by the department and communicated to providers, prior authorization is required before the first month's use. Needed repairs and modifications exceeding the dollar amount established by the department require prior authorization. Replacements of the total appliance unit require prior authorization.

(b) Purchase or rental of all power driven or semi and full reclining wheelchairs and purchase or rental of a wheelchair for a nursing home recipient.

(c) Purchase of hearing aids regardless of cost.

1. Once authorized, the hearing aid is under guarantee for the first year of usage. Any repairs to that aid after the guarantee period must have prior authorization when the dollar amount exceeds an upper limit set by the department and communicated to all hearing aid providers.

2. Hearing aid batteries and accessories do not require prior authorization.

3. Requests for prior authorization of hearing aids shall be reviewed only if such requests consist of the following reports on forms designated by the department, containing information requested by the department:

a. A medical report from the recipient's physician; and

b. An audiological report from an audiologist.

c. After a new or replacement hearing aid has been worn for a 30-day trial period, a performance check shall be obtained from a certified audiologist or certified speech and hearing center. The department shall provide reimbursement for the cost of the hearing aid only after the performance check has shown the hearing aid to be satisfactory, or the lapse of 45 days has occurred with no response from the recipient.

(d) Prior authorization shall be requested and obtained before service is provided. Requests for prior authorization of medical equipment shall be reviewed only if such requests contain the following information:

1. The name, address and medical assistance number of the recipient.
2. The name of the provider and provider number.
3. The name of the person or agency making the request.
4. The attending physician's diagnosis, indication of degree of impairment, and justification for the requested service.
5. An accurate cost estimate if the request is for the rental, purchase, or repair of an item.
6. If out-of-state non-emergency service is requested, a justification for obtaining service outside of Wisconsin, including an explanation of why service cannot be obtained in the state.
7. If the request is for a wheelchair required pursuant to section 7.24(3)(b)1.b. below, the following additional information shall be included:
   a. A physician's order for the wheelchair.
   b. A statement by the attending physician that the purchase of a wheelchair will contribute to the rehabilitation of the resident toward self-sufficiency.

(3) Other Limitations

(a) The services covered under this section are not covered for recipients who are nursing home residents or who are inpatients in a hospital, with the following exceptions:

1. Purchase of a wheelchair prescribed by a physician is covered for a nursing home recipient if the wheelchair will contribute towards the rehabilitation of the recipient through maximizing the recipient's potential for independence, and if:
   a. The recipient has a long-term or permanent disability and the wheelchair requested constitutes basic and necessary health care for the recipient consistent with a plan of health care; or
   b. The recipient is about to transfer from a nursing home to an alternative and more independent setting.
2. Corrective shoes, and prosthetic and orthotic devices.
3. Billing for such services for nursing home recipients shall be in accordance with section 7.09 of this rule.

(b) Hearing aid accessories, batteries and repairs do not require a physician's prescription.

(c) Only items in the following generic categories of medical supplies are covered:

1. Colostomy Appliances
2. Urostomy Appliances
3. Ostomy Appliances
4. Ileostomy Appliances
5. Catheters
6. Incontinence Equipment
7. Irrigation Apparatus
8. Head Halters
9. Parenteral Admin. Apparatus
10. Restraints
11. Support Stockings
12. Trusses
13. Urine Collection (external) Appliance

(4) Non-Covered Services. The following are not covered:

(a) Temporary breast prostheses.

(b) Medical supplies and devices not included in the categories listed in subsection (3) above, (e.g., heat lamps, hot water bottles, vaporizers, etc.), except when the provider documents to the satisfaction of the department's consultants, that the supply will prevent the recipient from being institutionalized, or that it is required to keep the recipient vocationally occupied, or both.

(c) Durable equipment such as but not limited to: waterbeds, air conditioners, seat lifts, medic-alerts, etc., except when the provider documents to the satisfaction of the department's consultants, that the equipment will prevent the recipient from being institutionalized, or that it is required to keep the recipient vocationally occupied, or both.

(d) A visit to a recipient's place of residence by a provider or member of the provider's staff for the purpose of fitting a prosthetic or orthotic device or a corrective shoe.

(e) Repair of rented durable medical equipment.

Sec. 7.25 is repealed and recreated below:

7.25 Diagnostic Testing Services

(1) Covered Services. Professional and technical diagnostic services covered by the medical assistance program are laboratory services provided by a certified physician or under the physician's supervision, or prescribed by a physician and provided by an independent certified laboratory and x-ray service prescribed by a physician and provided by or under the general supervision of a certified physician.

(2) Other Limitations.

(a) All diagnostic services shall be prescribed or ordered by a physician, dentist or podiatrist.

(b) Laboratory tests performed which are outside the laboratory's certified area(s) shall not be covered.

(c) Portable x-ray services are covered only for recipients who reside in nursing homes and only when provided in a nursing home.

(d) Reimbursement for diagnostic testing services shall be in accordance with limitations set by federal regulation.

Section 7.23(2)c is repealed and recreated below:

7.23 Transportation

(2) Services Requiring Prior Authorization

(c) Non-emergency transportation provided under sec. 7.23(1)(c) of a recipient to an out-of-state provider, or to a Wisconsin provider if the round trip exceeds 100 miles, must be approved by the county social service department before departure. In either case, the county agency may require a physician's documentation for the service received at the specific location.

Sec. 6.07(1)(2) and (3) is repealed and recreated below:

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6.07 Effects of termination under section 6.06.

(1) Upon the termination of a provider under section 6.06, a person with direct management responsibility for said provider at the time of the occurrence which served as the basis for such termination may be barred from future participation as a provider for a period not to exceed five (5) years.

(2) Upon termination of a corporate provider under section 6.06, officers and persons owning directly or indirectly 5% or more of the stock or other evidences of ownership in the corporation at the time of the occurrence which served as the basis for such termination, may be barred from future participation as a provider for a period of not to exceed five (5) years.

(3) Upon the termination of a sole proprietorship or partnership provider under section 6.06 an owner or partner in partnership at the time of the occurrence which served as the basis for the termination, may be barred from participation as a provider for a period not to exceed five (5) years.

The rules contained in this order shall take effect on the first day of the month following publication in the WISCONSIN ADMINISTRATIVE REGISTER as provided in section 227.026, Wis. Stats.

Dated: August 17, 1979

WISCONSIN DEPARTMENT OF HEALTH
AND SOCIAL SERVICES

D.E.P.

DONALD E. PERCY, SECRETARY

SEAL:

State of Wisconsin \ DEPARTMENT OF HEALTH & SOCIAL SERVICES

OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
119 King Street- Madison, Wisconsin 53702

Tel. (608)266-9664

August 17, 1979

Mr. Orlan Prestegard
Revisor of Statutes
411 West, State Capitol
Madison, WI 53702

Dear Mr. Prestegard:

As provided in section 227.023, Wis. Stats., there is hereby submitted a certified copy of revisions of selected sections of the Medicaid Administrative Rule, HSS 2, as adopted by this department on August 17, 1979. In accordance with section 227.018(2), Wis. Stats., the 30-day review by the appropriate legislative committee members expired.

This rule is being submitted to the Governor as required by section 14.06, Wis. Stats., and to the Secretary of State as required by section 227.023, Wis. Stats.

Sincerely,

Donald E. Percy
Secretary

Enclosure