CR 88-124

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CERTIFICATE

STATE OF WISCONSIN)
) SS
DEPARTMENT OF HEALTH AND SOCIAL SERVICES)

I, Patricia A. Goodrich, Secretary of the Department of Health and Social Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to the Medical Assistance Program were duly approved and adopted by this Department on November 11, 1988.

I further certify that this copy has been compared by me with the original on file in the Department and that this copy is a true copy of the original, and of the whole of the 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, in the city of Madison, this 11th day of November, 1988.

Patricia A. Goodrich

Patricia A. Goodrich, Secretary
Department of Health and Social Services

SEAL:

1-1-89

11-7-88

ORDER OF
THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
REPEALING, RENUMBERING, AMENDING, AND
CREATING RULES

To repeal HSS 107.06(2)(cm) and (5)(y); to renumber HSS 106.04(2)(b)5 to 9, 107.112(2) and 107.31(3)(d)2 to 4; to amend HSS 105.17(1)(intro.), 106.04(2)(b)9 and 10, as renumbered, 107.11(3)(d) and (e), 107.112(3)(e), 107.16(2)(b), (d) and (g) and (3)(d) and (e)(intro.), 107.17(2)(b), (d) and (g) and (3)(c) and (e)(intro.), 107.18(2)(b), (d) and (g) and (3)(c), 107.31(2)(a) and (3)(a)1 and (d)1; to repeal and recreate HSS 103.03(7), 107.02(4)(c), 107.03(15), 107.06(4)(h) and 107.31(3)(a)3; and to create HSS 101.03(30m) and (33m), 106.04(2)(b)5, 11 and 12, 107.09(4)(v), 107.11(3)(f), 107.112(2)(b), 107.31(3)(d)2 and 108.03(6), relating to the Medical Assistance Program.

Analysis Prepared by the Department of Health and Social Services

This order makes several changes in the Department's rules for the Medical Assistance (MA) Program to implement provisions in 1987 Wisconsin Acts 27 and 399 and to comply with s. 4143 of Public Law 100-203, the Omnibus Budget Reconciliation Act (OBRA) of 1987. Medical Assistance, also known as Medicaid, is a program that reimburses providers for the cost of health care services provided to eligible persons whose financial resources are not adequate to pay for their health care needs.

Definitions of "conditional release" and "convalescent leave" are added to ch. HSS 101. They apply to persons 21 to 64 years of age who are residents of institutions for mental diseases (IMDs). Residents in this age group are eligible to receive MA benefits if they are on conditional release to live temporarily in the community or if they are admitted for an inpatient stay in a general hospital, although not otherwise.

In regard to services covered by MA, prior authorization requirements for physical and occupational therapy and speech and language pathology services are revised from 45 days to 35 days per spell of illness. Hospice care is made available to all terminally ill MA recipients beginning July 1, 1988. Limitations to short-term inpatient care are described, correction of the reimbursement formula is made to comply with federal requirements, and hospices that provide inpatient care under Medicare are permitted to provide this care under MA as well. The prior authorization requirement for temporomandibular surgery has been deleted; instead, to comply with a provision of the federal Omnibus Budget Reconciliation Act of 1987, all dental services performed by physicians are made to comply with the dental service requirements in s. HSS 107.07. As a follow-up to personal care services becoming a new covered benefit distinct from home health care, effective July 1, 1988, the revised rules permit home health agencies, county social service and human service departments, county boards operating under s. 51.47 or 51.437, Stats., which are lead agencies for the Community Options Program, and independent living centers to be certified to provide these services.

Changes are made also in administrative provisions of the rules. In ss. HSS 106.04(2) and 107.02(4), the lists of recipients and services exempt from cost sharing (copayments) are amended to add personal care and case management services and recipients enrolled in a hospice. Procedures are added in s. HSS 107.09 for an IMD to choose a permanent reduction in its MA payment when a resident is relocated to the community. Rules are added for administration of an incentive payment to county agencies responsible for MA application processing and eligibility determination to encourage identification and reporting to the Department of recipients who have other medical insurance coverage. Payments will be made if the county agency identifies the recipient, the recipient's medical insurance carrier and any pertinent information regarding health insurance coverage during periods for which the person was eligible to receive Medical Assistance.

Emergency rules have been in effect since July 1, 1988 for the changes to prior authorization for therapies and provider certification for personal care services, and the changes affecting hospice care. Emergency rules have been in effect since August 1, 1988 for IMD residents on conditional release or convalescent leave and for a permanent reduction in an IMD's MA payments when a resident is relocated to the community.

The Department's authority to repeal, renumber, amend and create these rules is found in s. 46.266(1)(am), Stats., as created by 1987 Wisconsin Act 399, s. 49.45(3)(am)2, Stats., as created by 1987 Wisconsin Act 27, s.49.45(10), Stats., and ss. 49.46(2)(dm) and 49.47(6)(c)4, Stats., as repealed and recreated by 1987 Wisconsin Act 399. The rules interpret s. 46.266(1)(am), Stats., as created by 1987 Wisconsin Act 399, and ss. 49.45 to 49.47 and 49.49 to 49.497, Stats., as amended by 1987 Wisconsin Acts 27 and 399.

SECTION 1. HSS 101.03(30m) and (33m) are created to read:

HSS 101.03(30m) "Conditional release" means a resident's temporary release from an institution for mental diseases (IMD) to residency in a community setting, not more frequently than once a year and beginning on the fourth day after release, with the trial period of residence in the community lasting at least 4 days but not longer than 30 days or until the person is permanently discharged from the IMD, whichever occurs first.

(33m) "Convalescent leave" means the period of time that begins with inpatient admission of a resident of an institution for mental diseases (IMD) to a general hospital for the purpose of receiving treatment for a physical medical condition the nature or severity of which is such that treatment of the condition in the IMD is medically contraindicated.

SECTION 2. HSS 103.03(7) is repealed and recreated to read:

HSS 103.03(7) NOT A PERSON RESIDING IN AN INSTITUTION FOR MENTAL DISEASES. A person 21 to 64 years of age who resides in an institution for mental diseases (IMD) is not eligible for MA benefits, unless the person is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident of the IMD since then. An IMD resident 21 to 64 years of age may be eligible for MA benefits while on conditional release or convalescent leave from the IMD.

SECTION 3. HSS 105.17(1) (intro.) is amended to read:

HSS 105.17(1) REQUIREMENTS. (intro.) For MA certification, a personal care provider shall be a home health agency licensed under s. 141.15, Stats., and ch. HSS 133~~.~~, a county department established under s. 46.215, 46.22 or 46.23, Stats., a county department established under s. 51.42 or 51.437, Stats., which

has the lead responsibility in the county for administering the community options program under s. 46.27, Stats., or an independent living center as defined in s. 46.96(1)(a), Stats. A certified provider shall:

SECTION 4. HSS 106.04(2)(b)5 to 9 are renumbered HSS 106.04(2)(b)6 to 10.

SECTION 5. HSS 106.04(2)(b)5 is created to read:

HSS 106.04(2)(b)5. Services to any recipient enrolled in a hospice under s. HSS 107.31;

SECTION 6. HSS 106.04(2)(b)9 and 10, as renumbered, are amended to read:

HSS 106.04(2)(b)9. Transportation services provided through or paid for by a county social services department; ~~and~~

10. Home health services, or nursing services if a home health agency is not available~~.~~;

SECTION 7. HSS 106.04(2)(b)11 and 12 are created to read:

HSS 106.04(2)(b)11. Personal care services provided by a certified personal care provider; and

12. Case management services.

SECTION 8. HSS 107.02(4)(c) is repealed and recreated to read:

HSS 107.02(4)(c) Exempt recipients and services. Providers may not collect copayments, coinsurance or deductible amounts for:

1. Recipients who are nursing home residents;

2. Recipients who are members of a health maintenance organization or other prepaid health plan for those services provided by the HMO or PHP;

3. Recipients who are under age 18;

4. Services furnished to pregnant women if the services relate to the pregnancy or to any medical condition which may complicate the pregnancy when it can be determined from the claim submitted that the recipient was pregnant;

5. Services to any recipient enrolled in a hospice under s. HSS 107.31;

6. Emergency hospital and ambulance services, and emergency services related to the relief of dental pain;

7. Family planning services and related supplies;

8. Transportation services by a specialized medical vehicle;

9. Transportation services provided through or paid for by a county social services department;

10. Home health services, or nursing services if a home health agency is not available;

11. Outpatient psychotherapy services received over 15 hours or $500 in equivalent care, whichever comes first, during one calendar year;

12. Occupational, physical or speech therapy services received over 30 hours or $1,500 in equivalent care for any one therapy, whichever comes first, during one calendar year;

13. Personal care services provided by a certified personal care provider; or

14. Case management services.

SECTION 9. HSS 107.03(15) is repealed and recreated to read:

HSS 107.03(15) Expenditures for any service to an individual who is an inmate of a public institution or for any service to a person 21 to 64 years of age who is a resident of an institution for mental diseases (IMD), unless the

person is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, except that expenditures for a service to an individual on conditional release or convalescent leave from an IMD may be reimbursed by MA.

SECTION 10. HSS 107.06(2)(cm) is repealed.

SECTION 11. HSS 107.06(4)(h) is repealed and recreated to read:

HSS 107.06(4)(h). Dental services. Dental services performed by a physician shall be subject to all requirements for MA dental services described in s. HSS 107.07.

SECTION 12. HSS 107.06(5)(y) is repealed.

SECTION 13. HSS 107.09(4)(v) is created to read:

HSS 107.09(4)(v) Permanent reduction in MA payments when an IMD resident is relocated to the community. If a facility determined by the federal government or the department to be an institution for mental diseases (IMD) or by the department to be at risk of being determined to be an IMD under 42 CFR 435.1009 or s. 49.45(6g)(d), Stats., agrees under s. 46.266(1)(am), Stats., to receive a permanent limitation on its payment under s. 49.45(6m), Stats., for each resident who is relocated, the following restrictions apply:

1. MA payment to a facility may not exceed the payment which would otherwise be issued for the number of patients corresponding to the facility's patient day cap set by the department. The cap shall equal 365 multiplied by the number of MA-eligible residents on the date that the facility was found to be an IMD or was determined by the department to be at risk of being found to be an IMD, plus

the difference between the licensed bed capacity of the facility on the date that the facility agrees to a permanent limitation on its payments and the number of residents on the date that the facility was found to be an IMD or was determined by the department to be at risk of being found to be an IMD. The patient day cap may be increased by the patient days corresponding to the number of residents ineligible for MA at the time of the determination but who later become eligible for MA.

2. The department shall annually compare the MA patient days reported in the facility's most recent cost report to the patient day cap under subpar. 1. Payments for patient days exceeding the patient day cap shall be disallowed.

SECTION 14. HSS 107.11(3)(d) and (e) are amended to read:

HSS 107.11(3)(d) All registered nurse, practical nurse or home health aide extended visits; ~~and~~

(e) All medical supplies and equipment for which prior authorization is required under s. HSS 107.24~~.~~; and

SECTION 15. HSS 107.11(3)(f) is created to read:

HSS 107.11(3)(f) Home health aide services listed in sub. (2)(a) to (j) if performed by a personal care worker employed by a personal care agency which is not a home health agency and supervised by a registered nurse under s. HSS 107.112. Prior authorization may be granted only for those specific tasks necessary for the care of a recipient able to direct his or her own care and performed by a personal care worker specifically assigned to that recipient, as requested by the personal care worker's supervising registered nurse.

SECTION 16. HSS 107.112(2) is renumbered (2)(a).

SECTION 17. HSS 107.112(2)(b) is created to read:

HSS 107.112(2)(b) Prior authorization is required for specific services listed in s. HSS 107.11(2)(a) to (j), under the conditions cited in s. HSS 107.11(3)(f).

SECTION 18. HSS 107.112(3)(e) is amended to read:

HSS 107.112(3)(e) No more than ~~25%~~ one-third of the time spent by a personal care worker may be in performing housekeeping activities.

SECTION 19. HSS 107.16(2)(b), (d) and (g) and (3)(d) and (e) (intro.) are amended to read:

HSS 107.16(2)(b) Requirement. Prior authorization is required under this subsection for physical therapy services provided to an MA recipient in excess of ~~45~~ 35 treatment days per spell of illness, except that physical therapy services provided to ~~a~~ an MA recipient who is a hospital inpatient or who is receiving physical therapy services provided by a home health agency are not subject to prior authorization under this subsection.

Note: Physical therapy services provided by a home health agency are subject to prior authorization under s. HSS 107.11~~(2)~~(3).

(d) Onset and termination of spell of illness. The spell of illness begins with the first day of treatment or evaluation following the onset of the new disease, injury or medical condition or increased severity of a pre-existing medical condition and ends when the recipient improves so that treatment by a physical therapist for the condition causing the spell of illness is no longer required, or after ~~45~~ 35 treatment days, whichever comes first.

(g) Other coverage. Treatment days covered by medicare or other third-party insurance shall be included in computing the ~~45-day~~ 35-day per spell of illness total.

(3)(d) Evaluations. Evaluations shall be covered services. The need for an evaluation or re-evaluation shall be documented in the plan of care. Evaluations shall be counted toward the ~~45-day~~ 35-day per spell of illness prior authorization threshold.

(e) Extension of therapy services. (intro.) Extension of therapy services shall not be approved beyond the ~~45-day~~ 35-day per spell of illness prior authorization threshold in any of the following circumstances:

SECTION 20. HSS 107.17(2)(b), (d) and (g) and (3)(c) and (e) (intro.) are amended to read:

HSS 107.17(2)(b) Requirement. Prior authorization is required under this subsection for occupational therapy services provided to an MA recipient in excess of ~~45~~ 35 treatment days per spell of illness, except that occupational therapy services provided to an MA recipient who is a hospital inpatient or who is receiving occupational therapy services provided by a home health agency are not subject to prior authorization under this subsection.

Note: Occupational therapy services provided by a home health agency are subject to prior authorization under s. HSS 107.11~~(2)~~(3).

(d) Onset and termination of spell of illness. The spell of illness begins with the first day of treatment or evaluation following the onset of the new disease, injury or medical condition or increased severity of a pre-existing medical condition and ends when the recipient improves so that treatment by an occupational therapist for the condition causing the spell of illness is no longer required, or after ~~45~~ 35 treatment days, whichever comes first.

(g) Other coverage. Treatment days covered by medicare or other third-party insurance shall be included in computing the ~~45-day~~ 35-day per spell of illness total.

(3)(c) Evaluations. Evaluations shall be covered services. The need for an evaluation or re-evaluation shall be documented in the plan of care. Evaluations shall be counted toward the ~~45-day~~ 35-day per spell of illness prior authorization threshold.

(e) Extension of therapy services. (intro.) Extension of therapy services shall not be approved beyond the ~~45-day~~ 35-day per spell of illness prior authorization threshold in any of the following circumstances:

SECTION 21. HSS 107.18(2)(b), (d) and (g) and (3)(c) are amended to read:

HSS 107.18(2)(b) Requirement. Prior authorization is required under this subsection for speech and language pathology services provided to an MA recipient in excess of ~~45~~ 35 treatment days per spell of illness, except that speech and language pathology services provided to an MA recipient who is a hospital inpatient or who is receiving speech therapy services provided by a home health agency are not subject to prior authorization under this subsection.

Note: Speech and language pathology services provided by a home health agency are subject to prior authorization under s. HSS 107.11~~(2)~~(3).

(d) Onset and termination of spell of illness. The spell of illness begins with the first day of treatment or evaluation following the onset of the new disease, injury or medical condition or increased severity of a pre-existing medical condition and ends when the recipient improves so that treatment by a speech and language pathologist for the condition causing the spell of illness is no longer required, or after ~~45~~ 35 treatment days, whichever comes first.

(g) Other coverage. Treatment days covered by medicare or other third-party insurance shall be included in computing the ~~45-day~~ 35-day per spell of illness total.

(3)(c) Evaluations. Evaluations shall be covered services. The need for an evaluation or re-evaluation shall be documented in the plan of care. Evaluations shall be counted toward the ~~45-day~~ 35-day per spell of illness prior authorization threshold.

SECTION 22. HSS 107.31(2)(a) and (3)(a)1 are amended to read:

HSS 107.31(2)(a) General. Hospice services covered by the MA program effective July 1, 1988 are, except as otherwise limited in this chapter, those services provided to an eligible recipient by a provider certified under s. HSS 105.50 which are necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided to the family and other individuals caring for the terminally ill recipient. ~~Hospice services shall be provided only to those medical assistance recipients residing in a skilled nursing or intermediate care facility who are entitled, under medicare, to receive hospice care.~~

(3)(a)1 General inpatient care necessary for pain control and symptom management shall be provided by a hospital, ~~or~~ a skilled nursing facility certified under this chapter or a hospice providing inpatient care in accordance with the conditions of participation for Medicare under 42 CFR 418.98.

SECTION 23. HSS 107.31(3)(a)3 is repealed and recreated to read:

HSS 107.31(3)(a)3. The aggregate number of inpatient days may not exceed 20% of the aggregate total number of hospice care days provided to all MA recipients enrolled in the hospice during the period beginning November 1 of any year and

ending October 31 of the following year. Inpatient days for persons with acquired immune deficiency syndrome (AIDS) are not included in the calculation of aggregate inpatient days and are not subject to this limitation.

SECTION 24. HSS 107.31(3)(d)1 is amended to read:

HSS 107.31(3)(d)1. The hospice shall be reimbursed for care of a recipient at per diem rates set by the ~~department~~ federal health care financing administration (HCFA). ~~A maximum amount shall be established by the department for care of a recipient, to be applied to all recipients participating in the hospice's program.~~

SECTION 25. HSS 107.31(3)(d)2 to 4 are renumbered HSS 107.31(3)(d)3 to 5.

SECTION 26. HSS 107.31(3)(d)2 is created to read:

HSS 107.31(3)d)2. A maximum amount, or hospice cap, shall be established by the department for aggregate payments made to the hospice during a hospice cap period. A hospice cap period begins November 1 of each year and ends October 31 of the following year. Payments made to the hospice provider by the department in excess of the cap shall be repaid to the department by the hospice provider.

SECTION 27. HSS 108.03(6) is created to read:

HSS 108.03(6) INCENTIVE PAYMENTS FOR INSURANCE REPORTING. (a) Pursuant to approval by the federal health care financing administration, the department shall make payments under s. 49.45(3)(am), Stats., to county and tribal agencies under this subsection, including agencies subject to the requirements under sub. (5), to encourage identification and reporting by these agencies of MA

applicants and recipients who are covered by other medical insurance. Unless par. (b) applies, an agency shall receive an incentive payment if:

1. The agency identifies an MA applicant or recipient who is medically insured, identifies the person's insurance carrier providing the medical insurance coverage, and supplies information describing the person's insurance plan. The department's requirement for reporting specific information necessary to receive payment is further described in the Medical Assistance Eligibility Handbook; and

2. The department makes a reasonable effort to verify with the insurance carrier that the person's medical insurance was in effect during a coverage period corresponding to a period of MA eligibility occurring within the period of 12 months prior to the month in which the department received the county agency's information report for any MA applicant or recipient.

(b) Insurance policies which do not qualify for payment under this subsection shall be identified by the department based on factors that include cost effectiveness and the limitation of coverage. Policies which do not qualify under this subsection include the following:

1. A policy with coverage limited to specific diagnoses unless the policyholder has a diagnosis covered by the policy;

2. A policy limiting benefits to specific circumstances such as accidental injury;

3. A policy limiting benefits to the extent that coordinating benefits is administratively unfeasible; and

4. A policy not primarily intended as providing medical insurance coverage, such as a policy providing periodic benefits for disability or hospitalization, a policy providing liability insurance with payment for medical benefits or a policy which does not specifically cover medical services.

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 s. 227.22(2), Stats.

Wisconsin Department of Health and Social Services

Dated: November 11, 1988

By: Patricia A. Goodrich
Patricia A. Goodrich
Secretary

SEAL: