(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 subdiv. 1. Payments for patient days exceeding the patient day cap shall be disallowed.

(5) NON-COVERED SERVICES. The following services are not covered services:

(a) Services of private duty nurses when provided in a nursing home;

(b) For Christian Science sanatoria, custodial care and rest and study;

(c) Inpatient nursing care for ICF personal care and ICF residential care to residents who entered a nursing home after September 30, 1981; form

(d) ICF-lével services provided to a developmentally disabled person admitted after September 15, 1986, to an ICF facility other than to a facility certified under s. HSS 105.12 as an intermediate care facility for the mentally retarded unless the provisions of s. HSS 132.51 (2) (d) 1. have been waived for that person; and

(e) Inpatient services for residents between the ages of 21 and 64 when provided by an institution for mental disease, except that services may be provided to a 21 year old resident of an IMD if the person was a resident of the IMD immediately prior to turning 21 and continues to be a resident after turning 21.

Note: For more information about non-covered services, see s. HSS 107.03.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; renum. (1) to (4) to be (2) to (5) and am. (4) (g) 2. and (5) (6) and (c), cr. (1) (4) (u), (5) (d) and (e), Register, February, 1988, No. 386, eff. 3-1-88; emerg. cr. (4) (v), eff. 8-1-88; cr. (4) (v), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.10 Drugs. (1) COVERED SERVICES. Drugs and drug products covered by MA include legend and non-legend drugs and supplies listed in the Wisconsin medicaid drug index, which are prescribed by a physician licensed pursuant to s. 448.04, Stats., by a dentist licensed pursuant to s. 447.05, Stats., or by a podiatrist licensed pursuant to s. 448.04, Stats. The department may determine whether or not drugs judged by the U.S. food and drug administration to be "less than effective" shall be reimbursable under the program.

Note: The Wisconsin medicaid drug index is available from the Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53711.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. The following drugs and supplies require prior authorization:

(a) All schedule II stimulant drugs, except methylphenidate;

(b) All schedule III and IV stimulant drugs;

(c) Methaqualone;

(d) All food supplement or replacement products including ensure and vivonex;

(e) Decubitex; and

(f) Other drugs which have been demonstrated to entail substantial cost or utilization problems for the program, including antibiotics which cost $100 or more a day. These drugs shall be noted in the Wisconsin medicaid drug index.

Note: For more information on prior authorization, see s. HSS 107.02 (3).

(3) OTHER LIMITATIONS. (a) Dispensing of schedule III, IV and V drugs shall be limited to the original dispensing plus 5 refills, or 6 months from the date of the original prescription, whichever comes first.

(b) Dispensing of non-scheduled legend drugs shall be limited to the original dispensing plus 11 refills, or 12 months from the date of the original prescription, whichever comes first.

(c) Generically-written prescriptions for drugs in the approved prescription drug products list shall be filled with a generic drug included in that list.

(d) Except as provided in par. (e), legend drugs shall be dispensed in amounts not to exceed a 34-day supply.

(e) The following drugs may be dispensed in amounts of a 100-day supply:

1. Digoxin, digitoxin, digitalis;

2. Hydrochlorothiazide and chlorothiazide;

3. Prenatal vitamins;

4. Fluoride;

5. Levothyroxine, liothyronine, thyroid extract;

6. Phenobarbital; and

7. Phenytoin.

(f) Provision of drugs and supplies to nursing home recipients shall comply with the department's policy on ancillary costs in s. HSS 107.09 (3) (a).

(g) Provision of special dietary supplements used for tube feeding or oral feeding to nursing home recipients shall be included in the nursing home daily rate as provided in s. HSS 107.09 (1) (b).

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

1. Antacids;

2. Analgesics;

3. Insulins;

4. Contraceptives;

5. Cough preparations; and

6. Opthalmic lubricants.

(i) The department may create a list of drugs or drug categories to be excluded from coverage, known as the medicaid negative drug list. These non-covered drugs may include items such as legend laxatives and non-prenatal legend vitamins.

(4) NON-COVERED SERVICES. The following are not covered services:

(a) Claims of a pharmacy provider for reimbursement for drugs and medical supplies included in the daily rate for nursing home recipients;

(b) Refills of schedule II drugs;

(c) Refills beyond the limitations imposed under sub. (3);

(d) Personal care items such as non-therapeutic bath oils;

(e) Cosmetics such as non-therapeutic skin lotions and sun screens;

(f) Common medicine chest items such as antiseptics and band-aids;

(g) Personal hygiene items such as tooth paste and cotton balls;

(h) "Patent" medicines such as drugs or other medical preparations that can be bought without a prescription;

(i) Uneconomically small package sizes;

(j) Items which are in the inventory of a nursing home; and

(k) Over-the-counter drugs not specified in the medicaid drug index and not included in sub. (3), legend drugs not included in the medicaid drug index and drugs included in the medicaid negative drug list maintained by the department.

Note: For more information about non-covered services, see s. HSS 107.03.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (3) (h), Register, February, 1988, No. 386, eff. 3-1-88.

HSS 107.11 Home health services. (1) DEFINITIONS. In this section:

(a) "Extended visit" means each hour of a visit by a registered nurse or a practical nurse after 8 hours of home health service in a calendar day, or each hour of a visit by a home health aide after 8 hours of home health aide service in a calendar day.

(b) "Home health aide services" means medically oriented tasks necessitated by the recipient's physical requirements and performed by a

home health aide in the recipient's home to enable the physician to treat the recipient as an outpatient.

(c) "Home health visit" or "visit" means a period of time during which home health services are provided through personal contact in the recipient's place of residence for the purpose of providing a covered home health service. The services are provided by a home health worker on the staff of the home health agency, by a home health worker under contract to the home health agency or by another arrangement with the home health agency. A visit includes reasonable time spent on recordkeeping, travel time to and from the recipient's residence and actual service time in the home.

(d) "Initial visit" means the first 2 hours of service by a registered nurse or a practical nurse in a calendar day and the first hour of service by a home health aide in a calendar day.

(e) "Subsequent visit" means each hour of service following the initial visit in a calendar day up to a maximum of:

1. Eight hours of registered nurse or practical nurse service, including the initial visit; or

2. Eight hours of home health aide service, including the initial visit.

(f) "Therapy visit" means a visit by a physical therapist, occupational therapist or speech and language pathologist to provide a service for a period of time which lasts from at least 15 minutes to 90 minutes.

(2) COVERED SERVICES. Services provided by an agency certified under s. HSS 105.16 which are covered by MA are: nursing services, home health aide services, medical supplies, equipment and appliances suitable for use in the home, and therapy services which the agency is certified to provide. These services are covered only when provided upon prescription of a physician to a recipient confined to a place of residence other than a hospital, a skilled nursing facility or an intermediate care facility. Home health aide services include, but are not limited to:

(a) Prescribed range of motion exercises;

(b) Taking of temperature, pulse and respiratory rates;

(c) Bowel and bladder care except for routine toileting;

(d) Application of heat and cold treatments as prescribed;

(e) Recording fluid intake and output;

(f) Respiratory assistance, including assistance with oxygen and other equipment;

(g) Catheter care;

(h) Bathing in bed or complete bathing;

(i) Wound care;

(j) Turning and positioning; and

(k) All medically oriented services provided to an ill and bed-bound recipient. In this subdivision, "bed-bound" means that the recipient, due to illness or frailty, is required to remain in bed essentially full time and