Chapter HFS 105

PROVIDER CERTIFICATION

Note: Chapter HSS 105 as it existed on February 28, 1986 was repealed and a new chapter HSS 105 was created effective March 1, 1986. Chapter HSS 105 was renumbered Chapter HFS 105 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, January, 1997, No. 493.

HFS 105.01 Introduction. (1) PURPOSE. This chapter identifies the terms and conditions under which providers of health care services are certified for participation in the medical assistance program (MA).

(2) DEFINITIONS. In this chapter:

(a) "Group billing provider" means an entity which provides or arranges for the provision of medical services by more than one certified provider.

(b) "Provider assistant" means a provider such as a physical therapist assistant whose services must be provided under the supervision of a certified or licensed professional provider, and who, while required to be certified, is not eligible for direct reimbursement from MA.

(3) GENERAL CONDITIONS FOR PARTICIPATION. In order to be certified by the department to provide specified services for a reasonable period of time as specified by the department, a provider shall:

(a) Affirm in writing that, with respect to each service for which certification is sought, the provider and each person employed by the provider for the purpose of providing the service holds all licenses or similar entitlements as specified in chs. HFS 101 to 108 and required by federal or state statute, regulation or rule for the provision of the service;

(b) Affirm in writing that neither the provider, nor any person in whom the provider has a controlling interest, nor any person having a controlling interest in the provider, has, since the inception of the medicare, medicaid, or title 20 services program, been convicted of a crime related to, or been terminated from, a federal−assisted or state−assisted medical program;

(c) Disclose in writing to the department all instances in which the provider, any person in whom the provider has a controlling interest, or any person having a controlling interest in the provider has been sanctioned by a federal−assisted or state−assisted medical program, since the inception of medicare, medicaid or the title 20 services program;

(d) Furnish the following information to the department, in writing:

1. The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

2. The names and addresses of all persons who have a controlling interest in the provider; and

3. Whether any of the persons named in compliance with subd. 1. or 2., is related to another as spouse, parent, child or sibling;

(e) Execute a provider agreement with the department; and

(f) 1. Accept and consent to the use, based on a methodology determined by the investigating or auditing agency, of statistical sampling and extrapolation as the means to determine amounts owed by the provider to MA as the result of an investigation or audit conducted by the department, the department of justice medicaid fraud control unit, the federal department of health and human services, the federal bureau of investigation, or an authorized agent of any of these.

2. The sampling and extrapolation methodologies, if any, used in the investigation or audit shall be generally consistent, as applicable, with the guidelines on audit sampling issued by the statistical sampling subcommittee of the American institute of certified public accountants. Extrapolation, when performed, shall apply to the same period of time upon which the sampling is derived.

3. The department and the other investigative agencies shall retain the right to use alternative means to determine, consistent with applicable and generally accepted auditing practices, amounts owed as the result of an investigation or audit.

4. Nothing in this paragraph shall be construed to limit the right of a provider to appeal a department recovery action brought under s. HFS 108.02 (9).

(4) PROVIDERS REQUIRED TO BE CERTIFIED. The following types of providers are required to be certified by the department in order to participate in the MA program:

(a) Institutional providers;

(b) Non−institutional providers;

(c) Provider assistants;

(d) Group billing providers; and

(e) Providers performing professional services for hospital inpatients under s. HFS 107.08 (4) (d). Hospitals which provide the setting for the performance of professional services to its inpatients shall ensure that the providers of those services are appropriately certified under this chapter.

(5) PERSONS NOT REQUIRED TO BE INDIVIDUALLY CERTIFIED. The following persons are not required to be individually certified by the department in order to participate in the MA program:

(a) Technicians or support staff for a provider, including:

1. Dental hygienists;

2. Medical record librarians or technicians;

3. Hospital and nursing home administrators, clinic managers, and administrative and billing staff;

4. Nursing aides, assistants and orderlies;

5. Home health aides;

6. Dieticians;

7. Laboratory technologists;

8. X−ray technicians;

9. Patient activities coordinators;

10. Volunteers; and

11. All other persons whose cost of service is built into the charge submitted by the provider, including housekeeping and maintenance staff; and

(b) Except for providers required to be separately certified under sub. (4) (b) to (e), providers employed by or under contract to certified institutional providers, including but not limited to physicians, therapists, nurses and provider assistants. These providers shall meet certification standards applicable to their respective provider type.

(6) NOTIFICATION OF CERTIFICATION DECISION. Within 60 days after receipt by the department or its fiscal agent of a complete application for certification, including evidence of licensure or medicare certification, or both, if required, the department shall either approve the application and issue the certification or deny the application. If the application for certification is denied, the department shall give the applicant reasons, in writing, for the denial.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. (2) (b) and (c), (5) (a) 6., renum. (2) (d) and (5) (a) 7. to 12. to be (2) (b) and (5) (a) 6. to 11., Register, February, 1988, No. 386, eff. 3−1−88; am. (4) (c) and (d) and (5) (b), cr. (4) (e), Register, September, 1991, No. 429, eff. 10−1−91; emerg. am. (3) (d) 3. and (e), cr. (3) (f), eff. 7−1−92; am. (3) (d) 3. and (e), cr. (3) (f), Register, February, 1993, No. 446, eff. 3−1−93.

HFS 105.02 Requirements for maintaining certification. Providers shall comply with the requirements in this section in order to maintain MA certification.

(1) CHANGE IN PROVIDER STATUS. Providers shall report to the department in writing any change in licensure, certification, group affiliation, corporate name or ownership by the time of the effective date of the change. The department may require the provider to complete a new provider application and a new provider agreement when a change in status occurs. A provider shall immediately notify the department of any change of address but the department may not require the completion of a new provider application or a new provider agreement for a change of address.

(2) CHANGE IN OWNERSHIP. (a) *Non−nursing home provider.* In the event of a change in the ownership of a certified provider, except a nursing home, the provider agreement shall automatically terminate, except that the provider shall continue to maintain records required by subs. (4), (6) and (7) unless an alternative method of providing for maintenance of these records has been established in writing and approved by the department.

(b) *Nursing home provider.* In the event of a change in the ownership of a nursing home, the provider agreement shall automatically be assigned to the new owner.

(3) RESPONSE TO INQUIRIES. A provider shall respond as directed to inquiries by the department regarding the validity of information in the provider file maintained by the department or its fiscal agent.

(4) MAINTENANCE OF RECORDS. Providers shall prepare and maintain whatever records are necessary to fully disclose the nature and extent of services provided by the provider under the program. Records to be maintained are those enumerated in subs. (6) and (7). All records shall be retained by providers for a period of not less than 5 years from the date of payment by the department for the services rendered, unless otherwise stated in chs. HFS 101 to 108. In the event a provider's participation in the program is terminated for any reason, all MA−related records shall remain subject to the conditions enumerated in this subsection and sub. (2).

(5) PARTICIPATION IN SURVEYS. Nursing home and hospital providers shall participate in surveys conducted for research and MA policy purposes by the department or its designated contractors. Participation involves accurate completion of the survey questionnaire and return of the completed survey form to the department or to the designated contractor within the specified time period.

(6) RECORDS TO BE MAINTAINED BY ALL PROVIDERS. All providers shall maintain the following records:

(a) Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by MA;

(b) MA billings and records of services or supplies which are the subject of the billings, that are necessary to fully disclose the nature and extent of the services or supplies; and

(c) Any and all prescriptions necessary to disclose the nature and extent of services provided and billed under the program.

(7) RECORDS TO BE MAINTAINED BY CERTAIN PROVIDERS. (a) *Specific types of providers.* The following records shall be maintained by hospitals, skilled nursing facilities (SNFs), intermediate care facilities (ICFs) and home health agencies, except that home health agencies are not required to maintain records listed in subds. 5, 11 and 14, and SNFs, ICFs and home health agencies are not required to maintain records listed in subd. 4.:

1. Annual budgets;

2. Patient census information, separately:

a. For all patients; and

b. For MA recipients;

3. Annual cost settlement reports for medicare;

4. MA patient logs as required by the department for hospitals;

5. Annual MA cost reports for SNFs, ICFs and hospitals;

6. Independent accountants' audit reports;

7. Records supporting historical costs of buildings and equipment;

8. Building and equipment depreciation records;

9. Cash receipt and receivable ledgers, and supporting receipts and billings;

10. Accounts payable, operating expense ledgers and cash disbursement ledgers, with supporting purchase orders, invoices, or checks;

11. Records, by department, of the use of support services such as dietary, laundry, plant and equipment, and housekeeping;

12. Payroll records;

13. Inventory records;

14. Ledger identifying dates and amounts of all deposits to and withdrawals from MA resident trust fund accounts, including documentation of the amount, date, and purpose of the withdrawal when withdrawal is made by anyone other than the resident. When the resident chooses to retain control of the funds, that decision shall be documented in writing and retained in the resident's records. Once that decision is made and documented, the facility is relieved of responsibility to document expenditures under this subsection; and

15. All policies and regulations adopted by the provider's governing body.

(b) *Prescribed service providers.* The following records shall be kept by pharmacies and other providers of services requiring a prescription:

1. Prescriptions which support MA billings;

2. MA patient profiles;

3. Purchase invoices and receipts for medical supplies and equipment billed to MA; and

4. Receipts for costs associated with services billed to MA.

(8) PROVIDER AGREEMENT DURATION. The provider agreement shall, unless terminated, remain in full force and effect for a maximum of one year from the date the provider is accepted into the program. In the absence of a notice of termination by either party, the agreement shall automatically be renewed and extended for a period of one year.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.03 Participation by non−certified persons. **(1)** REIMBURSEMENT FOR EMERGENCY SERVICES. If a resident of Wisconsin or of another state who is not certified by MA in this state provides emergency services to a Wisconsin recipient, that person shall not be reimbursed for those services by MA unless the services are covered services under ch. HFS 107 and:

(a) The person submits to the fiscal agent a provider data form and a claim for reimbursement of emergency services on forms prescribed by the department;

(b) The person submits to the department a statement in writing on a form prescribed by the department explaining the nature of the emergency, including a description of the recipient's condition, cause of emergency, if known, diagnosis and extent of injuries, the services which were provided and when, and the reason that the recipient could not receive services from a certified provider; and

(c) The person possesses all licenses and other entitlements required under state and federal statutes, rules and regulations, and is qualified to provide all services for which a claim is submitted.

(2) REIMBURSEMENT PROHIBITED FOR NON−EMERGENCY SERVICES. No non−emergency services provided by a non−certified person may be reimbursed by MA.

(3) REIMBURSEMENT DETERMINATION. Based upon the signed statement and the claim for reimbursement, the department's professional consultants shall determine whether the services are reimbursable.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.04 Supervision of provider assistants. Provider assistants shall be supervised. Unless otherwise specified under ss. HFS 105.05 to 105.49, supervision shall consist of at least intermittent face−to−face contact between the supervisor and the assistant and a regular review of the assistant's work by the supervisor.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.05 Physicians and assistants. **(1)** PHYSICIANS. For MA certification, physicians shall be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 1, 2, 3, 4, 5 and 14.

(2) PHYSICIAN ASSISTANTS. For MA certification, physician assistants shall be certified and registered pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 8 and 14.

Note: For covered physician services, see s. HFS 107.06.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.055 Nurse anesthetists and anesthesiologist assistants. **(1)** CERTIFIED REGISTERED NURSE ANESTHETIST. For MA certification, a nurse anesthetist shall be licensed as a registered nurse pursuant to s. 441.06, Stat., and shall meet one of the following additional requirements:

(a) Be certified by either the council on certification of nurse anesthetists or the council on recertification of nurse anesthetists; or

(b) Have graduated within the past 18 months from a nurse anesthesia program that meets the standards of the council on accreditation of nurse anesthesia educational programs and be awaiting initial certification.

(2) ANESTHESIOLOGIST ASSISTANT. For MA certification, an anesthesiologist assistant shall meet the following requirements:

(a) Have successfully completed a 6 year program for anesthesiologist assistants, 2 years of which consists of specialized academic and clinical training in anesthesia; and

(b) Work under the direct supervision of an anesthesiologist who is physically present during provision of services.

History: Cr. Register, September, 1991, No. 429, eff. 10−1−91.

HFS 105.06 Dentists. For MA certification, dentists shall be licensed pursuant to ss. 447.03 and 447.04, Stats.

Note: For covered dental services, see s. HFS 107.07.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1994, No. 462.

HFS 105.07 General hospitals. For MA certification a hospital shall be approved as a general hospital under s. 50.35, Stats., and ch. HFS 124, shall meet conditions of participation for medicare and shall have a utilization review plan that meets the requirements of 42 CFR 456.101. No facility determined by the department or the federal health care financing administration to be an institution for mental disease (IMD) may be certified as a general hospital under this section. In addition:

(1) A hospital providing outpatient psychotherapy shall meet the requirements specified in s. HFS 105.22 (1) and (2);

(2) A hospital providing outpatient alcohol and other drug abuse (AODA) services shall meet the requirements specified in s. HFS 105.23;

(3) A hospital providing mental health day treatment services shall be certified under s. HFS 105.24;

(4) A hospital participating in a PRO review program shall meet the requirements of 42 CFR 456.101 and any additional requirements established under state contract with the PRO; and

(5) A hospital providing AODA day treatment services shall be certified under s. HFS 105.25.

Note: For certification of a hospital that is an institution for mental disease, see s. HFS 105.21. For covered hospital services, see s. HFS 107.08.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. and recr. (intro.), am. (1) to (4), cr. (5), Register, September, 1991, No. 429, eff. 10−1−91.

HFS 105.075 Rehabilitation hospitals. For MA certification, a rehabilitation hospital shall be approved as a general hospital under s. 50.35, Stats., and ch. HFS 124, including the requirements for rehabilitation services under s. HFS 124.21, shall meet conditions of participation for medicare and shall have a utilization review plan that meets the requirements of 42 CFR 456.101. No facility determined by the department or the federal health care financing administration to be an institution for mental disease (IMD) may be certified as a rehabilitation hospital under this section.

Note: For covered hospital services, see s. HFS 107.08.

History: Cr. Register, September, 1991, No. 429, eff. 10−1−91.

HFS 105.08 Skilled nursing facilities. For MA certification, skilled nursing facilities shall be licensed pursuant to s. 50.03, Stats., and ch. HFS 132.

Note: For covered nursing home services, see s. HFS 107.09.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.09 Medicare bed requirement. (1) DEFINITION. In this section, "sufficient number of medicare−certified beds" means a supply of beds that accommodates the demand for medicare beds from both the home county and contiguous counties so that no dual eligible recipient is denied access to medicare SNF benefits because of a lack of available beds. In this subsection, "dual eligible recipient" means a person who qualifies for both medical assistance and medicare.

(2) MEDICARE BED OBLIGATION. Each county shall have a sufficient number of skilled nursing beds certified by the medicare program pursuant to ss. 49.45 (6m) (g) and 50.02 (2), Stats. The number of medicare−certified beds required in each county shall be at least 3 beds per 1000 persons 65 years of age and older in the county.

(3) PENALTY. (a) If a county does not have sufficient medicare−certified beds as determined under sub. (1), each SNF within that county which does not have one or more medicare−certified beds shall be subject to a fine to be determined by the department of not less than $10 nor more than $100 for each day that the county continues to have an inadequate number of medicare−certified beds.

(b) The department may not enforce penalty in par. (a) if the department has not given the SNF prior notification of criteria specific to its county which shall be used to determine whether or not the county has a sufficient number of medicare−certified beds.

(c) If the number of medicare−certified beds in a county is reduced so that the county no longer has a sufficient number of medicare−certified beds under sub. (1), the department shall notify each SNF in the county of the number of additional medicare−certified beds needed in the county. The department may not enforce the penalty in par. (a) until 90 days after this notification has been provided.

(4) EXEMPTIONS. (a) In this subsection, a "swing−bed hospital"means a hospital approved by the federal health care financing administration to furnish skilled nursing facility services in the medicare program.

(b) A home or portion of a home certified as an ICF/MR is exempt from this section.

(c) The department may grant an exemption based on but not limited to:

1. Availability of a swing−bed hospital operating within a 30 mile radius of the nursing home; or

2. Availability of an adequate number of medicare−certified beds in a facility within a 30 mile radius of the nursing home.

(d) A skilled nursing facility located within a county determined to have an inadequate number of medicare−certified beds and which has less than 100 beds may apply to the department for partial exemption from the requirements of this section. An SNF which applies for partial exemption shall recommend to the department the number of medicare−certified beds that the SNF should have to meet the requirements of this section based on the facility's analysis of the demand for medicare−certified beds in the community. The department shall review all recommendations and issue a determination to each SNF requesting a partial exemption.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; renum. (1), (2), (3) (a) and (b) to be (2), (3), (4) (a) and (b) and am. (2) and (4) (b), cr. (1), (4) (c) and (d), Register, February, 1988, No. 386, eff. 7−1−88.

HFS 105.10 SNFs and ICFs with deficiencies. If the department finds a facility deficient in meeting the standards specified in s. HFS 105.08, 105.09, 105.11 or 105.12, the department may nonetheless certify the facility for MA under the conditions specified in s. HFS 132.21 and 42 CFR 442, Subpart C.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.11 Intermediate care facilities. For MA certification, intermediate care facilities shall be licensed pursuant to s. 50.03, Stats., and ch. HFS 132.

Note: For covered nursing home services, see s. HFS 107.09.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.12 ICFs for mentally retarded persons or persons with related conditions. For MA certification, institutions for mentally retarded persons or persons with related conditions shall be licensed pursuant to s. 50.03, Stats., and ch. HFS 134.

Note: For covered ICF/MR services, see s. HFS 107.09.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1991, No. 432.

HFS 105.15 Pharmacies. For MA certification, pharmacies shall meet the requirements for registration and practice under ch. 450, Stats, and chs. Phar 1 to 14.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; am. Register, December, 1991, No. 432, eff. 1−1−92.

HFS 105.16 Home health agencies. For MA certification, a home health agency shall be certified to participate in medicare as a home health agency, be licensed pursuant to ch. HFS 133 and meet the requirements of this section as follows:

(1) HOME HEALTH AGENCY SERVICES. For MA certification, a home health agency shall provide part−time, intermittent skilled nursing services performed by a registered nurse or licensed practical nurse and home health aide services and may provide physical therapy, occupational therapy, speech and language pathology services and medical supplies and equipment. Services may be provided only on visits to a recipient's home and that home may not be a hospital or nursing home. Home health services shall be provided in accordance with a written plan of care, which the physician shall review at least every 62 days or when the recipient's medical condition changes, whichever occurs first.

(2) HOME HEALTH AIDES. (a) *Assignment and duties.* Home health aides shall be assigned to specific recipients by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse, a physical or occupational therapist or a speech and language pathologist, as appropriate. Duties shall include medically oriented tasks, assistance with the recipient's activities of daily living and household tasks as specified in s. HFS 107.11 (2) (b) and further described in the Wisconsin medical assistance home health agency provider handbook.

(b) *Supervision.* A registered nurse shall make supervisory visits to the recipient's home as often as necessary, but at least every 60 days, to review, monitor and evaluate the recipient's medical condition and medical needs according to the written plan of care during the period in which agency care is being provided. The RN shall evaluate the appropriateness of the relationship between the direct care giver and the recipient, assess the extent to which goals are being met, and determine if the current level of home health services provided to the recipient continues to be appropriate to treat the recipient's medical condition and if the services are medically necessary. The supervising RN shall discuss and review with the recipient the services received by the recipient and discuss the results of the supervisory visit with the LPN, home health aide or personal care worker. The results of each supervisory visit shall be documented in the recipient's medical record.

(c) *Training.* Home health aides shall be trained and tested in accordance with the requirements of s. 146.40, Stats., and ch. HFS 129. Aides shall not be assigned any tasks for which they are not trained, and training and competency in all assigned tasks shall be documented and made part of the provider's records.

(3) PHYSICAL THERAPISTS. Physical therapists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under the contract to the home health agency.

(4) OCCUPATIONAL THERAPISTS. Occupational therapists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under contract to the home health agency.

(5) SPEECH AND LANGUAGE PATHOLOGISTS. Speech and language pathologists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under contract to the home health agency.

(6) RESPIRATORY CARE SERVICES. (a) A certified home health agency may be certified to provide respiratory care services under s. HFS 107.113 if registered nurses, licensed practical nurses and respiratory therapists employed by or under contract to the agency and providing these services are certified under ch. Med 20 and:

1. Are credentialed by the national board on respiratory care; or

2. Know how to perform services under s. HFS 107.113 (1) and have the skills necessary to perform those services. Skills required to perform services listed in s. HFS 107.113 (1) (e) to (f) are required on a case−by−case basis, as appropriate. In no case may a person provide respiratory care before that person has demonstrated competence in all areas under s. HFS 107.113 (1) (a) to (d).

(b) A registered nurse who fulfills the requirements of this subsection shall coordinate the recipient's care.

(c) The department shall review an agency's continued compliance with this subsection.

(7) PRIVATE DUTY NURSING. A home health agency may provide private duty nursing services under s. HFS 107.12 performed by a registered nurse or licensed practical nurse.

(8) COST REPORTS. The department may, when necessary, require home health agencies to report information which is supplementary to information required on medicare cost reports.

(9) DEPARTMENT REVIEW. (a) *Record review.* The department may periodically review the records described in this section and s. HFS 106.02 (9), subject only to restrictions of law. All records shall be made immediately available upon the request of an authorized department representative.

(b) *In−home visits.* As part of the review under par. (a), the department may contact recipients who have received or are receiving MA services from a home health care provider. The provider shall provide any identifying information requested by the department. The department may select the recipients for visits and may visit a recipient with the approval of the recipient or recipient's guardian. The recipient to be visited has the opportunity to have any person present whom he or she chooses, during the visit by personnel of the department or other governmental investigating agency.

(c) *Investigation of complaints.* The department may investigate any complaint received by it concerning the provision of MA services by a home health care provider. Following the investigation, the department may issue a preliminary final report to the home health care provider in question, except when doing so would jeopardize any other investigation by the department or other state or federal agency.

(10) REQUIREMENTS FOR PROVIDING PRIVATE DUTY NURSING OR RESPIRATORY CARE SERVICES. For certified agencies providing private duty nursing or respiratory care services or both under this section, the following requirements apply:

(a) *Duties of the nurse.* 1. The following nursing services may be performed only by a registered nurse:

a. Making the initial evaluation visit;

b. Initiating the physician's plan of care and necessary revisions;

c. Providing those services that require care of a registered nurse as defined in ch. N 6;

d. Initiating appropriate preventive and rehabilitative procedures;

e. Accepting only those delegated medical acts which the RN is competent to perform based on his or her nursing education, training or experience; and

f. Regularly reevaluating the patient's needs.

2. Nursing services not requiring a registered nurse may be provided by a licensed practical nurse under the supervision of a registered nurse. Licensed practical nurse duties include:

a. Performing nursing care delegated by an RN under s. N 6.03;

b. Assisting the patient in learning appropriate self−care techniques; and

c. Meeting the nursing needs of the recipient according to the written plan of care.

3. Both RNs and LPNs shall:

a. Arrange for or provide health care counseling within the scope of nursing practice to the recipient and recipient's family in meeting needs related to the recipient's condition;

b. Provide coordination of care for the recipient;

c. Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience;

d. Prepare written clinical notes that document the care provided within 24 hours of providing service and incorporate them into the recipient's clinical record within 7 days; and

e. Promptly inform the physician and other personnel participating in the patient's care of changes in the patient's condition and needs.

(b) *Patient rights.* A nurse shall provide a written statement of the rights of the recipient for whom services are provided to the recipient or guardian or any interested party prior to the provision of services. The recipient or guardian shall acknowledge receipt of the statement in writing. The nurse shall promote and protect the exercise of these rights and keep written documentation of compliance with this subsection. Each recipient receiving care shall have the following rights:

1. To be fully informed of all rules and regulations affecting the recipient;

2. To be fully informed of services to be provided by the nurse and of related charges, including any charges for services for which the recipient may be responsible;

3. To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of services, including referral to a health care institution or other agency;

4. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of that refusal;

5. To confidential treatment of personal and medical records and to approve or refuse their release to any individual, except in the case of transfer to a health care facility;

6. To be taught, and have the family or other persons living with the recipient taught, the treatment required, so that the recipient can, to the extent possible, help himself or herself, and the family or other party designated by the recipient can understand and help the recipient;

7. To have one's property treated with respect; and

8. To complain about care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

(c) *Universal precautions.* A nurse shall have the necessary orientation, education and training in epidemiology, modes of

transmission and prevention of HIV and other blood−borne or body fluid−borne infections and shall follow universal blood and body−fluid precautions for each recipient for whom services are provided. The nurse shall employ protective measures recommended by the federal centers for disease control (CDC), including those pertaining to medical equipment and supplies, to minimize the risk of infection from HIV and other blood−borne pathogens.

Note: A copy of the CDC recommended universal precautions may be obtained from the Bureau of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701.

(d) *Medical record.* The nurse shall maintain a medical record for each recipient. The record shall document the nature and scope of all services provided and shall be systematically organized and readily accessible to authorized department personnel. The medical record shall document the recipient's condition, problems, progress and all services rendered, and shall include:

1. Recipient identification information;

2. Appropriate hospital information, including discharge information, diagnosis, current patient status and post−discharge plan of care;

3. Recipient admission evaluation and assessment;

4. All medical orders, including the physician's written plan of care and all interim physician's orders;

5. A consolidated list of medications, including start and stop dates, dosage, route of administration and frequency. This list shall be reviewed and updated for each nursing visit, if necessary;

6. Progress notes posted as frequently as necessary to clearly and accurately document the recipient's status and services provided. In this paragraph, "progress note" means a written notation, dated and signed by a member of the health team providing covered services, that summarizes facts about care furnished and the recipient's response during a given period of time;

7. Clinical notes written the day service is provided and incorporated into the clinical record within 7 days after the visit or recipient contact. In this paragraph, "clinical note" means a notation of a contact with a recipient that is written and dated by a member of the home health team providing covered services, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition;

8. Written summaries of the recipient's care provided by the nurse to the physician at least every 62 days; and

9. Written authorizations from the recipient or the recipient's guardian when it is necessary for the nurse to procure medical supplies or equipment needed by the recipient, unless the recipient's care is being provided by an MA−certified home health agency.

(e) *Back−up and emergency procedures.* 1. The recipient shall be informed of the identity of the agency−assigned alternate nurse before the alternate nurse provides services.

2. The nurse shall document a plan for recipient−specific emergency procedures in the event a life−threatening situation or fire occurs or there are severe weather warnings. This plan shall be made available to the recipient and all caregivers prior to initiation of these procedures.

3. The nurse shall take appropriate action and immediately notify the recipient's physician, guardian, if any, and any other responsible person designated in writing by the patient or guardian of any significant accident, injury or adverse change in the recipient's condition.

(f) *Discharge of the recipient.* A recipient shall be discharged from services provided by the nurse upon the recipient's request, upon the decision of the recipient's physician, or if the nurse documents that continuing to provide services to the recipient presents a direct threat to the nurse's health or safety and further documents the refusal of the attending physician to authorized discharge of the recipient with full knowledge and understanding of the threat to the nurse. The nurse shall recommend discharge to the physician and recipient if the recipient does not require services or requires services beyond the nurse's capability. The nurse provider shall issue a notification of discharge to the recipient or guardian, if possible at least 2 calendar weeks prior to cessation of skilled nursing services, and shall, in all circumstances, provide assistance in arranging for the continuity of all medically necessary care prior to discharge.

History: Cr. Register, February, 1986, No .362, eff. 3−1−86; am. (intro.), (1) and (2), r. and recr. (3), cr. (4) and (5), Register, April, 1988, No. 388, eff. 7−1−88; emerg. r. and recr. (1) and (2), cr. (6), eff. 7−1−92; r. and recr. (1) and (2), cr. (6) to (10), Register, February, 1993, No. 446, eff. 3−1−93; correction in (intro.) made under s. 13.93 (2m) (b) 7., Stats., Register, October, 2000, No. 538.

HFS 105.17 Personal care providers. (1) REQUIREMENTS. For MA certification, a personal care provider shall be a home health agency licensed under s. 50.49, Stats., and ch. HFS 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) (ah), Stats. A certified provider shall:

(a) Possess the capacity to enter into a legally binding contract;

(b) Present a proposal to the department to provide personal care services that:

1. Documents cost−effective provision of services;

2. Documents a quality assurance mechanism and quality assurance activities;

3. Demonstrates that employees possess knowledge of and training and experience with special needs, including independent living needs, of the recipient group or groups receiving services;

(c) Document adequate resources to maintain a cash flow sufficient to cover operating expenses for 60 days;

(d) Document a financial accounting system that complies with generally accepted accounting principles;

(e) Maintain the records identified in sub. (4);

(f) Document a system of personnel management if more than one personal care worker is employed;

(g) Maintain the following records for each recipient:

1. The nursing assessment, physician prescription, plan of care, personal care worker's assignment and record of all assignments, and record of registered nurse supervisory visits;

2. The record of all visits by the personal care worker, including observations and assigned activities completed and not completed; and

3. A copy of written agreements between the personal care provider and RN supervisor, if applicable;

(h) Employ or contract with personal care workers to provide personal care services;

(i) Employ trained workers as described under sub. (3), or train or arrange and pay for training of employed or subcontracted personal care workers as necessary;

(j) Employ or contract with at least one registered nurse;

(k) Supervise the provision of personal care services;

(L) Ensure that qualifications and requirements of the registered nurse supervisor and personal care worker under subs. (2) and (3) are met or are being met;

(m) Bill the medical assistance program for personal care services, for registered nurse supervisory visits and for disposable medical supplies;

(n) Give full consideration to a recipient's preferences for service arrangements and choice of personal care workers;

(o) Document a grievance mechanism to resolve recipients' complaints about personal care services, including a personal care provider's decision not to hire a recipient's choice of a personal care worker;

(p) Perform all functions and provide all services specified in a written personal care provider contract between the personal care provider and personal care workers under contract, and main-

tain a copy of that contract on file. Document performance of personal care workers under contract by maintaining time sheets of personal care workers which will document the types and duration of services provided, by funding source;

(q) Provide a written plan of operation describing the entire process from referral through delivery of services and follow−up;

(r) Provide the personal care worker with the basic materials and equipment needed to deliver personal care services;

(s) Cooperate with other health and social service agencies in the area and with interested community referral groups to avoid duplication of services and to provide coordination of personal care services to recipients; and

(t) Evaluate each personal care worker's work performance on a periodic basis.

(2) QUALIFICATIONS AND DUTIES OF THE REGISTERED NURSE SUPERVISOR. (a) *Qualifications.* An RN supervisor under contract with or employed by a personal care provider shall have the following qualifications:

1. Be licensed in Wisconsin pursuant to s. 441.06, Stats.;

2. Be a public health nurse or be currently or previously employed by a home health agency, an independent living center or a hospital rehabilitation unit; and

3. Provide documentation of experience in providing personal care services in the home.

(b) *Duties.* The RN supervisor shall perform the following duties:

1. Evaluate the need for service and make referrals to other services as appropriate;

2. Secure written orders from the recipient's physician. These orders are to be renewed once every 3 months unless the physician specifies that orders covering a period of time up to one year are appropriate, or when the recipient's needs change, whichever occurs first;

3. Develop a plan of care for the recipient, giving full consideration to the recipient's preferences for service arrangements and choice of personal care workers, interpret the plan to the personal care worker, include a copy of the plan in the recipient's health record, and review the plan at least every 60 days and update it as necessary;

4. Develop appropriate time and service reporting mechanisms for personal care workers and instruct the workers on their use;

5. Give the worker written instructions about the services to be performed and demonstrate to the worker how to perform the services; and

6. Evaluate the competency of the worker to perform the services.

(3) QUALIFICATIONS AND DUTIES OF PERSONAL CARE WORKERS. (a) *Qualifications.* Personal care workers shall have the following qualifications:

1. Be trained in the provision of personal care services. Training shall consist of a minimum of 40 classroom hours, at least 25 of which shall be devoted to personal and restorative care, or 6 months of equivalent experience. Training shall emphasize techniques for and aspects of caring for the population served by the provider;

2. Provide documentation of required training to the personal care provider for the provider's records;

3. Be a person who is not a legally responsible relative of the recipient under s. 49.90 (1), Stats.; and

4. Be a person who has not been convicted of a crime which directly relates to the occupation of providing personal care or other health care services.

(b) *Duties.* Personal care workers shall perform the following duties:

1. Perform tasks assigned by the RN supervisor;

2. Report in writing to the RN supervisor on each assignment;

3. Report any changes in the recipient's condition to the RN supervisor; and

4. Confer as required with the RN supervisor regarding the recipient's progress.

(4) ANNUAL REVIEW OF PERSONAL CARE PROVIDERS. The department's bureau of quality compliance shall conduct an annual on−site review of each personal care provider. Records to be reviewed include:

(a) Written personnel policies;

(b) Written job descriptions;

(c) A written plan of operations indicating the entire process from making referrals through delivery of services and follow−up;

(d) A written statement defining the scope of personal care services provided, including the population being served, service needs and service priorities;

(e) A written record of personal care workers' 40 hours of training;

(f) Workers' time sheets;

(g) Health care records of recipients;

(h) Contracts with workers and other agencies; and

(i) Records of supervisory visits.

History: Cr. Register, April, 1988, No. 388, eff. 7−1−88; emerg. am. (1) (intro.), eff. 7−1−88; am. (1) (intro.), Register, December, 1988, No. 396, eff. 1−1−89; am. (3) (a) 1., Register, February, 1993, No. 446, eff. 3−1−93; correction in (1) (intro.) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

HFS 105.19 Nurses in independent practice.

(1) QUALIFICATIONS.. (a) For MA certification to perform skilled nursing services as a nurse in independent practice providing home health services under s. HFS 107.11 (6) or private duty nursing services under s. HFS 107.12, the nurse shall be:

1. Licensed as a registered nurse pursuant to s. 441.06, Stats.;

2. Licensed as a practical nurse pursuant to s. 441.10, Stats.; or

3. A registered nurse providing supervision of a licensed practical nurse certified under this section.

(b) For MA certification to perform respiratory care services as a provider in independent practice, the provider shall be certified pursuant to ch. Med 20 and shall be a nurse described in par. (a) or a respiratory therapist. Any person providing or supervising respiratory care who is not credentialed by the national board on respiratory care shall know how to perform the services under s. HFS 107.113 (1) and shall have the skills necessary to perform those services. Skills required to perform services listed in s. HFS 107.113 (1) (e) to (f) are required on a case−by−case basis, as appropriate. In no case may a person provide respiratory care before that person has demonstrated competence in all areas under s. HFS 107.113 (1) (a) to (d). A registered nurse who fulfills these requirements shall coordinate the recipient's care.

(2) PLAN OF CARE. Nursing services and respiratory care shall be provided in accordance with a written plan of care which the physician reviews and signs at least every 62 days or when the recipient's condition changes, whichever occurs first.

(3) SUPERVISION OF A LICENSED PRACTICAL NURSE. A registered nurse or physician designated by the LPN providing nursing or respiratory care services shall supervise the LPN as often as necessary under the requirements of ss. N 6.03 and 6.04 (2) and shall document the results of supervisory activities. An LPN may provide nursing or respiratory care services delegated by an RN as delegated nursing acts under ss. N 6.03 and 6.04 and guidelines established by the board of nursing.

(4) DUTIES OF THE NURSE. (a) The following nursing services may be performed only by a registered nurse:

1. Making the initial evaluation visit;

2. Initiating the physician's plan of care and necessary revisions;

3. Providing those services that require care of a registered nurse as defined in ch. N 6;

4. Initiating appropriate preventive and rehabilitative procedures;

5. Accepting only those delegated medical acts which the RN is competent to perform based on his or her nursing education, training or experience; and

6. Regularly reevaluating the patient's needs.

(b) Nursing services not requiring a registered nurse may be provided by a licensed practical nurse under the supervision of a registered nurse. Licensed practical nurse duties include:

1. Performing nursing care delegated by an RN under s. N 6.03;

2. Assisting the patient in learning appropriate self−care techniques; and

3. Meeting the nursing needs of the recipient according to the written plan of care.

(c) Both RNs and LPNs shall:

1. Arrange for or provide health care counseling within the scope of nursing practice to the recipient and recipient's family in meeting needs related to the recipient's condition;

2. Provide coordination of care for the recipient, including ensuring that provision is made for all required hours of care for the recipient;

3. Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience;

4. Prepare written clinical notes that document the care provided within 24 hours of providing service and incorporate them into the recipient's clinical record within 7 days; and

5. Promptly inform the physician and other personnel participating in the patient's care of changes in the patient's condition and needs.

(5) PATIENT RIGHTS. A nurse shall provide a written statement of the rights of the recipient for whom services are provided to the recipient or guardian or any interested party prior to the provision of services. The recipient or guardian shall acknowledge recipient of the statement in writing. The nurse shall promote and protect the exercise of these rights and keep written documentation of compliance with this subsection. Each recipient receiving care shall have the following rights:

(a) To be fully informed of all rules and regulations affecting the recipient;

(b) To be fully informed of all services to be provided by the nurse and of related charges, including any charges for services for which the recipient may be responsible;

(c) To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of services, including referral to a health care institution or other agency;

(d) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of that refusal;

(e) To confidential treatment of personal and medical records and to approve or refuse their release to any individual, except in the case of transfer to a health care facility;

(f) To be taught, and have the family or other persons living with the recipient taught, the treatment required, so that the recipient can, to the extent possible, help himself or herself, and the family or other party designated by the recipient can understand and help the recipient;

(g) To have one's property treated with respect; and

(h) To complain about care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

(6) UNIVERSAL PRECAUTIONS. A nurse shall have the necessary orientation, education and training in epidemiology, modes of transmission and prevention of HIV and other blood−borne or body fluid−borne infections and shall follow universal blood and body−fluid precautions for each recipient for whom services are provided. The nurse shall employ protective measures recommended by the federal centers for disease control (CDC), including those pertaining to medical equipment and supplies, to minimize the risk of infection from HIV and other blood−borne pathogens.

Note: Note: A copy of the CDC recommended universal precautions may be obtained from the Bureau of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701.

(7) MEDICAL RECORD. The nurse shall maintain a medical record for each recipient. The record shall document the nature and scope of all services provided and shall be systematically organized and readily accessible to authorized department personnel. The medical record shall document the recipient's condition, problems, progress and all services rendered, and shall include:

(a) Recipient identification information;

(b) Appropriate hospital information, including discharge information, diagnosis, current patient status and post−discharge plan of care;

(c) Recipient admission evaluation and assessment;

(d) All medical orders, including the written plan of care and all interim physician's orders;

(e) A consolidated list of medications, including start and stop dates, dosage, route of administration and frequency. This list shall be reviewed and updated for each nursing visit, if necessary;

(f) Progress notes posted as frequently as necessary to clearly and accurately document the recipient's status and services provided. In this paragraph, "progress note" means a written notation, dated and signed by a member of the health team providing covered services, that summarizes facts about care furnished and the recipient's response during a given period of time;

(g) Clinical notes written the day service is provided and incorporated into the clinical record within 7 days after the visit or recipient contact. In this paragraph, "clinical note" means a notation of a contact with a recipient that is written and dated by a member of the home health team providing covered services, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition;

(h) Written summaries of the recipient's care provided by the nurse to the physician at least every 62 days; and

(i) Written authorizations from the recipient or the recipient's guardian when it is necessary for the nurse to procure medical supplies or equipment needed by the recipient.

(8) BACK−UP AND EMERGENCY PROCEDURES. (a) A recipient's nurse shall designate an alternate nurse to provide services to the recipient in the event the nurse is temporarily unable to provide services. The recipient shall be informed of the identity of the alternate nurse before the alternate nurse provides services.

(b) The nurse shall document a plan for recipient−specific emergency procedures in the event a life−threatening situation or fire occurs or there are severe weather warnings. This plan shall be made available to the recipient and all caregivers prior to initiation of these procedures.

(c) The nurse shall take appropriate action and immediately notify the recipient's physician, guardian, if any, and any other responsible person designated in writing by the patient or guardian of any significant accident, injury or adverse change in the recipient's condition.

(9) DISCHARGE OF THE RECIPIENT. A recipient shall be discharged from services provided by the nurse upon the recipient's request, upon the decision of the recipient's physician, or if the nurse documents that continuing to provide services to the recipient presents a direct threat to the nurse's health or safety and further documents the refusal of the attending physician to authorize discharge of the recipient with full knowledge and understanding of the threat to the nurse. The nurse shall recommend discharge to the physician and recipient if the recipient does not require services or requires services beyond the nurse's capability. The nurse provider shall issue a notification of discharge to the recipient or guardian, if possible at least 2 calendar weeks prior to cessation of skilled nursing services, and shall, in all circumstances, provide assistance in arranging for the continuity of all medically necessary care prior to discharge.

(10) DEPARTMENT REVIEW. (a) *Record review.* The department may periodically review the records described in this section and s. HFS 106.02 (9), subject only to restrictions of law. All records shall be made immediately available upon the request of an authorized department representative.

(b) *In−home visits.* As part of the review under par. (a), the department may contact recipients who have received or are receiving MA services from a nurse provider. The nurse provider shall provide any identifying information requested by the department. The department may select the recipients for visits and may visit a recipient with the approval of the recipient or recipient's guardian. The recipient to be visited shall be given the opportunity to have any person present whom he or she chooses during the visit by personnel of the department or other governmental investigating agency.

(c) *Investigation complaints.* The department may investigate any complaint received by it concerning the provision of MA services by a nurse provider. Following the investigation, the department may issue a preliminary final report to the nurse provider in question, except when doing so would jeopardize any other investigation by the department or other state or federal agency.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. and recr. Register, January, 1991, No. 421, eff. 2−1−91; emerg. r. and recr., eff. 7−1−92; r. and recr. Register, February, 1993, No. 446, eff., 3−1−93.

HFS 105.20 Nurse practitioners. (1) QUALIFICATIONS. For MA certification, a nurse practitioner shall be licensed as a registered nurse pursuant to s. 441.06, Stats., and fulfill one of the following requirements:

(a) If practicing as a pediatric nurse practitioner, be currently certified by the American nurses' association or by the national board of pediatric nurse practitioners and associates;

(b) If practicing as any family nurse practitioner, be currently certified by the American nurses' association; or

(c) If practicing as any other primary care nurse practitioner or as a clinical nurse specialist, be currently certified by the American nurses' association, the national certification board of pediatric nurse practitioners and associates, or the nurses' association of the American college of obstetricians and gynecologists' certification corporation, or have a master's degree in nursing from a school accredited by a program designed to prepare a registered nurse for advanced clinical nurse practice.

(2) PROTOCOLS. A written protocol covering a service or delegated medical act that may be provided and procedures that are to be followed for provision of services by nurse practitioners shall be developed and maintained by the nurse practitioner and the delegating licensed physician according to the requirements of s. N 6.03 (2) and the guidelines set forth by the board of nursing. This protocol shall include, but is not limited to, explicit agreements regarding those delegated medical acts which the nurse practitioner or clinical nurse specialist is delegated by the physician to provide. A protocol shall also include arrangements for communication of the physician's directions, consultation with the physician, assistance with medical emergencies, patient referrals and other provisions relating to medical procedures and treatment.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. and recr. Register, January, 1991, No. 421, eff. 2−1−91.

HFS 105.201 Nurse−midwives. For MA certification, a nurse midwife shall be certified as a registered nurse under s. HFS 105.19 (1) and shall be certified as a nurse midwife under ch. N 4.

History: Cr. Register, January, 1991, No. 421, eff. 2−1−91.

HFS 105.21 Hospital IMDS. (1) REQUIREMENTS. For MA certification, a hospital which is an institution for mental disease (IMD) shall:

(a) Meet the requirements of s. HFS 105.07, and;

1. Maintain clinical records on all patients, including records sufficient to permit determination of the degree and intensity of treatment furnished to MA recipients, as specified in 42 CFR 482.61; and

2. Maintain adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as specified in 42 CFR 482.62;

(b) Have a utilization review plan that meets the requirements of 42 CFR 405.1035, 405.1037 and 405.1038;

(c) If participating in the PRO review program, meet the requirements of that program and any other requirements established under the state contract with the PROs;

(d) If providing outpatient psychotherapy, comply with s. HFS 105.22;

(e) If providing outpatient alcohol and other drug abuse services, comply with s. HFS 105.23; and

(f) If providing day treatment services, comply with s. HFS 105.24.

(2) WAIVERS AND VARIANCES. The department shall consider applications for waivers or variances of the requirements in sub. (1) if the requirements and procedures stated in s. HFS 106.11 are followed.

Note: For covered mental health services, see s. HFS 107.13.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; correction in (1) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1990, No. 414.

HFS 105.22 Psychotherapy providers. (1) TYPES OF PSYCHOTHERAPY PROVIDERS. For MA certification, a psychotherapy provider shall be one of the following:

(a) A physician meeting the requirements of s. HFS 105.05 (1) who has completed a residency in psychiatry. Proof of residency shall be provided to the department. Proof of residency shall either be board−certification from the American board of psychiatry and neurology or a letter from the hospital in which the residency was completed;

(b) A psychologist licensed under ch. 455, Stats., who is listed or eligible to be listed in the national register of health service providers in psychology;

(c) A board−operated outpatient facility or hospital outpatient mental health facility certified under ss. HFS 61.91 to 61.98; or

(d) Another outpatient facility certified under ss. HFS 61.91 to 61.98.

(2) STAFFING OF OUTPATIENT FACILITIES. (a) To provide psychotherapy reimbursable by MA, personnel employed by an outpatient facility deemed a provider under sub. (1) (d) shall be individually certified and shall work under the supervision of a physician or psychologist who meets the requirements of sub. (1) (a) or (b). Persons employed by a board−operated or hospital outpatient mental health facility need not be individually certified as providers but 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 maintain a list of the

names of persons employed by the facility who are performing psychotherapy services for which reimbursement may be claimed under MA. This listing shall document the credentials possessed by the named persons which would qualify them for certification under the standards specified in this subsection and shall include the dates that the named persons began employment.

(b) A person eligible to provide psychotherapy under this subsection in an outpatient facility shall meet the requirements under s. HFS 61.96.

(3) REIMBURSEMENT FOR OUTPATIENT PSYCHOTHERAPY SERVICES. Reimbursement shall be made to any certified outpatient facility for services rendered by any provider under sub. (2) (b) and working for that facility, except that a provider certified under sub. (1) (a) or (b) may be reimbursed directly.

Note: For covered mental health services, see s. HFS 107.13.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. and recr. Register, September, 1991, No. 429, eff. 10−1−91.

HFS 105.23 Alcohol and other drug abuse (AODA) treatment providers. (1) TYPES OF PROVIDERS. For MA certification, an outpatient alcohol and other drug abuse (AODA) treatment provider shall be:

(a) An outpatient facility operated by a board and certified under ss. HFS 61.50 to 61.68;

(b) An outpatient facility or hospital outpatient AODA facility certified under ss. HFS 61.50 to 61.68; or

(c) A provider certified under s. HFS 105.05 (1) or 105.22 (1) (b).

(2) STAFFING REQUIREMENTS. (a) To provide AODA services reimbursable under MA, personnel employed by an outpatient facility under sub. (1) (a) or (b) shall:

1. Meet the requirements in s. HFS 105.22 (1) (b) or 105.05 (1); or

2. Be an AODA counselor certified by the Wisconsin alcoholism and drug abuse counselor certification board and work under the supervision of a provider who is a licensed physician or licensed psychologist and employed by the same facility.

Note: Certification standards of the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board may be obtained by writing the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board, Inc., 416 East Main Street, Waukesha, WI 53186.

(b) The facility shall provide the department with a list of persons employed by the facility who perform AODA services for which reimbursement may be claimed under MA. The listing shall identify the credentials possessed by the named persons which would qualify them for certification under the standards specified in par. (a). A facility, once certified, shall promptly advise the department in writing of the employment or termination of employees who will be or have been providing AODA services under MA.

(3) REIMBURSEMENT FOR AODA SERVICES. Reimbursement for outpatient AODA treatment services shall be as follows:

(a) For the services of any provider employed by or under contract to a certified AODA facility, reimbursement shall be made to the facility; and

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

Note: For covered alcohol and other drug abuse treatment services, see s. HFS 107.13 (3).

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; am. (1) (b) and(c) and (2) (a) 1., Register, September, 1991, No. 429, eff. 10−1−91.

HFS 105.24 Mental health day treatment or day hospital service providers. (1) REQUIREMENTS. For MA certification, a day treatment or day hospital service provider shall:

(a) Be a medical program certified under s. HFS 61.75; and

(b) Meet the following personnel and staffing requirements:

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

2. The day treatment program shall be planned for and directed by designated members of an interdisciplinary team that includes a social worker, a psychologist, an occupational therapist and a registered nurse or a physician, physician's assistant or another appropriate health care professional;

3. A written patient evaluation involving an assessment of the patient's progress by each member of the multidisciplinary team shall be made at least every 60 days; and

4. For the purposes of daily program performance, coordination guidance and evaluation:

a. One qualified professional staff member such as an OTR, masters degree social worker, registered nurse, licensed psychologist or masters degree psychologist for each group, or one certified occupational therapy assistant and one other paraprofessional staff person for each group; and

b. Other appropriate staff, including volunteer staff.

(2) BILLING AND REIMBURSEMENT. (a) Reimbursement for medical day treatment or day hospital services shall be at a rate established and approved by the department.

(b) Reimbursement payable under par. (a) shall be subject to reductions for third party recoupments.

Note: For covered day treatment and day hospital services, see s. HFS 107.13 (4).

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. and recr. (1) (a), am. (2) (b), r. (2) (c), Register, September, 1991, No. 429, eff. 10−1−91.

HFS 105.25 Alcohol and other drug abuse (AODA) day treatment providers. (1) TYPES OF PROVIDERS. For MA certification, an alcohol and other drug abuse (AODA) day treatment provider shall be certified under ss. HFS 61.61 and 105.23.

(2) STAFFING REQUIREMENTS. (a) An alcohol and drug counselor certified as provided in s. HFS 61.06 (14) shall be on duty during all hours in which services are provided to participate in treatment planning and implementation and daily program coordination.

(b) A treatment plan for each participating recipient shall be developed, directed and monitored by designated members of an interdisciplinary treatment team which includes an alcohol and drug counselor II or III, certified as provided in s. HFS 61.06 (14), a physician or licensed psychologist, and other health care professionals. The treatment team shall maintain a written record of each recipient's treatment and progress toward meeting the goals described in the recipient's plan of care.

(c) All treatment shall be coordinated and provided by at least one qualified professional staff member who has demonstrated experience in delivering direct treatment to persons with alcohol and other drug abuse problems. Other staff members, such as an AODA counselor I who has filed for certification with the Wisconsin alcoholism and drug counselor certification board, inc., may assist in treatment under the supervision of a qualified professional staff member.

History: Emerg. cr. eff. 3−9−89; cr. Register, December, 1989, No. 408, eff. 1−1−90.

HFS 105.255 Community support programs. (1) GENERAL REQUIREMENTS. For MA certification, a community support program (CSP) service provider shall meet the requirements under ss. HFS 63.06 to 63.17 and this section. The department may waive a requirement in ss. HFS 63.06 to 63.17 under the conditions specified in s. HFS 63.05 if requested by a provider. Certified providers under this section may provide services directly or may contract with other qualified providers to provide all or some of the services described in s. HFS 107.13 (6).

(2) MENTAL HEALTH TECHNICIAN. (a) In this subsection, "mental health technician" means a paraprofessional employee of the

CSP who is limited to performing the services set out in s. HFS 63.11 (3) (c) and (4).

(b) Except as provided in par. (c), a mental health technician shall have at least 1,000 hours of supervised work experience with long−term mentally ill persons and meet at least one of the following conditions:

1. Has satisfactorily completed the educational curriculum developed by the department;

2. Is certified by the American occupational therapy association as an occupational therapy assistant;

3. Is a practical nurse (LPN) licensed under s. 441.10, Stats.;

4. Has satisfied the training requirements under s. HFS 133.17 (4) for a home health aide;

5. Is included in the registry of persons under ch. HFS 129 who have completed a nurse's assistant training and testing program or only a testing program; or

6. Has satisfied the requirements under s. HFS 105.17 (3) (a) 1. to provide personal care services and has completed an additional 1000 hours of supervised work experience with long−term mentally ill persons.

(c) A mental health technician providing CSP services who does not meet the requirements of par. (b) shall meet the requirements of s. HFS 63.06 (4) (a) 9. and shall in addition meet the requirements of par. (b) within one year following the effective date of the provider's MA certification or the technician's date of employment by the CSP, whichever is later.

(3) DOCUMENTATION OF EMPLOYEE QUALIFICATIONS. Providers shall maintain current written documentation of employee qualifications required under s. HFS 63.06 (4) and this section.

History: Cr. Register, September, 1990, No. 417, eff. 10−1−90; corrections in (1), (2) (c) and (3) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1999, No. 520; **correction in (2) (b) 5. made under s. 13.93 (2m) (b) 7., Stats., October, 2000, No. 538.**

HFS 105.26 Chiropractors. For MA certification, chiropractors shall be licensed pursuant to s. 446.02, Stats.

Note: For covered chiropractic services, see s. HFS 107.15.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.265 Podiatrists. For MA certification, podiatrists shall be licensed under s. 448.63, Stats., and ch. Pod 1 and registered under s. 448.07, Stats., and ch. Pod 4.

History: Cr. Register, January, 1991, No. 421, eff. 2−1−91; corrections made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

HFS 105.27 Physical therapists and assistants. (1) PHYSICAL THERAPISTS. For MA certification, physical therapists shall be licensed pursuant to ss. 448.05 and 448.07, Stats., and ch. Med 7.

(2) PHYSICAL THERAPIST ASSISTANTS. For MA certification, physical therapist assistants shall have graduated from a 2−year college−level program approved by the American physical therapy association, and shall provide their services under the direct, immediate, on−premises supervision of a physical therapist certified pursuant to sub. (1). Physical therapist assistants may not bill or be reimbursed directly for their services.

Note: For covered physical therapy services, see s. HFS 107.16.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.28 Occupational therapists and assistants. (1) OCCUPATIONAL THERAPISTS. For MA certification, an occupational therapist shall:

(a) Be certified by the American occupational therapy association as an occupational therapist, registered; or

(b) Have graduated from a program in occupational therapy accredited by the council on medical education of the American medical association and the American occupational therapy association, have completed the required field work experience, and have made application to the American occupational therapy association for the certification examination for occupational therapist, registered. Certification under this paragraph shall be valid until 8 weeks after the examination is taken. On passing the examination, the therapist shall obtain certification by the American occupational therapy association in the calendar year in which the examination is taken. An individual certified under this paragraph for medical assistance who fails the examination may be recertified for medical assistance only under the conditions of par. (a).

(2) OCCUPATIONAL THERAPY ASSISTANTS. For MA certification, occupational therapy assistants shall be certified by the American occupational therapy association. Occupational therapy assistants may not bill or be reimbursed directly for their services. Occupational therapy assistants shall provide services under the direct, immediate on−premises supervision of an occupational therapist certified under sub. (1), except that they may provide services under the general supervision of an occupational therapist certified under sub. (1) under the following circumstances:

(a) The occupational therapy assistant is performing services which are for the purpose of providing activities of daily living skills;

(b) The occupational therapy assistant's supervisor visits the recipient on a bi−weekly basis or after every 5 visits by the occupational therapy assistant to the recipient, whichever is greater; and

(c) The occupational therapy assistant and his or her supervisor meet to discuss treatment of the recipient after every 5 contacts between the occupational therapy assistant and the recipient.

Note: For covered occupational therapy services, see s. HFS 107.17.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.29 Speech and hearing clinics. For MA certification, speech and hearing clinics shall be currently accredited by the American speech and hearing association (ASHA) pursuant to the guidelines for "accreditation of professional services programs in speech pathology and audiology" published by ASHA.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.30 Speech pathologists. For MA certification, speech pathologists shall:

(1) Possess a current certification of clinical competence from the American speech and hearing association;

(2) Have completed the educational requirements and work experience necessary for such a certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate of clinical competence under sub. (1).

Note: For covered speech pathology services, see. s. HFS 107.18.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.31 Audiologists. For MA certification, audiologists shall:

(1) Possess a certificate of clinical competence from the American speech and hearing association (ASHA);

(2) Have completed the educational requirements and work experience necessary for the certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate under sub. (1).

Note: For covered audiology services, see s. HFS 107.19.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; am. (1) and (3), Register, May, 1990, No. 413, eff. 6−1−90.

HFS 105.32 Optometrists. For MA certification, optometrists shall be licensed and registered pursuant to ss. 449.04 and 449.06, Stats.

Note: For covered vision care services, see s. HFS 107.20.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.33 Opticians. For MA certification, opticians shall practice as described in s. 449.01 (2), Stats.

Note: For covered vision care services, see s. HFS 107.20.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.34 Rehabilitation agencies. For MA certification on or after January 1, 1988, a rehabilitation agency providing outpatient physical therapy, or speech and language pathology form, or occupational therapy shall be certified to participate in medicare as an outpatient rehabilitation agency under 42 CFR 405.1702 to 405.1726.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; am. Register, February, 1988, No. 386, eff. 3−1−88.

HFS 105.35 Rural health clinics. For MA certification, a rural health clinic shall be:

(1) Certified to participate in medicare;

(2) Licensed as required under all other local and state laws; and

(3) Staffed with persons who are licensed, certified form or registered in accordance with appropriate state laws.

Note: For covered rural health clinic services, see s. HFS 107.29.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.36 Family planning clinics or agencies. For MA certification, family planning clinics or agencies shall meet the following conditions:

(1) GENERAL. In order to qualify for MA reimbursement, family planning clinics shall certify to the department that:

(a) An MA card has been shown before services are provided;

(b) Services are prescribed by a physician or are provided by a nurse midwife as provided under s. 441.15, Stats.; and

(c) No sterilization procedures are available to persons who are mentally incompetent, institutionalized or under the age of 21.

(2) PRINCIPLES OF OPERATION. (a) Family planning services shall be made available:

1. Upon referral from any source or upon the patient's own application;

2. Without regard to race, nationality, religion, family size, martial status, maternity, paternity, handicap or age, in conformity with the spirit and intent of the civil rights act of 1964, as amended, and the rehabilitation act of 1973, as amended;

3. With respect for the dignity of the individual; and

4. With efficient administrative procedures for registration and delivery of services, avoiding prolonged waiting and multiple visits for registration. Patients shall be seen on an appointment basis whenever possible.

(b) Acceptance of family planning service shall be voluntary, and individuals shall not be subjected to coercion either to receive services or to employ or not to employ any particular method of family planning. Acceptance or nonacceptance of family planning services shall not be a prerequisite to eligibility for or receipt of any other service funded by local, state, or federal tax revenue.

(c) A variety of medically approved methods of family planning, including the natural family planning method, shall be available to persons to whom family planning services are offered and provided.

(d) The clinic shall not provide abortion as a method of family planning.

(e) Efforts shall be made to obtain third party payments when available for services provided.

(f) All personal information obtained shall be treated as privileged communication, shall be held confidential, and shall be divulged only upon the recipient's written consent except when necessary to provide services to the individual or to seek reimbursement for the services. The agency director shall ensure that all participating agencies preserve the confidentiality of patient records. Information may be disclosed in summary, statistical or other form which does not identify specific recipients.

(3) ADMINISTRATION. (a) The family planning clinic shall have a governing body which is responsible for the conduct of the staff and the operation of the clinic.

(b) A designated person shall be responsible for the day−to−day operation of the clinic.

(c) Written policies and procedures shall be developed which govern the utilization of staff, services to patients and the general operation of the clinic.

(d) Job descriptions for volunteer and paid staff shall be prepared to assist staff members in the performance of their duties.

(e) Each clinic shall have a record system that includes the following components:

1. Patient records:

a. With pertinent medical and social history;

b. With all patient contacts and outcomes;

c. With accumulated data on supplies, staffing, appointments and other administrative functions;

d. For purposes of following up on patients for medical services or referrals to other community resources; and

e. For purposes of program evaluation;

2. Fiscal records accounting for cash flow; and

3. Organizational records to document staff time, governing body meetings, administrative decisions and fund raising.

(f) Each clinic shall engage in a continuing effort of evaluating, reporting, planning and implementing changes in program operation.

(g) Each clinic shall develop a system of appointments and referrals which is flexible enough to meet community needs.

(h) Each clinic shall make provision for a medical back−up for patients who experience family planning related problems at a time when the clinic staff is unavailable.

(4) STAFFING. (a) Clinic staff, either paid or volunteer, shall perform the following functions:

1. Outreach workers or community health personnel shall have primary responsibility to contact individuals in need of family planning services, initiate family planning counseling, and assist in receiving, successfully using and continuing medical services;

2. The secretary or receptionist shall greet patients at the clinic, arrange for services and perform a variety of necessary clerical duties;

3. The interviewer or counselor shall take social histories, provide family planning information to patients and counsel patients regarding their family planning and related problems;

4. The nurse or clinic aide shall assist the physician in providing medical services to the patient;

5. The physician shall be responsible for providing or exercising supervision over all medical and related services provided to patients; and

6. The clinic coordinator shall oversee the operation of the clinic.

(b) 1. Training programs shall be developed for new staff, and time shall be made available periodically for their training.

2. For existing staff, time shall be made available for staff conferences and for inservice training in new techniques and procedures.

3. For volunteers, time shall be made available for staff to coordinate, train, and supervise them to be an effective, integral part of the clinic.

(c) Paraprofessional personnel may be hired and trained.

(5) PATIENT AND COMMUNITY OUTREACH. Each clinic shall have an active outreach effort aimed at:

(a) Recruiting and retaining patients in the family planning clinic, through:

1. A system of identifying the primary target populations;

2. A method of contacting the target population;

3. Procedures for family planning counseling and motivating appropriate persons to avail themselves of family planning medical services;

4. Assisting individuals in receiving family planning medical services;

5. Activities designed to follow−up potential and actual family planning patients as indicated; and

6. A record system sufficient to support the functions in subds. 1. to 5.;

(b) Meeting all human needs through appropriate and effective referral to other community resources; and

(c) Increasing community awareness and acceptance of the family planning clinic through:

1. The use of mass media;

2. Presentations to community organizations and agencies;

3. Public information campaigns utilizing all channels of communication;

4. Development of formal referral arrangements with community resources; and

5. Involvement of appropriate community residents in the operation of the family planning clinic.

(6) PATIENT EDUCATION AND COUNSELING. At the time the patient is to receive family planning medical services, the following components of social services shall be provided:

(a) An intake interview designed to obtain pertinent information regarding the patient, to explain the conditions under which services are provided and to create the opportunity for a discussion of the patient's problems;

(b) A group or individual information session which includes:

1. Reproductive anatomy and physiology;

2. Methods of contraception, including how they work, side effects and effectiveness;

3. An explanation of applicable medical procedures;

4. An opportunity for patients to ask questions and discuss their concerns; and

5. An optional discussion of such topics as breast and cervical cancer, venereal disease, human sexuality or vaginopathies; and

(c) An exit interview which is designed to:

1. Clarify any areas of concern or questions regarding medical services;

2. Elicit from the patient evidence of a complete understanding of the use of family planning methods;

3. Effectively inform the patient what procedures are to be followed if problems are experienced;

4. Inform the patient about the clinic's follow−up procedures and possible referral to other community resources; and

5. Arrange for the next visit to the clinic.

(7) MEDICAL SERVICES. (a) All medical and related services shall be provided by or under the supervision and responsibility of a physician.

(b) The following medical services shall be made available:

1. Complete medical and obstetrical history;

2. Physical examination;

3. Laboratory evaluation;

4. Prescription of the family planning method selected by the patient unless medically contraindicated;

5. Instructions on the use of the chosen method, provision of supplies and schedule for revisits; and

6. Referral to inpatient service when necessary to treat complications of contraceptive services provided by the clinic.

(c) Equipment and supplies in the clinic shall be commensurate with the services offered. Sufficient first aid equipment shall be available for use when needed.

(d) Treatment for minor vaginal infections and venereal disease may be made available either by the clinic or through referral.

(8) FACILITIES. The family planning clinic shall be designed to provide comfort and dignity for the patients and to facilitate the work of the staff. A clinic facility shall be adequate for the quantity of services provided, and shall include:

(a) A comfortable waiting room with an area for patient reception, record processing and children's play;

(b) Private interviewing and counseling areas;

(c) A group conference room for staff meetings and patient education;

(d) A work room or laboratory area with sufficient equipment and nearby storage space, none of which is accessible to the patient;

(e) A sufficient number of private and well−equipped examining rooms with proximal dressing areas which ensure the dignity of the patient;

(f) Adequate toilet facilities, preferably near the dressing room; and

(g) Arrangements for routine and restorative facility maintenance.

Note: For covered family planning services, see s. HFS 107.21.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. (2) (e), (7) (b) 6., renum. (2) (f) and (g) to be (2) (e) and (f), (7) (b) 7. to be (7) (b) 6., Register, January, 1997, No. 493, eff. 2−1−97; correction in (1) (b) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

HFS 105.37 Early and periodic screening, diagnosis and treatment (EPSDT) providers. (1) EPSDT HEALTH ASSESSMENT AND EVALUATION SERVICES. (a) *Eligible providers.* The following providers are eligible for certification as providers of EPSDT health assessment and evaluation services:

1. Physicians;

2. Outpatient hospital facilities;

3. Health maintenance organizations;

4. Visiting nurse associations;

5. Clinics operated under a physician's supervision;

6. Local public health agencies;

7. Home health agencies;

8. Rural health clinics;

9. Indian health agencies; and

10. Neighborhood health centers.

(b) *Procedures and personnel requirements.* 1. EPSDT providers shall provide periodic comprehensive child health assessments and evaluations of the general health, growth, development and nutritional status of infants, children and youth. Immunizations shall be administered at the time of the screening if determined medically necessary and appropriate. The results of a health assessment and evaluation shall be explained to the recipient's parent or guardian and to the recipient if appropriate.

2. EPSDT health assessment and evaluation services shall be delivered under the supervision of skilled medical personnel. In this section"skilled medical personnel" means physicians, physician assistants, nurse practitioners, public health nurses or registered nurses. Skilled medical personnel who perform physical assessment screening procedures shall have successfully completed either a formal pediatric assessment or an inservice training course on physical assessments approved by the department. Individual procedures may be completed by paraprofessional staff who are supervised by skilled medical personnel. Registered nurses who perform EPSDT physical assessments shall have sat-

isfactorily completed a curriculum for pediatric physical assessments approved by the department.

3. All conditions uncovered which warrant further care shall be diagnosed or treated or both by the provider, if appropriate, or referred to other appropriate providers. A referral may either be a direct referral to the appropriate health care provider or a referral recommendation submitted through the agency responsible for the patient's case management and advocacy.

4. Health maintenance organizations and prepaid health plans providing EPSDT services shall meet all requirements of 42 CFR 441.60 in addition to the requirements under subds. 1. to 3.

(c) *Records and documentation.* 1. Certified providers of EPSDT screening services shall:

a. Complete the department's EPSDT claim form and an individual health and developmental history for each client; and

b. Maintain a file on each client receiving EPSDT services which includes a copy of the EPSDT claim form, individual health and developmental history and follow−up for necessary diagnosis and treatment services.

2. The EPSDT provider shall release information on the results of the health assessment to appropriate health care providers and health authorities when authorized by the patient or the patient's parent or guardian to do so.

(2) EPSDT CASE MANAGEMENT ACTIVITIES. (a) *Case management reimbursement.* Providers certified under sub. (1) as providers of EPSDT health assessment and evaluation services shall be eligible to receive reimbursement for EPSDT case management in accordance with the limitations contained in the case management agreement between the provider and the department.

(b) *Case management plan.* 1. All EPSDT providers who apply to receive reimbursement for EPSDT case management services shall submit to the department a case management plan. The case management plan shall describe the geographic service area, target population, coordination with support activities conducted by the department and other health−related services, case management activities and the method of documenting the activities.

2. The department shall evaluate the adequacy of each provider's case management plan according to the case management requirements of the proposed service area and target population, the extent to which the plan would ensure that children receive the necessary diagnosis and treatment services for conditions detected during EPSDT health examinations, the proposed coordination with the EPSDT central notification system and other health related services, and proposed methods for documenting case management services. Based on the evaluation, the department shall either approve or deny the provider's request for reimbursement of case management activities and shall impose on providers as conditions for reimbursement any personnel, staffing or procedural requirements that it determines are necessary pursuant to 42 CFR 441 Part B.

(c) *Records and documentations.* Providers shall maintain records and documentation required by the department in order to verify appropriate use of funds provided by the department for EPSDT case management activities.

(3) DIAGNOSIS AND TREATMENT SERVICES. Providers of diagnosis and treatment services for EPSDT recipients shall be certified according to the appropriate provisions of this chapter.

Note: For covered EPSDT services, see s. HFS 107.22.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.38 Ambulance providers. (1) For MA certification, ambulance service providers shall be licensed pursuant to s. 146.50, Stats., and ch. HFS 110, and shall meet ambulance inspection standards of the Wisconsin department of transportation under s. 341.085, Stats., and ch. Trans 309.

(2) An ambulance service provider that also provides air ambulance services shall submit a separate application under s. HFS 105.01 for certification as an air ambulance provider.

Note: For a copy of the application form for an ambulance service provider license, write the EMS Section, Division of Public Health, P.O. Box 2659, Madison, Wisconsin, 53701.

Note: For covered transportation services, see s. HFS 107.23.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; renum. 105.38 to 105.38 (1) and am., cr. (2), Register, November, 1994, No. 467, eff. 12−1−94; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1999, No. 520.

HFS 105.39 Specialized medical vehicle providers. (1) For MA certification, a specialized medical vehicle provider shall meet the requirements of this section and shall sign the affidavit required under sub. (6) stipulating that the provider is in compliance with the requirements of this section as well as with the requirements of the department of transportation for human service vehicles under ss. 110.05 and 340.01 (23g), Stats., and ch. Trans 301, and shall provide proof of compliance when requested by the department.

(2) VEHICLES. (a) Insurance of not less than $250,000 personal liability for each person, not less than $500,000 personal liability for each occurrence and not less than $10,000 property damage shall be carried on each specialized medical vehicle used to transport a recipient.

(b) Each vehicle shall be inspected and the inspection documented at least every 7 days by an assigned driver or mechanic, to ensure:

1. The proper functioning of the vehicle systems including but not limited to all headlights, emergency flasher lights, turn signal lights, tail lights, brake lights, clearance lights, internal lights, windshield wipers, brakes, front suspension and steering mechanisms, shock absorbers, heater and defroster systems, structural integrity of passenger compartment, air conditioning system, wheelchair locking systems, doors, lifts and ramps, moveable windows and passenger and driver restraint systems;

2. That all brakes, front suspension and steering mechanisms and shock absorbers are functioning correctly;

3. That all tires are properly inflated according to vehicle or tire manufacturers' recommendations and that all tires possess a minimum of 1/8−inch of tread at the point of greatest wear; and

4. That windshields and mirrors are free from cracks or breaks.

(c) The driver inspecting the vehicle shall document all vehicle inspections in writing, noting any deficiencies.

(d) All deficiencies shall be corrected before any recipient is transported in the vehicle. Corrections shall be documented by the driver. Documentation shall be retained for not less than 12 months, except as authorized in writing by the department.

(e) Windows, windshield and mirrors shall be maintained in a clean condition with no obstruction to vision.

(f) Smoking is not permitted in the vehicle.

(g) Police, sheriff's department and ambulance emergency telephone numbers shall be posted on the dash of the vehicle in an easily readable manner. If the vehicle is not equipped with a working two−way radio, sufficient money in suitable denominations shall be carried to enable not less than 3 local telephone calls to be made from a pay telephone.

(h) A provider shall maintain a list showing for each vehicle its registration number, identification number, license number, manufacturer, model, year, passenger capacity, insurance policy number, insurer, types of restraint systems for wheelchairs and whether it is fitted with a wheelchair lift or with a ramp. Attached to the list shall be evidence of compliance with ch. Trans 301.

(3) VEHICLE EQUIPMENT. (a) The vehicle shall be equipped at all times with a flashlight in working condition, a first aid kit and a fire extinguisher. The fire extinguisher shall be periodically serviced as recommended by the local fire department.

(b) The vehicle shall be equipped with a lift or ramp for loading wheelchairs. The vehicle shall also be equipped with passenger restraint devices for each passenger, including restraint devices for recipients in wheelchairs or on cots or stretchers as defined in

s. HFS 107.23 (1) (c) 4. Both a recipient and the recipient's wheelchair, cot or stretcher shall be secured.

(c) Provision shall be made for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and the driver in the event of an accident.

(4) DRIVERS. (a) Each driver shall possess a valid regular or commercial operator's license which shall be unrestricted, except that the vision restrictions may be waived if the driver's vision is corrected to an acuity of 20/30 or better by the use of corrective lenses. In this event, the driver shall wear corrective lenses while transporting recipients.

(b) 1. Each driver before driving a vehicle or serving as an attendant shall have received all of the following:

a. Basic Red Cross or equivalent training in first aid and cardiopulmonary resuscitation (CPR);

b. Specific instructions on care of passengers in seizure; and

c. Specific instructions in the use of all ramps, lift equipment and restraint devices used by the provider.

2. A driver who was employed before December 1, 1994 and who attests in writing that he or she has had prior training in the topics under subd. 1. shall be considered to have fulfilled the requirements under subd. 1.

3. Each driver shall receive refresher training in first aid at least every 3 years and shall maintain CPR certification. A driver who is an emergency medical technician licensed under ch. HFS 110, 111 or 112, a licensed practical nurse, a registered nurse or a physician assistant shall be considered to have met these requirements by completion of continuing education which includes first aid and CPR.

(c) The provider shall maintain a current list of all drivers showing the name, license number and any driving violations or license restrictions of each and shall keep that list current.

(5) COMPANY POLICY. Company policies and procedures shall include:

(a) Compliance with state and local laws governing the conduct of businesses, including ch. Trans 301.

(b) Establishment and implementation of scheduling policies that assure timely pick−up and delivery of passengers going to and returning from medical appointments;

(c) Documentation that transportation services for which MA reimbursement is sought are:

1. For medical purposes only;

2. Ordered by the attending provider of medical service; and

3. Provided only to persons who require this transportation because they lack other means of transport, and who are also physically or mentally incapable of using public transportation;

(d) Maintenance of records of services for 5 years, unless otherwise authorized in writing by the department; and

(e) On request of the department, making available for inspection records that document both medical service providers' orders for services and the actual provision of services.

(6) AFFIDAVIT. The provider shall submit to the department a notarized affidavit attesting that the provider meets the requirements listed in this section. The affidavit shall be on a form developed by and available from the department, and shall contain the following:

(a) A statement of the requirements listed in this section;

(b) The date the form is completed by the provider;

(c) The provider's business name, address, telephone number and type of ownership;

(d) The name and signature of the provider or a person authorized to act on behalf of the provider; and

(e) A notarization.

Note: For covered transportation services, see s. HFS 107.23.

(7) DENIAL OF RECERTIFICATION. If a provider violates provisions of this chapter, s. HFS 106.06, 107.23 or any other instruction in MA program manuals, handbooks, bulletins or letters on provision of SMV services 3 times in a 36−month period, the department may deny that provider's request for re−certification.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; am. (1), (2) (a), (b) (intro.), 1., (3) (a), (b), (4) (a), (5) (a), renum. (2) (b) 2. and 3. to be 3. and 4., cr. (2) (b) 2., (h), (7), r. and recr. (4) (b), (c), Register, November, 1994, No. 467, eff. 12−1−94; reprinted to restore dropped copy in (3), Register, January, 1997, No. 493; emerg. am. (4) (b) 3., eff. 7−3−99; am. (4) (b) 3., Register, December, 1999, No. 528, eff. 1−1−00; **correction in (1) made under s. 13.93 (2m) (b) 7., Stats**.

HFS 105.40 Durable medical equipment and medical supply vendors. (1) Except as provided in sub. (2), vendors of durable medical equipment and medical supplies shall be eligible to participate in the MA program.

(2) Orthotists and prosthetists who develop and fit appliances for recipients shall be certified by the American board for certification in orthotics and prosthetics (A.B.C.). Certification shall be a result of successful participation in an A.B.C. examination in prosthetics, orthotics, or both, and shall be for:

(a) Certified prosthetist (C.P.);

(b) Certified orthotist (C.O.); or

(c) Certified prosthetist and orthotist (C.P.O.)

Note: For covered durable medical equipment and medical supply services, see s. HFS 107.24.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.41 Hearing aid dealers. For MA certification, hearing aid dealers shall be licensed pursuant to s. 459.05, Stats.

Note: For covered hearing aids and supplies, see s. HFS 107.24.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 105.42 Physician office laboratories. (1) REQUIREMENTS. For MA certification, physician office laboratories, except as noted in sub. (2), shall be licensed pursuant to 42 CFR 493 (CLIA).

(2) EXCEPTION. Physician office laboratories servicing no more than 2 physicians, chiropractors or dentists, and not accepting specimens on referral from outside providers, are not required to be licensed under 42 CFR 493 (CLIA). These laboratories, however, shall submit an affidavit to the department declaring that they do not accept outside specimens.

(3) MEDICARE CERTIFICATION REQUIREMENT. Physician office laboratories which accept referrals of 100 or more specimens a year in a specialty shall be certified to participate in medicare in addition to meeting the requirements under sub. (1).

Note: For covered diagnostic testing services, see s. HFS 107.25.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; correction in (1) and (2) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

HFS 105.43 Hospital and independent clinical laboratories. For MA certification, a clinical laboratory that is a hospital laboratory or an independent laboratory shall be licensed pursuant to 42 CFR 493 (CLIA). In addition, the laboratory shall be certified to participate in medicare and meet the requirements of 42 CFR 405.1310 to 405.1317.

Note: For covered diagnostic testing services, see s. HFS 107.25.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

HFS 105.44 Portable x−ray providers. For MA certification, a portable x−ray provider shall be directed by a physician or group of physicians, registered pursuant to s. 254.35, Stats., and ch. HSS 157, certified to participate in medicare, and shall meet the requirements of 42 CFR 405.1411 to 405.1416.

Note: For covered diagnostic testing services, see s. HFS 107.25.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

HFS 105.45 Dialysis facilities. For MA certification, dialysis facilities shall meet the requirements enumerated in ss. HFS 152.05 and 152.08, and shall be certified to participate in medicare.

Note: For covered dialysis services, see s. HFS 107.26.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, November, 1994, No. 467.

HFS 105.46 Blood banks. For MA certification, blood banks shall be licensed or registered with the U.S. food and drug administration and shall be approved pursuant to 42 CFR 493 (CLIA).
Note: For covered blood services, see s. HFS 107.27.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

HFS 105.47 Health maintenance organizations and prepaid health plans. (1) CONTRACTS AND LICENSING. Except as provided in sub. (3), for MA certification, a health maintenance organization or prepaid health plan shall enter into a written contract with the department to provide services to enrolled recipients and shall be licensed by the Wisconsin commissioner of insurance.

(2) REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS. For MA certification, an HMO shall:

(a) Meet the requirements of 42 CFR 434.20 (c);

(b) Make services it provides to individuals eligible under MA accessible to these individuals, within the area served by the organization, to the same extent that the services are made accessible under the MA state plan to individuals eligible for MA who are not enrolled with the organization; and

(c) Make adequate provision against the risk of insolvency, which is satisfactory to the department and which ensures that individuals eligible for benefits under MA are not held liable for debts of the organization in case of the organization's insolvency.
Note: For covered health maintenance organization and prepaid health plan services, see s. HFS 107.28.

(3) CARE ORGANIZATIONS PROVIDING THE FAMILY CARE BENEFIT. A care management organization under contract with the department under s. HFS 10.42 is not required to be licensed by the Wisconsin commissioner of insurance if both of the following apply:

(a) The organization enrolls only individuals who are eligible under s. 46.286, Stats.

(b) The services offered by the organization do not include hospital or physician services.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; cr. (3), Register, October, 2000, No. 538, eff. 11−1−00.

HFS 105.48 Out−of−state providers. (1) When a provider in a state that borders on Wisconsin documents to the department's satisfaction that it is common practice for recipients in a particular area of Wisconsin to go for medical services to the provider's locality in the neighboring state, the provider may be certified as a Wisconsin border status provider, subject to the certification requirements in this chapter and the same rules and contractual agreements that apply to Wisconsin providers, except that nursing homes are not eligible for border status.

(2) Out−of−state independent laboratories, regardless of location, may apply for certification as Wisconsin border status providers.

(3) Other out−of−state providers who do not meet the requirements of sub. (1) may be reimbursed for non−emergency services provided to a Wisconsin MA recipient upon approval by the department under s. HFS 107.04.

(4) The department may review border status certification of a provider annually. Border status certification may be canceled by the department if it is found to be no longer warranted by medical necessity, volume or other considerations.

(5) (a) A provider certified in another state for services not covered in Wisconsin shall be denied border status certification for these services in the Wisconsin program.
Note: Examples of providers whose services are not covered in Wisconsin are music therapists and art therapists.

(b) A provider denied certification in another state shall be denied certification in Wisconsin, except that a provider denied certification in another state because the provider's services are not MA−covered in that state may be eligible for Wisconsin border status certification if the provider's services are covered in Wisconsin.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. and recr. Register, September, 1991, No. 429, eff. 10−1−91.

HFS 105.49 Ambulatory surgical centers. For MA certification, an ambulatory surgical center shall be certified to participate in medicare as an ambulatory surgical center under 42 CFR 416.39.
Note: For covered ambulatory surgical center services, see s. HFS 107.30.
History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; am. Register, February, 1988, No. 386, eff. 3−1−88.

HFS 105.50 Hospices. For MA certification, a hospice shall be certified to participate in medicare as a hospice under 42 CFR 418.50 to 418.100.
History: Cr. Register, February, 1988, No. 386, eff. 3−1−88.

HFS 105.51 Case management agency providers. (1) AGENCY. For MA certification, a provider of case management services shall be an agency with state statutory authority to operate one or more community human service programs. A case management agency may be a county or Indian tribal department of community programs, a department of social services, a department of human services, or a county or tribal aging unit. Each applicant agency shall specify each population eligible for case management under s. HFS 107.32 (1) (a) 2. for which it will provide case management services. Each certified agency shall offer all 3 case management components described under s. HFS 107.32 (1) so that a recipient can receive the component or components that meet his or her needs.

(2) EMPLOYED PERSONNEL. (a) To provide case assessment or case planning services reimbursable under MA, persons employed by or under contract to the case management agency under sub. (1) shall:

1. Possess a degree in a human services−related field, possess knowledge regarding the service delivery system, the needs of the recipient group or groups served, the need for integrated services and the resources available or needing to be developed, and have acquired at least one year of supervised experience with the type of recipients with whom he or she will work; or

2. Possess 2 years of supervised experience or an equivalent combination of training and experience.
Note: The knowledge required in subd. 1. is typically gained through supervised experience working with persons in the target population.

(b) To provide ongoing monitoring and service coordination reimbursable under MA, personnel employed by a case management agency under sub. (1) shall possess knowledge regarding the service delivery system, the needs of the recipient group or groups served, the need for integrated services and the resources available or needing to be developed.

(3) SUFFICIENCY OF AGENCY CERTIFICATION FOR EMPLOYED PERSONNEL. Individuals employed by or under contract to an agency certified to provide case management services under this section may provide case management services upon the department's issuance of certification to the agency. The agency shall maintain a list of the names of individuals employed by or under contract to the agency who are performing case management services for which reimbursement may be claimed under MA. This list shall certify the credentials possessed by the named individuals which qualify them under the standards specified in sub. (2). Upon request, an agency shall promptly advise the department in writing of the employment of persons who will be providing case management services under MA and the termination of employees who have been providing case management services under MA.

(4) CONTRACTED PERSONNEL. Persons under contract with a certified case management agency to provide assessments or case plans shall meet the requirements of sub. (2) (a), and to provide ongoing monitoring and service coordination, shall meet the requirements of sub. (2) (b).

(5) RECORDKEEPING. The case manager under s. HFS 107.32 (1) (d) shall maintain a file for each recipient receiving case management services which includes the following:

(a) The assessment document;

(b) The case plan;

(c) Service contracts;

(d) Financial forms;

(e) Release of information forms;

(f) Case reviews;

(g) A written record of all monitoring and quality assurance activities; and

(h) All pertinent correspondence relating to the recipient's case management.

(6) REIMBURSEMENT. (a) Case management services shall be reimbursed when the services are provided by certified providers or their subcontractors to recipients eligible for case management.

(b) Payment shall be made to certified providers of case management services according to terms of reimbursement established by the department.

(7) COUNTY ELECTION TO PARTICIPATE. (a) The department may not certify a case management agency for a target population unless the county board or tribal government of the area in which the agency will operate has elected to participate in providing benefits under s. HFS 107.32 through providers operating in the county or tribal area. The county board or tribal government may terminate or modify its participation by giving a 30 day written notice to the department. This election is binding on any case management agencies providing services within the affected county or tribal area.

(b) Any case management agency provider requesting certification under this section shall provide written proof of the election of the county or tribal government to participate under this subsection.

History: Cr. Register, February, 1988, No. 386, eff. 3−1−88.

HFS 105.52 Prenatal care coordination providers.

(1) AGENCY. For MA certification, an agency that provides prenatal care coordination services under s. HFS 107.34 (1) may be:

(a) A community−based health organization;

(b) A community−based social services agency or organization;

(c) A county, city, or combined city and county public health agency;

(d) A county department of human services under s. 46.23, Stats., or social services under s. 46.215 or 46.22, Stats.;

(e) A family planning agency certified under s. HFS 105.36;

(f) A federally qualified health center (FQHC) as defined in 42 CFR 405.2401 (b);

(g) A health maintenance organization (HMO);

(h) An independent physician association (IPA);

(i) A hospital;

(j) A physician's office or clinic;

(k) A private case management agency;

(L) A certified nurse or nurse practitioner;

(m) A rural health clinic certified under s. HFS 105.35;

(n) A tribal agency health center; or

(o) A women, infants, and children (WIC) program under 42 USC 1786.

(2) QUALIFIED PROFESSIONALS. (a) *Definition.* In this subsection, "qualified professional" means and is limited to any of the following:

1. A nurse practitioner licensed as a certified nurse pursuant to s. 441.06, Stats., and currently certified by the American nurses' association, the national board of pediatric nurse practitioners and associates or the nurses' association of the American college of obstetricians and gynecologists' certification corporation;

2. A nurse midwife certified under s. HFS 105.201;

3. A public health nurse meeting the qualifications of s. HFS 139.08;

4. A physician licensed under ch. 448, Stats., to practice medicine or osteopathy;

5. A physician assistant certified under ch. 448, Stats;

6. A dietician certified or eligible for registration by the commission on dietetic registration of the American dietetic association with at least 2 years of community health experience;

7. A certified nurse with at least 2 years of experience in maternity nursing or community health services or a combination of maternity nursing and community health services;

8. A social worker with at least a bachelor's degree and 2 years of experience in a health care or family services program; or

9. A health educator with a master's degree in health education and at least 2 years of experience in community health services.

(b) *Required qualified professionals.* To be certified to provide prenatal care coordination services that are reimbursable under MA, the prenatal care coordination agency under sub. (1) shall:

1. Employ at least one qualified professional with at least 2 years of experience in coordinating services for at−risk or low income women;

2. Have on staff, under contract or available in a volunteer capacity a qualified professional to supervise risk assessment and ongoing care coordination and monitoring; and

3. Have on staff, under contract or available in a volunteer capacity one or more qualified professionals with the necessary expertise, based on education or at least one year of work experience, to provide health education and nutrition counseling.

(3) SUFFICIENCY OF AGENCY CERTIFICATION. Individuals employed by or under contract with an agency that is certified to provide prenatal care coordination services under this section may provide prenatal care coordination services upon the department's issuance of certification to the agency. The agency shall maintain a list of all persons who provide or supervise the provision of prenatal care coordination services. The list shall include the credentials of each named individual who is qualified to supervise risk assessment and ongoing care coordination under sub. (2) (b) 2. and to provide health education or nutrition counseling under sub. (2) (b) 3. Upon the department's request, an agency shall promptly report to the department in writing the names of persons hired to provide prenatal care coordination services under MA and the termination of employees who have been providing prenatal care coordination services under MA.

(4) ADMINISTRATIVE RECORDS AND REQUIRED DOCUMENTATION. To be certified to provide prenatal care coordination services reimbursable under MA, the prenatal care coordination agency under sub. (1) shall comply with s. HFS 106.02 (9) and shall submit a plan to the department documenting:

(a) That the agency is located in the area it will serve;

(b) That the agency has a variety of techniques to identify low−income pregnant women;

(c) That, at a minimum, the agency has the name, location and telephone number of the following resources in the area to be served:

1. Women, infants, and children (WIC) programs;

2. Maternal and child health services;

3. The county, city, or combined city and county public health agency;

4. Child day care services;

5. Mental health and alcohol or other drug abuse prevention and treatment agencies;

6. The county protective service agency;

7. Domestic abuse agencies;

8. Translator and interpreter services including services for the hearing−impaired;

9. Family support services;

10. Transportation services; and

11. MA−certified primary care and obstetric providers, including health maintenance organizations participating in the medical assistance program's HMO program.

(d) That the agency, if located in a county with health maintenance organizations (HMO) participating in the medical assistance HMO program, has on file a signed copy of a memorandum of understanding with each HMO participating in the medical assistance HMO program in the county;

(e) That the agency has contacted in writing MA−certified primary and obstetric care providers in its area and has identified the types of services the prenatal care coordination agency provides. These contacts and this information shall be documented and the documentation retained in the agency's administrative records;

(f) That the agency has the ability and willingness to deliver services in a manner that is sensitive to the particular characteristics of the racial or ethnic group or groups with which it intends to work. Documentation of that ability shall be maintained and kept up−to−date. Documentation shall consist of one or more of the following at all times:

1. Records showing the racial and ethnic composition of the population served in the past;

2. Records showing that the agency has developed, implemented and evaluated programs specifically targeted toward the racial or ethnic group or groups;

3. Records showing that the agency has provided health care services in a geographic area where a significant percentage of the population was the same as the agency's targeted racial or ethnic group or groups;

4. Evidence that the agency's board or administration has a significant amount of representation from the targeted group or groups;

5. Letters of support from minority health service organizations which represent the targeted group or groups; or

6. Evidence of the agency's ability to address pertinent cultural issues such as cultural norms and beliefs, language, outreach networking and extended family relationships;

(g) That the agency has the ability to arrange for supportive services provided by other funding sources such as county transportation, county protective services, interpreter services, child care services and housing. This description shall include the methods, techniques and contacts which will be used to offer and provide assistance in accessing those services;

(h) That the agency has the capability to provide ongoing prenatal care coordination monitoring of high−risk pregnant women and to ensure that all necessary services are obtained; and

(i) That the agency has on staff, under contract or available in a volunteer capacity, individuals who are qualified professionals under sub. (2) (a) with the expertise required under sub. (2) (b).

(5) RECIPIENT RECORD. The prenatal care coordination agency shall maintain a confidential prenatal care coordination file for each recipient receiving prenatal care coordination services, which includes the following items required or produced in connection with provision of covered services under s. HFS 107.34 (1):

(a) Verification of the pregnancy;

(b) Completed risk assessment document;

(c) Care plan;

(d) Completed consent documents for release of information;

(e) A written record of all recipient−specific prenatal care coordination monitoring which includes, but is not limited to: the dates of service, description of service provided, the staff person doing the monitoring, the contacts made and the results;

(f) Referrals and follow−up; and

(g) All pertinent correspondence relating to coordination of the recipient's prenatal care.

History: Cr. Register, June, 1994, No. 462, eff. 7−1−94.

HFS 105.53 School−based service providers. **(1)** ELIGIBLE PROVIDERS. For MA certification, a school−based service provider shall be either a school district under ch. 120, Stats., or a cooperative educational service agency (CESA) under ch. 116, Stats.

(2) SEPARATE CERTIFICATION PROHIBITED. No school district or CESA may be separately certified as a provider of nursing services under ss. HFS 105.19 and 105.20, physical therapy services under s. HFS 105.27, occupational therapy services under s. HFS 105.28, speech and language pathology services under ss. HFS 105.29 and 105.30, audiology services under s. HFS 105.31 or transportation services under s. HFS 105.39.

(3) RECORD−KEEPING REQUIREMENTS. (a) For each recipient of school−based services, the provider shall keep a record containing, at a minimum, all of the following:

1. The recipient's first and last name and date of birth;

2. The prescription or, if referred, the referral for the service;

3. Documentation used to develop the recipient's IEP or IFSP and to annually revise the IEP or IFSP; and

4. Annual documentation of the individual's progress toward treatment goals identified in the IEP or IFSP, changes in the individual's physical or mental status and changes in the treatment plan identified in the IEP or IFSP.

(b) For each date of service, the provider shall keep a service record within the recipient's record containing all of the following:

1. The date of service;

2. The general type of service provided;

3. A brief description of the specific service provided;

4. The unit of service delivered as defined through handbooks distributed by the department under s. HFS 108.02 (4);

5. A description and the cost of each durable medical equipment item with sufficient detail to allow the MA program to determine the reimbursement rate, when appropriate; and

6. Documentation of whether the procedure was provided in a group or individual setting, when appropriate.

(c) Periodically, at least monthly, the provider shall include in the service record under par. (b) the following:

1. For each service provided, a brief description of the recipient's response to the service and progress toward the treatment goals identified in the IEP or IFSP; and

2. The service provider's signature.

(d) The provider shall include in the records other information identified by the department in publications in accordance with s. HFS 108.02 (4).

(4) REPORTING REQUIREMENTS. The required annual audit of school district accounts under s. 120.14, Stats., and the audit of CESA receipts and expenditures under s. 115.28 (3m), Stats., shall include evidence, in accordance with instructions distributed by the department under s. HFS 108.02 (4), that requirements for billing and for paying expenses under s. 49.45 (39) (b), Stats., are

being met. Sections of those annual audits shall be made available to the department upon request.

(5) REIMBURSEMENT. (a) School−based services shall be reimbursed when the services are provided by certified providers or their contractors to recipients eligible for school−based services.

(b) Payment, based on the cost to provide the service, shall be made to certified providers of school−based services according to terms of reimbursement established by the department and stated in the medicaid state plan under 42 CFR 430.10.

(c) Services provided between July 1, 1995 and June 30,1996 may be billed through June 30, 1997, to the extent allowed by federal law, notwithstanding s. HFS 106.03 (3) (b) 1.

(6) COORDINATION WITH OTHER MA−CERTIFIED PROVIDERS. (a) *Memorandum of understanding with HMO.* School−based services providers shall have on file a signed copy of a memorandum of understanding with each HMO participating in the medical assistance HMO program when the geographic service area of the HMO coincides with part or all of the geographic service area of the school−based services provider.

(b) *Coordination with fee−for−service providers.* When a recipient receives similar services from both an MA fee−for−service provider and a school−based service provider, the school−based service provider shall document, at least annually, regular contacts with the MA fee−for−service provider, and provide the MA fee−for−service provider with copies of the recipient's IEP or IFSP and relevant components of the multidisciplinary team evaluation under s. 115.80 (3) and (5), Stats., upon request.

History: Emerg. cr. eff. 6−15−96; cr. Register, January, 1997, No. 497, eff. 2−1−97.