(b) *Reasons for prior authorization.* Reasons for prior authorization are:

1. To safeguard against unnecessary or inappropriate care and services;

2. To safeguard against excess payments;

3. To assess the quality and timeliness of services;

4. To determine if less expensive alternative care, services or supplies are usable;

5. To promote the most effective and appropriate use of available services and facilities; and

6. To curtail misutilization practices of providers and recipients.

(c) *Penalty for non-compliance.* If prior authorization is not requested and obtained before a service requiring prior authorization is provided, reimbursement shall not be made except in extraordinary circumstances such as emergency cases where the department has given verbal authorization for a service.

(d) *Required information.* A request for prior authorization submitted to the department or its fiscal agent shall, unless otherwise specified in chs. HSS 101 to 108, identify at a minimum:

1. The name, address and MA number of the recipient for whom the service or item is requested;

2. The name and provider number of the provider who will perform the service requested;

3. The person or provider requesting prior authorization;

4. The attending physician's or dentist's diagnosis including, where applicable, the degree of impairment;

5. A description of the service being requested, including the procedure code, the amount of time involved, and dollar amount where appropriate; and

6. Justification for the provision of the service.

(e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:

1. The medical necessity of the service;

2. The appropriateness of the service;

3. The cost of the service;

4. The frequency of furnishing the service;

5. The quality and timeliness of the service;

6. The extent to which less expensive alternative services are available;

7. The effective and appropriate use of available services;

8. The misutilization practices of providers and recipients;

9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;

10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;

11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and

12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

(f) *Professional consultants.* The department or its fiscal agent may use the services of qualified professional consultants in determining whether requests for prior authorization meet the criteria in par. (e).

(g) *Authorization not transferrable.* Prior authorization, once granted, may not be transferred to another recipient or to another provider. In certain cases the department may allow multiple services to be divided among non-billing providers certified under one billing provider. For example, prior authorization for 15 visits for occupational therapy may be performed by more than one therapist working for the billing provider for whom prior authorization was granted. In emergency circumstances the service may be provided by a different provider.

(h) *Medical opinion reports.* Medical evaluations and written medical opinions used in establishing a claim in a tort action against a third party may be covered services if they are prior-authorized. Prior authorization shall be issued only where:

1. A recipient has sustained personal injuries requiring medical or other health care services as a result of injury, damage or a wrongful act caused by another person;

2. Services for these injuries are covered under the MA program;

3. The recipient or the recipient's representative has initiated or will initiate a claim or tort action against the negligent third party, joining the department in the action as provided under s. 49.65, Stats.; and

4. The recipient or the recipient's representative agrees in writing to reimburse the program in whole for all payments made for the prior-authorized services from the proceeds of any judgment, award, determination or settlement on the recipient's claim or action.

(4) COST-SHARING. (a) *General policy.* The department shall establish cost-sharing provisions for MA recipients, pursuant to s. 49.45 (18), Stats.

(b) *Notification of applicable services and rates.* All services for which cost-sharing is applicable shall be identified by the department to all recipients and providers prior to enforcement of the provisions.

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

1. Recipients who are nursing home residents;

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

3. Recipients who are under age 18;

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

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

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

7. Family planning services and related supplies;

8. Transportation services by a specialized medical vehicle;

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

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

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

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

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

14. Case management services.

(d) *Limitation on copayments for prescription drugs.* Providers may not collect copayments in excess of $5 a month from a recipient for prescription drugs if the recipient uses one pharmacy or pharmacist as his or her sole provider of prescription drugs.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. (1) and am. (14) (c) 12. and 13., Register, February, 1988, No. 386, eff. 3-1-88; cr. (4) (c) 14., Register, April, 1988, No. 388, eff. 7-1-88; r. and recr. (4) (c), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.03 Services not covered. The following services are not covered services under MA:

(1) Charges for telephone calls;

(2) Charges for missed appointments;

(3) Sales tax on items for resale;

(4) Services provided by a particular provider that are considered experimental in nature;

(5) Procedures considered by the department to be obsolete, inaccurate, unreliable, ineffectual, unnecessary, imprudent or superfluous;

(6) Personal comfort items, such as radios, television sets and telephones, which do not contribute meaningfully to the treatment of an illness;

(7) Alcoholic beverages, even if prescribed for remedial or therapeutic reasons;

(8) Autopsies;

(9) Any service requiring prior authorization for which prior authorization is denied, or for which prior authorization was not obtained prior to the provision of the service except in emergency circumstances;

(10) Services subject to review and approval pursuant to ss. 150.21 and 150.61, Stats., but which have not yet received approval;

(11) Psychiatric examinations and evaluations ordered by a court following a person's conviction of a crime, pursuant to s. 972.15, Stats.;

(12) Consultations between or among providers, except as specified in s. HSS 107.06 (4) (f);

(13) Medical services for adult inmates of the correctional institutions listed in s. 53.01, Stats.;

(14) Medical services for a child placed in a detention facility;

(15) Expenditures for any service to an individual who is an inmate of a public institution or for any service to a person 21 to 64 years of age who is a resident of an institution for mental diseases (IMD), unless the person is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, except that expenditures for a service to an individual on conditional release or convalescent leave from an IMD may be reimbursed by MA.

(16) Services provided to recipients when outside the United States, except Canada or Mexico; and

(17) Separate charges for the time involved in completing necessary forms, claims or reports.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; emerg. r. and recr. (15), eff. 8-1-88; r. and recr. (15), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.035 Definition and identification of experimental services. (1) DEFINITION. "Experimental in nature," as used in s. HSS 107.03 (4) and this section, means a service, procedure or treatment provided by a particular provider which the department has determined under sub. (2) not to be a proven and effective treatment for the condition for which it is intended or used.

(2) DEPARTMENTAL REVIEW. In assessing whether a service provided by a particular provider is experimental in nature, the department shall consider whether the service is a proven and effective treatment for the condition which it is intended or used, as evidenced by:

(a) The current and historical judgment of the medical community as evidenced by medical research, studies, journals or treatises;

(b) The extent to which medicare and private health insurers recognize and provide coverage for the service;

(c) The current judgment of experts and specialists in the medical specialty area or areas in which the service is applicable or used; and

(d) The judgment of the MA medical audit committee of the state medical society of Wisconsin or the judgment of any other committee which may be under contract with the department to perform health care services review within the meaning of s. 146.37, Stats.

(3) EXCLUSION OF COVERAGE. If on the basis of its review the department determines that a particular service provided by a particular provider is experimental in nature and should therefore be denied MA coverage in whole or in part, the department shall send written notice to physicians or other affected certified providers who have requested reimbursement for the provision of the experimental service. The notice shall identify the service, the basis for its exclusion from MA coverage and the specific circumstances, if any, under which coverage will or may be provided.

(4) REVIEW OF EXCLUSION FROM COVERAGE. At least once a year following a determination under sub. (3), the department shall reassess services previously designated as experimental to ascertain whether the services have advanced through the research and experimental stage to become established as proven and effective means of treatment for the particular condition or conditions for which they are designed. If the department concludes that a service should no longer be considered experimental, written notice of that determination shall be given to the affected providers. That notice shall identify the extent to which MA coverage will be recognized.

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

HSS 107.04 Coverage of out-of-state services. All non-emergency out-of-state services require prior authorization, except where the provider has been granted border status pursuant to s. HSS 105.48.

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

HSS 107.05 Coverage of emergency services provided by a person not a certified provider. Emergency services necessary to prevent the death or serious impairment of the health of a recipient shall be covered services even if provided by a person not a certified provider. A person who is not a certified provider shall submit documentation to the department to justify provision of emergency services, according to the procedures outlined in s. HSS 105.03. The appropriate consultant to the department shall determine whether a service was an emergency service.

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

HSS 107.06 Physician services. (1) COVERED SERVICES. Physician services covered by the MA program are, except as otherwise limited in this chapter, any medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative services provided in a physician's office, in a hospital, in a nursing home, in a recipient's residence or elsewhere, and performed by or under the direct, on-premises supervision of a physician within the scope of the practice of medicine and surgery as defined in s. 448.01 (9), Stats. These services shall be in conformity with generally accepted good medical practice.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. The following physician services require prior authorization in order to be covered under the MA program:

(a) All covered physician services if provided out-of-state under nonemergency circumstances by a provider who does not have border status. Transportation to and from these services shall also require prior authorization, which shall be obtained by the transportation provider;

(b) All medical, surgical, or psychiatric services aimed specifically at weight control or reduction, and procedures to reverse the result of these services;

(c) Surgical or other medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability, an example of which is cosmetic surgery;

(d) Prescriptions for those drugs listed in s. HSS 107.10 (2);

(e) Ligation of internal mammary arteries, unilateral or bilateral;

(f) Omentopexy for establishing collateral circulation in portal obstruction;

(g) 1. Kidney decapsulation, unilateral and bilateral;

2. Perirenal insufflation; and

3. Nephropexy: fixation or suspension of kidney (independent procedure), unilateral;

(h) Circumcision, female;

(i) Hysterotomy, non-obstetrical or vaginal;

(j) Supracervical hysterectomy, that is, subtotal hysterectomy, with or without removal of tubes or ovaries or both tubes and ovaries;

(k) Uterine suspension, with or without presacral sympathectomy;

(l) Ligation of thyroid arteries as an independent procedure;

(m) Hypogastric or presacral neurectomy as an independent procedure;

(n) 1. Fascia lata by stripper when used as treatment for lower back pain;

2. Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain;

(o) Ligation of femoral vein, unilateral and bilateral, when used as treatment for post-phlebitic syndrome;

(p) Excision of carotid body tumor without excision of carotid artery, or with excision of carotid artery, when used as treatment for asthma;

2. Consultation requiring a history and direct patient confrontation by a psychiatrist;

3. Consultation requiring evaluation of frozen sections or pathological slides by a pathologist; and

4. Consultation involving evaluation of radiological studies or radiotherapy by a radiologist;

(e) *Foot care.* 1. Services pertaining to the cleaning, trimming, and cutting of toenails, often referred to as palliative care, maintenance care, or debridement, shall be reimbursed no more than one time for each 31-day period and only if the recipient's condition is one or more of the following:

a. Diabetes mellitus;

b. Arteriosclerosis obliterans evidenced by claudication; or

c. Peripheral neuropathies involving the feet, which are associated with malnutrition or vitamin deficiency, carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis, uremia or cerebral palsy.

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

3. For multiple surgical procedures performed on the foot on the same day, the physician shall be reimbursed for the first procedure at the full rate and the second and all subsequent procedures at a reduced rate as determined by the department.

4. Debridement of mycotic conditions and mycotic nails shall be a covered service in accordance with utilization guidelines established and published by the department.

5. The application of unna boots is allowed once every 2 weeks, with a maximum of 12 applications for each 12-month period.

(f) *Second opinions.* A second medical opinion is required when a selected elective surgical procedure is prescribed for a recipient. On this occasion the final decision to proceed with surgery shall remain with the recipient, regardless of the second opinion. The second opinion physician may not be reimbursed if he or she ultimately performs the surgery. The following procedures are subject to second opinion requirements:

1. Cataract extraction, with or without lens implant;

2. Cholecystectomy;

3. D. & C., diagnostic and therapeutic, or both;

4. Hemorrhoidectomy;

5. Hernia repair, inguinal;

6. Hysterectomy;

7. Joint replacement, hip or knee;

8. Tonsillectomy or adenoidectomy, or both; and

9. Varicose vein surgery.

(g) *Services performed under a physician's supervision.* Services performed under the supervision of a physician shall comply with federal and state regulations relating to supervision of covered services. Specific documentation of the services shall be included in the recipient's medical record.

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

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

(a) Artificial insemination;

(b) Abortions performed which do not comply with s. 20.927, Stats.;

(c) Services performed by means of a telephone call between a physician and a recipient, including those in which the physician provides advice or instructions to or on behalf of a recipient, or between or among physicians on behalf of the recipient;

(d) As separate charges, preoperative and postoperative surgical care, including office visits for suture and cast removal, which commonly are included in the payment of the surgical procedure;

(e) As separate charges, transportation expenses incurred by a physician, to include but not limited to mileage;

(f) Dab's and Wynn's solution;

(g) Except as provided in sub. (3) (b) 1, a hysterectomy if it was performed solely for the purpose of rendering an individual permanently incapable of reproducing or, if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing;

(h) Ear piercing;

(i) Electrolysis;

(j) Tattooing;

(k) Hair transplants;

(l) Vitamin C injections;

(m) Lincocin (lincomycin) injections performed on an outpatient basis;

(n) Orthopedic shoes and supportive devices such as arch supports, shoe inlays and pads;

(o) Services directed toward the care and correction of "flat feet";

(p) Sterilization of a mentally incompetent or institutionalized person, or of a person who is less than 21 years of age;

(q) Inpatient laboratory tests not ordered by a physician or other responsible practitioner, except in emergencies;

(r) Hospital care following admission on a Friday or Saturday, except for emergencies, accident care or obstetrical cases, unless the hospital can demonstrate to the satisfaction of the department that the hospital provides all of its services 7 days a week;

(s) Liver injections;

(t) Acupuncture;

(u) Phonocardiogram with interpretation and report;

(v) Vector cardiogram;

(w) Intestinal bypass for obesity; and

(x) Separate charges for pump technician services; and

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; cr. (2) (cm), (4) (h) and (5) (y), am. (4) (a) 3. Register, February, 1988, No. 386, eff. 3-1-88; am. (4) (a) 1. c., p. and q., cr. (4) (a) 1. r., Register, April, 1988, No. 388, eff. 7-1-88; r. (2) (cm) and (5) (y), r. and recr. (4) (h), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.07 Dental services. (1) COVERED SERVICES. (a) *General.* Covered dental services are the services identified in this subsection and the MA dental provider handbook which are provided by or under the supervision of a dentist or physician and within the scope of practice of dentistry as defined in s. 447.02, Stats., except when limited under subs. (2) and (3).

(b) *Diagnostic procedures.* Covered diagnostic procedures are:

1. Clinical oral examinations; and

2. Radiographs:

a. Intraoral — occlusal, single film;

b. Extraoral, in emergency or trauma situations only and excluding panoramic films; and

c. Bitewing films, when required to substantiate prior authorization.

(c) *Preventive procedures.* Covered preventive procedures are:

1. Dental prophylaxis — scaling and polishing, including prophylaxis treatment paste, if used; and

2. Space maintenance fixed unilateral, for premature loss of second primary molar only.

(d) *Restorative procedures.* Covered restorative procedures are:

1. Amalgam restorations, includes polishing — primary and permanent teeth;

2. Pin retention, exclusive of restoration;

3. Acrylic, plastic, silicate or composite restoration; and

4. Crowns:

a. Stainless steel — primary cuspid and posteriors only;

b. Stainless steel — primary lateral and centrals; and

c. Recement crowns; and

5. Recement inlays and facings.

(e) *Endodontic procedures.* Covered endodontic procedures are:

1. Vital or non-vital pulpotomy — primary teeth only;

2. Root canal therapy — gutta percha or silver points only:

a. Anterior exclusion of final restoration;

b. Bicuspids exclusion of final restoration;

c. Apexification or therapeutic apical closure; and

d. Molar, exclusive of final restoration; and

3. Replantation and splinting of traumatically avulsed tooth.

(f) *Removable prosthodontic procedures.* Covered removable prosthodontic procedures are:

1. Complete upper dentures, including 6 months' postdelivery care;

2. Complete lower dentures, including 6 months' postdelivery care;

3. Relining upper complete denture;

4. Relining lower complete denture; and

5. Repair damaged complete or partial dentures.

(g) *Fixed prosthodontic procedures.* Recement bridge is a covered prosthodontic procedure.

(h) *Periodontic procedures.* Covered periodontic procedures are:

1. Gingivectomy or gingivoplasty; and

2. Gingival curettage for each quadrant.

(i) *Oral surgery procedures.* Covered oral surgery procedures, including anesthetics and routine postoperative care, are:

1. Simple extractions, including sutures;

2. Extraction of impacted teeth under emergency circumstances;

3. Oral antral fistual closure and antral root recovery;

4. Biopsy of oral tissue, hard or soft;

5. Excision of tumors, but not hyperplastic tissue;

6. Removal of cysts and neoplasms, to include local anesthetic and routine postoperative care;

7. Surgical incision:

a. Incision and drainage of abscess whether intraoral or extraoral;

b. Sequestrectomy for osteomyelitis;

care, including review and modification to the plan of care; and plans for discharge.

4. The attending or staff physician and a physician assistant and other personnel involved in the recipient's care shall review the physician's plan of care at least every 60 days for SNF recipients and at least every 90 days for ICF recipients.

(r) *Reports of evaluations and plans of care - ICF and SNF.* A written report of each evaluation and the physician's plan of care shall be made part of the applicant's or recipient's record:

1. At the time of admission; or

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

(s) *Recovery of costs of services.* All medicare-certified SNF facilities shall recover all medicare-allowable costs of services provided to recipients entitled to medicare benefits prior to billing MA. Refusal to recover these costs may result in a fine of not less than $10 nor more than $100 a day, as determined by the department.

(t) *Prospective payment system.* Provisions regarding services and reimbursement contained in this subsection are subject to s. 49.45 (6m), Stats.

(u) *Active treatment.* All developmentally disabled residents of SNF or ICF certified facilities who require active treatment shall receive active treatment subject to the requirements of s. HSS 132.695.

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

1. MA payment to a facility may not exceed the payment which would otherwise be issued for the number of patients corresponding to the facility's patient day cap set by the department. The cap shall equal 365 multiplied by the number of MA-eligible residents on the date that the facility was found to be an IMD or was determined by the department to be at risk of being found to be an IMD, plus the difference between the licensed bed capacity of the facility on the date that the facility agrees to a permanent limitation on its payments and the number of residents on the date that the facility was found to be an IMD or was determined by the department to be at risk of being found to be an IMD. The patient day cap may be increased by the patient days corresponding to the number of residents ineligible for MA at the time of the determination but who later become eligible for MA.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) All schedule III and IV stimulant drugs;

(c) Methaqualone;

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

(e) Decubitex; and

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

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

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

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

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

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

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

1. Digoxin, digitoxin, digitalis;

2. Hydrochlorothiazide and chlorothiazide;

3. Prenatal vitamins;

4. Fluoride;

5. Levothyroxine, liothyronine, thyroid extract;

6. Phenobarbital; and

7. Phenytoin.

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

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

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

1. Antacids;

2. Analgesics;

3. Insulins;

4. Contraceptives;

5. Cough preparations; and

6. Opthalmic lubricants.

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

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

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

(b) Refills of schedule II drugs;

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

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

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

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

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

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

(i) Uneconomically small package sizes;

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

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

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

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

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

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

(b) "Home health aide services" means medically oriented tasks necessitated by the recipient's physical requirements and performed by a home health aide in the recipient's home to enable the physician to treat the recipient as an outpatient.

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

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

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

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

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

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

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

(a) Prescribed range of motion exercises;

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

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

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

(e) Recording fluid intake and output;

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

(g) Catheter care;

(h) Bathing in bed or complete bathing;

(i) Wound care;

(j) Turning and positioning; and

(k) All medically oriented services provided to an ill and bed-bound recipient. In this subdivision, "bed-bound" means that the recipient, due to illness or frailty, is required to remain in bed essentially full time and cannot leave his or her bed without assistance. The illness or frailty encompassed by this definition does not include uncomplicated neurological, neuromuscular or musculoskeletal deficit.

(3) PRIOR AUTHORIZATION REQUIREMENT. Prior authorization is required for:

(a) Initial visits by a registered nurse or practical nurse in excess of 50 visits in a calendar year;

(b) Initial visits by a home health aide in excess of 50 visits in a calendar year;

(c) Therapy visits by a physical therapist, occupational therapist or speech and language pathologist in excess of 50 visits in a calendar year;

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

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

(f) Home health aide services listed in sub. (2) (a) to (j) if performed by a personal care worker employed by a personal care agency which is

not a home health agency and supervised by a registered nurse under s. HSS 107.112. Prior authorization may be granted only for those specific tasks necessary for the care of a recipient able to direct his or her own care and performed by a personal care worker specifically assigned to that recipient, as requested by the personal care worker's supervising registered nurse.

(4) OTHER LIMITATIONS. (a) All durable medical equipment and disposable medical supplies shall meet the requirements of s. HSS 107.24.

(b) Services provided to residents of community-based residential facilities may not exceed the limits of ch. HSS 3.

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

(a) Services provided by a home health agency to a recipient who is able to leave the home without assistance, when the services are available outside the home;

(b) Respite care;

(c) Parenting;

(d) Supervision of a recipient, when supervision is the only service provided at the time;

(e) Services to other members of the recipient's household;

(f) Mental health services and services for alcohol and other drug abuse, for which certification is required under ss. HSS 105.22 and 105.23;

(g) Hospice care as provided under s. HSS 107.31;

(h) More than one initial visit per discipline in a calendar day;

(i) More than 6 hours of subsequent visits by a registered nurse or a practical nurse in a calendar day;

(j) More than 7 hours of subsequent visits by a home health aide in a calendar day;

(k) More than 16 hours of extended visits by a registered nurse or a practical nurse in a calendar day;

(l) Housekeeping tasks exceeding 25% of the home health aide's time in a visit;

(m) Services requiring prior authorization that are provided without prior authorization;

(n) Nursing services contracted by a home health agency; and

(o) Any other service not mentioned in this section.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. Register, April, 1988, No. 388, eff. 7-1-88; am. (3) (d) and (e), cr. (3) (f), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.112 Personal care services. (1) COVERED SERVICES. (a) Personal care services are medically oriented activities related to assisting a recipient with activities of daily living necessary to maintain the recipi-

ent in his or her place of residence in the community. These services shall be provided upon written orders of a physician by a provider certified under s. HSS 105.17 and by a personal care worker employed by the provider or under contract to the provider who is supervised by a registered nurse according to a written plan of care. The personal care worker shall be assigned by the supervising registered nurse to specific recipients to do specific tasks for those recipients for which the personal care worker has been trained. The personal care worker's training for these specific tasks shall be assured by the supervising registered nurse. The personal care worker is limited to performing only those tasks and services as assigned for each recipient and for which he or she has been specifically trained.

(b) Covered personal care services are:

1. Assistance with bathing;

2. Assistance with getting in and out of bed;

3. Teeth, mouth, denture and hair care;

4. Assistance with mobility and ambulation including use of walker, cane or crutches;

5. Changing the recipient's bed and laundering the bed linens and the recipient's personal clothing;

6. Skin care excluding wound care;

7. Care of eyeglasses and hearing aids;

8. Assistance with dressing and undressing;

9. Toileting, including use and care of bedpan, urinal, commode or toilet;

10. Light cleaning in essential areas of the home used during personal care service activities;

11. Meal preparation, food purchasing and meal serving;

12. Simple transfers including bed to chair or wheelchair and reverse; and

13. Accompanying the recipient to obtain medical diagnosis and treatment.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) Prior authorization is required for personal care services in excess of 250 hours per calendar year.

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

(3) OTHER LIMITATIONS. (a) Personal care services shall be performed under the supervision of a registered nurse by a personal care worker who meets the requirements of s. HSS 105.17 (3) and who is employed by or is under contract to a provider certified under s. HSS 105.17.

(b) Services shall be performed according to a written plan of care for the recipient developed by a registered nurse for purposes of providing necessary and appropriate services, allowing appropriate assignment of a personal care worker and setting standards for personal care activities,

giving full consideration to the recipient's preferences for service arrangements and choice of personal care workers. The plan shall be based on the registered nurse's visit to the recipient's home and shall include:

1. Review and interpretation of the physician's orders;

2. Frequency and anticipated duration of service;

3. Evaluation of the recipient's needs and preferences; and

4. Assessment of the recipient's social and physical environment, including family involvement, living conditions, the recipient's level of functioning and any pertinent cultural factors such as language.

(c) Review of the plan of care, evaluation of the recipient's condition and supervisory review of the personal care worker shall be made by a registered nurse at least every 60 days. The review shall include a visit to the recipient's home, review of the personal care worker's daily written record and discussion with the physician of any necessary changes in the plan of care.

(d) Reimbursement for registered nurse supervisory visits is limited to one visit per month.

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

(f) Home health aide services may not include personal care services under sub. (1) (b) unless the recipient is ill and is bed-bound as defined in s. HSS 107.11 (2) (k).

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

(a) Personal care services provided in a hospital or a nursing home or in a community-based residential facility, as defined in s. 50.01 (1), Stats., with more than 20 beds;

(b) Homemaking services and cleaning of areas not used during personal care service activities, unless directly related to the care of the person and essential to the recipient's health;

(c) Personal care services not documented in the plan of care;

(d) Personal care services provided by a responsible relative under s. 49.90, Stats.;

(e) Personal care services provided in excess of 250 hours per calendar year without prior authorization;

(f) Services other than those listed in sub. (1) (b);

(g) Skilled nursing services, including:

1. Insertion and sterile irrigation of catheters;

2. Giving of injections;

3. Application of dressings involving prescription medication and use of aseptic techniques; and

4. Administration of medicine that is not usually self-administered; and

(h) Therapy services.

History: Cr. Register, April, 1988, No. 388, eff. 7-1-88; renum. (2) to be (2) (a), cr. (2) (b), am. (3) (e), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.12 Independent nursing and nurse-midwife services. (1) COVERED SERVICES. (a) Services provided by a certified registered nurse in independent practice which are covered by the MA program are those part-time or intermittent nursing services which comprise the practice of professional nursing as defined in s. 441.11 (4) Stats., when documentation is provided to the department that an existing agency cannot provide the services and when the services are prescribed by a physician.

(b) Certified registered nurses or licensed practical nurses may provide private duty nursing services when the services are prescribed by a physician and if the prescription calls for a level of care which the nurse is licensed to provide.

(c) Covered services provided by certified nurse-midwives may include the care of mothers and their babies throughout the maternity cycle, including pregnancy, labor, normal childbirth and the immediate postpartum period, provided that the nurse-midwife services are provided within the limitations established in s. 441.15 (2), Stats., and ch. N 6.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. Prior authorization shall be required for:

(a) Part-time or intermittent nursing services beyond 20 hours per recipient per calendar year; and

(b) Private duty nursing services beyond 30 hours per recipient per calendar year.

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

(3) OTHER LIMITATIONS. (a) Private duty and part-time or intermittent nursing services provided by a certified nurse in independent practice shall be provided upon a physician's orders as part of a written plan of care which is reviewed by the physician at least every 30 days. The plan of care shall include diagnosis, specific medical orders, specific services required and any other appropriate items. The nurse shall retain the plan of care.

(b)Prior to the provision of part-time or intermittent nursing services, the nurse shall contact the district public health nursing consultant in the area to receive orientation to acceptable clinical and administrative recordkeeping.

(c) Each nurse shall document the care and services provided and shall make that documentation available to the department upon request.

(d) Private duty nursing services shall only be provided when the recipient requires individual and continuous care beyond that available on a part-time or intermittent basis. If a change in level of care is necessary, the recipient's physician shall be notified and an appropriate referral shall be made.

(e) Nurses certified under ch. N 6 and s. HSS 105.20 (3) to provide nurse-midwife services shall end the management and care of the mother and newborn child after the sixth week of postpartum care.

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c. Neurodevelopmental techniques — PNR, Rood, Temple-Fay, Doman-Delacato, Cabot, Bobath;

d. Perceputual training;

e. Sensori-stimulation; and

f. Facilitation techniques;

8. Ambulation training:

a. Gait training with crutch, cane or walker;

b. Gait training for level, incline or stair climbing; and

c. Gait training on parallel bars; and

9. Miscellaneous:

a. Aseptic or sterile procedures;

b. Functional training, also known as activities of daily living — self-care training, transfers and wheelchair independence;

c. Orthotic training;

d. Positioning;

e. Posture training;

f. Preprosthetic training — desensitization;

g. Preprosthetic training — strengthening;

h. Preprosthetic training — wrapping;

i. Prosthetic training;

j. Postural drainage; and

k. Home program.

(e) *Physical therapy aide services.* 1. Services which are reimbursable when performed by a physical therapy aide meeting the requirements of subds. 2 and 3 are the following:

a. Performing simple activities required to prepare a recipient for treatment, assist in the performance of treatment, or assist at the conclusion of treatment, such as assisting the recipient to dress or undress, transferring a recipient to or from a mat, and applying or removing orthopedic devices;

Note: Transportation of the recipient to or from the area in which therapy services are provided is not reimbursable.

b. Assembling and disassembling equipment and accessories in preparation for treatment or after treatment has taken place;

Note: Examples of activities are adjustment of restorator, N.K. table, cybex, weights and weight boots for the patient, and the filling, cleaning and emptying of whirlpools.

c. Assisting with the use of equipment and performing simple modalities once the recipient's program has been established and the recipient's response to the equipment or modality is highly predictable; and

Note: Examples of activies are application of hot or cold packs, application of paraffin, assisting recipient with whirlpool, tilt table, weights and pulleys.

d. Providing protective assistance during exercise, activities of daily living, and ambulation activities related to the development of strength and refinement of activity.

Note: Examples of activities are improving recipient's gait safety and functional distance technique through repetitious gait training and increasing recipient's strength through the use of such techniques as weights, pulleys, and cane exercises.

2. The physical therapy aide shall be trained in a manner appropriate to his or her job duties. The supervising therapist is responsible for the training of the aide or for securing documentation that the aide has been trained by a physical therapist. The supervising therapist is responsible for determining and monitoring the aide's competency to perform assigned duties. The supervising therapist shall document in writing the modalities or activities for which the aide has received training.

3. a. The physical therapy aide shall provide services under the direct, immediate, one-to-one supervision of a physical therapist. In this subdivision, "direct immediate, one-to-one supervision" means one-to-one supervision with face-to-face contact between the physical therapy aide and the supervising therapist during each treatment session, with the physical therapy aide assisting the therapist by providing services under subd. 1. The direct immediate one-to-one supervision requirement does not apply to non-billable physical therapy aide services.

b. The department may exempt a facility providing physical therapy services from the supervision requirement under subpar. a if it determines that direct, immediate one-to-one supervision is not required for specific assignments which physical therapy aides are performing at that facility. If an exemption is granted, the department shall indicate specific physical therapy aide services for which the exemption is granted and shall set a supervision ratio appropriate for those services.

Note: For example, facilities providing significant amounts of hydrotherapy may be eligible for an exemption to the direct, immediate one-to-one supervision requirement for physical therapy aides who fill or clean tubs.

4. Physical therapy aides may not bill or be reimbursed directly for their services.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) *Definition.* In this subsection, "spell of illness" means a condition characterized by a demonstrated loss of functional ability to perform daily living skills, caused by a new disease, injury or medical condition or by an increase in the severity of a pre-existing medical condition. For a condition to be classified as a new spell of illness, the recipient must display the potential to reachieve the skill level that he or she had previously.

(b) *Requirement.* Prior authorization is required under this subsection for physical therapy services provided to an MA recipient in excess of 35 treatment days per spell of illness, except that physical therapy services provided to an MA recipient who is a hospital inpatient or who is receiv-

ing physical therapy services provided by a home health agency are not subject to prior authorization under this subsection.

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

(c) *Conditions justifying spell of illness designation.* The following conditions may justify designation of a new spell of illness:

1. An acute onset of a new disease, injury or condition such as:

a. Neuromuscular dysfunction, including stroke-hemiparesis, multiple sclerosis, Parkinson's disease and diabetic neuropathy;

b. Musculoskeletal dysfunction, including fracture, amputation, strains and sprains, and complications associated with surgical procedures; or

c. Problems and complications associated with physiologic dysfunction, including severe pain, vascular conditions, and cardio-pulmonary conditions.

2. An exacerbation of a pre-existing condition, including but not limited to the following, which requires physical therapy intervention on an intensive basis:

a. Multiple sclerosis;

b. Rheumatoid arthritis; or

c. Parkinson's disease.

3. A regression in the recipient's condition due to lack of physical therapy, as indicated by a decrease of functional ability, strength, mobility or motion.

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

(e) *Documentation.* The physical therapist shall document the spell of illness in the patient plan of care, including measurable evidence that the recipient has incurred a demonstrated functional loss of ability to perform daily living skills.

(f) *Non-transferability of treatment days.* Unused treatment days from one spell of illness may not be carried over into a new spell of illness.

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

(h) *Department expertise.* The department may have on its staff qualified physical therapists to develop prior authorization criteria and perform other consultative activities.

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

(3) OTHER LIMITATIONS. (a) *Plan of care for therapy services.* Services shall be furnished to a recipient under a plan of care established and periodically reviewed by a physician. The plan shall be reduced to writing before treatment is begun, either by the physician who makes the plan available to the provider or by the provider of therapy when the provider makes a written record of the physician's oral orders. The plan shall be promptly signed by the ordering physician and incorporated into the provider's permanent record for the recipient. The plan shall:

1. State the type, amount, frequency and duration of the therapy services that are to be furnished the recipient and shall indicate the diagnosis and anticipated goals. Any changes shall be made in writing and signed by the physician, the provider of therapy services or the physician on the staff of the provider pursuant to the attending physician's oral orders; and

2. Be reviewed by the attending physician in consultation with the therapist providing services, at whatever intervals the severity of the recipient's condition requires, but at least every 90 days. Each review of the plan shall be indicated on the plan by the initials of the physician and the date performed. The plan for the recipient shall be retained in the provider's file.

(b) *Restorative therapy services.* Restorative therapy services shall be covered services, except as provided in sub. (4) (b).

(c) *Maintenance therapy services.* Preventive or maintenance therapy services shall be covered services only when one of the following conditions are met:

1. The skills and training of a therapist are required to execute the entire preventive and maintenance program;

2. The specialized knowledge and judgment of a physical therapist are required to establish and monitor the therapy program, including the initial evaluation, the design of the program appropriate to the individual recipient, the instruction of nursing personnel, family or recipient, and the necessary re-evaluations; or

3. When, due to the severity or complexity of the recipient's condition, nursing personnel cannot handle the recipient safely and effectively.

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

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

1. The recipient has shown no progress toward meeting or maintaining established and measurable treatment goals over a 6-month period, or the recipient has shown no ability within 6 months to carry over abilities gained from treatment in a facility to the recipient's home;

2. The recipient's chronological or developmental age, way of life or home situation indicates that the stated therapy goals are not appropriate for the recipient or serve no functional or maintenance purpose;

3. The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel;

4. The evaluation indicates that the recipient's abilities are functional for the person's present way of life;

5. The recipient shows no motivation, interest, or desire to participate in therapy, which may be for reasons of an overriding severe emotional disturbance;

6. Other therapies are providing sufficient services to meet the recipient's functioning needs; or

7. The procedures requested are not medical in nature or are not covered services. Inappropriate diagnoses for therapy services and procedures of questionable medical necessity may not receive departmental authorization, depending upon the individual circumstances.

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

(a) Services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation;

(b) Those services that can be performed by restorative nursing, as under s. HSS 132.60 (1) (b) through (d);

(c) Activities such as end-of-the-day clean-up time, transportation time, consultations and required paper reports. These are considered components of the provider's overhead costs and are not covered as separately reimbursable items;

(d) Group physical therapy services; and

(e) When performed by a physical therapy aide, interpretation of physician referrals, patient evaluation, evaluation of procedures, initiation or adjustment of treatment, assumption of responsibility for planning patient care, or making entries in patient records.

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

History: Cr. Register, February, 1986, No 362, eff. 3-1-86; emerg. am. (2) (b), (d), (g), (3) (d) and (e) (intro.), eff. 7-1-88; am. (2) (b), (d), (g), (3) (d) and (e) (intro.), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.17 Occupational therapy. (1) COVERED SERVICES. Covered occupational therapy services are the following medically necessary services when prescribed by a physician and performed by a certified occupational therapist (OT) or by a certified occupational therapist assistant (COTA) under the direct, immediate, on-premises supervision of a certified occupational therapist or, for services under par. (d), by a certified occupational therapist assistant under the general supervision of a certified occupational therapist pursuant to the requirements of s. HSS 105.28 (2):

(a) Motor skills, as follows:

1. Range-of-motion;

2. Gross/fine coordination;

3. Strengthening;

4. Endurance/tolerance; and

5. Balance;

(b) Sensory integrative skills, as follows:

1. Reflex/sensory status;

2. Body concept;

3. Visual-spatial relationships;

4. Posture and body integration; and

5. Sensorimotor integration;

(c) Cognitive skills, as follows:

1. Orientation;

2. Attention span;

3. Problem-solving;

4. Conceptualization; and

5. Integration of learning;

(d) Activities of daily living skills, as follows:

1. Self-care;

2. Work skills; and

3. Avocational skills;

(e) Social interpersonal skills, as follows:

1. Dyadic interaction skills; and

2. Group interaction skills;

(f) Psychological intrapersonal skills, as follows:

1. Self-identity and self-concept;

2. Coping skills; and

3. Independent living skills;

(g) Preventive skills, as follows:

1. Energy conservation;

2. Joint protection;

3. Edema control; and

4. Positioning;

(h) Therapeutic adaptions, as follows:

1. Orthotics/splinting;

2. Prosthetics;

3. Assistive/adaptive equipment; and

4. Environmental adaptations;

(i) Environmental planning; and

(j) Evaluations or re-evaluations. Covered evaluations, the results of which shall be set out in a written report attached to the test chart or form in the recipient's medical record, are the following:

1. Motor skills:

a. Range-of-motion;

b. Gross muscle test;

c. Manual muscle test;

d. Coordination evaluation;

e. Nine hole peg test;

f. Purdue pegboard test;

g. Strength evaluation;

h. Head-trunk balance evaluation;

i. Standing balance — endurance;

j. Sitting balance — endurance;

k. Prosthetic check-out;

l. Hemiplegic evaluation;

m. Arthritis evaluation; and

n. Hand evaluation — strength and range-of-motion;

2. Sensory integrative skills:

a. Beery test of visual motor integration;

b. Southern California kinesthesia and tactile perception test;

c. A. Milloni-Comparetti developmental scale;

d. Gesell developmental scale;

e. Southern California perceptual motor test battery;

f. Marianne Frostig developmental test of visual perception;

g. Reflex testing;

h. Ayres space test;

i. Sensory evaluation;

j. Denver developmental test;

k. Perceptual motor evaluation; and

l. Visual field evaluation;

3. Cognitive skills:

a. Reality orientation assessment; and

b. Level of cognition evaluation;

4. Activities of daily living skills:

a. Bennet hand tool evaluation;

b. Crawford small parts dexterity test;

c. Avocational interest and skill battery;

d. Minnesota rate of manipulation; and

e. ADL evaluation – men and women;

5. Social interpersonal skills — evaluation of response in group;

6. Psychological intrapersonal skills:

a. Subjective assessment of current emotional status;

b. Azima diagnostic battery; and

c. Goodenough draw-a-man test;

7. Therapeutic adaptions; and

8. Environmental planning — environmental evaluation.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) *Definition.* In this subsection, "spell of illness" means a condition characterized by a demonstrated loss of functional ability to perform daily living skills, caused by a new disease, injury or medical condition or by an increase in the severity of a pre-existing medical condition. For a condition to be classified as a new spell of illness, the recipient must display the potential to reachieve the skill level that he or she had previously.

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

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

(c) *Conditions justifying spell of illness designation.* The following conditions may justify designation of a new spell of illness:

1. An acute onset of a new disease, injury or condition such as:

a. Neuromuscular dysfunction, including stroke-hemiparesis, multiple sclerosis, Parkinson's disease and diabetic neuropathy;

b. Musculoskeletal dysfunction, including fracture, amputation, strains and sprains, and complications associated with surgical procedures;

c. Problems and complications associated with physiologic dysfunction, including severe pain, vascular conditions, and cardio-pulmonary conditions; or

d. Psychological dysfunction, including thought disorders, organic conditions and affective disorders;

2. An exacerbation of a pre-existing condition including but not limited to the following, which requires occupational therapy intervention on an intensive basis:

a. Multiple sclerosis;

b. Rheumatoid arthritis;

c. Parkinson's disease; or

d. Schizophrenia; or

3. A regression in the recipient's condition due to lack of occupational therapy, as indicated by a decrease of functional ability, strength, mobility or motion.

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

(e) *Documentation.* The occupational therapist shall document the spell of illness in the patient plan of care, including measurable evidence that the recipient has incurred a demonstrated functional loss of ability to perform daily living skills.

(f) *Non-transferability of treatment days.* Unused treatment days from one spell of illness may not be carried over into a new spell of illness.

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

(h) *Department expertise.* The department may have on its staff qualified occupational therapists to develop prior authorization criteria and perform other consultative activities.

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

(3) OTHER LIMITATIONS. (a) *Plan of care for therapy services.* Services shall be furnished to a recipient under a plan of care established and periodically reviewed by a physician. The plan shall be reduced to writing before treatment is begun, either by the physician who makes the plan available to the provider or by the provider of therapy when the provider makes a written record of the physician's oral orders. The plan shall be promptly signed by the ordering physician and incorporated into the provider's permanent record for the recipient. The plan shall:

1. State the type, amount, frequency, and duration of the therapy services that are to be furnished the recipient and shall indicate the diagnosis and anticipated goals. Any changes shall be made in writing and

signed by the physician, the provider of therapy services or the physician on the staff of the provider pursuant to the attending physician's oral orders; and

2. Be reviewed by the attending physician in consultation with the therapist providing services, at whatever intervals the severity of the recipient's condition requires, but at least every 90 days. Each review of the plan shall be indicated on the plan by the initials of the physician and the date performed. The plan for the recipient shall be retained in the provider's file.

(b) *Restorative therapy services.* Restorative therapy services shall be covered services except as provided under sub. (4) (b).

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

(d) *Maintenance therapy services.* Preventive or maintenance therapy services shall be covered services only when one or more of the following conditions are met:

1. The skills and training of a therapist are required to execute the entire preventive and maintenance program;

2. The specialized knowledge and judgment of an occupational therapist are required to establish and monitor the therapy program, including the initial evaluation, the design of the program appropriate to the individual recipient, the instruction of nursing personnel, family or recipient, and the re-evaluations required; or

3. When, due to the severity or complexity of the recipient's condition, nursing personnel cannot handle the recipient safely and effectively.

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

1. The recipient has shown no progress toward meeting or maintaining established and measurable treatment goals over a 6-month period, or the recipient has shown no ability within 6 months to carry over abilities gained from treatment in a facility to the recipient's home;

2. The recipient's chronological or developmental age, way of life or home situation indicates that the stated therapy goals are not appropriate for the recipient or serve no functional or maintenance purpose;

3. The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel;

4. The evaluation indicates that the recipient's abilities are functional for the person's present way of life;

5. The recipient shows no motivation, interest, or desire to participate in therapy, which may be for reasons of an overriding severe emotional disturbance;

6. Other therapies are providing sufficient services to meet the recipient's functioning needs; or

7. The procedures requested are not medical in nature or are not covered services. Inappropriate diagnoses for therapy services and procedures of questionable medical necessity may not receive departmental authorization, depending upon the individual circumstances.

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

(a) Services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation;

(b) Services that can be performed by restorative nursing, as under s. HSS 132.60 (1) (b) to (d);

(c) Crafts and other supplies used in occupational therapy services for inpatients in an institutional program. These are not billable by the therapist; and

(d) Activities such as end-of-the-day clean-up time, transportation time, consultations and required paper reports. These are considered components of the provider's overhead costs and are not covered as separately reimbursable items.

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; emerg. am. (2) (b), (d), (g), (3) (c) and (e) (intro.), eff. 7-1-88; am. (2) (b) (d), (g) (3) (c) and (e) (intro.), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.18 Speech and language pathology services. (1) COVERED SERVICES. (a) *General.* Covered speech and language pathology services are those medically necessary diagnostic, screening, preventive or corrective speech and language pathology services prescribed by a physician and provided by a certified speech and language pathologist or under the direct, immediate on-premises supervision of a certified speech and language pathologist.

(b) *Evaluation procedures.* Evaluation or re-evaluation procedures shall be performed by certified speech and language pathologists. Tests and measurements that speech and language pathologists may perform include the following:

1. Expressive language:

a. Aphasia evaluation (examples of tests are Eisenson, PICA, Schuell);

b. Articulation evaluation (examples of tests are Arizona articulation, proficiency scale, Goldman-Fristoe test of articulation, Templin-Darley screening and diagnostic tests of articulation);

c. Cognitive assessment (examples are tests of classification, conservation, Piagetian concepts);

d. Language concept evaluation (examples are tests of temporal, spatial, and quantity concepts, environmental concepts, and the language of direction);

e. Morphological evaluation (examples are the Miller-Yoder test and the Michigan inventory);

f. Question evaluation — yes-no, is-are, where, who, why, how and when;

g. Stuttering evaluation;

h. Syntax evaluation;

i. Vocabulary evaluation;

j. Voice evaluation;

k. Zimmerman pre-school language scale; and

l. Illinois test of psycholinguistic abilities;

2. Receptive language:

a. ACLC or assessment of children's language comprehension;

b. Aphasia evaluation (examples of tests are Eisenson, PICA, Schuell);

c. Auditory discrimination evaluation (examples are the Goldman-Fristoe-Woodcock test of auditory discrimination and the Wepman test of auditory discrimination);

d. Auditory memory (an example is Spencer-MacGrady memory for sentences test);

e. Auditory processing evaluation;

f. Cognitive assessment (examples are tests of one-to-one correspondence, and seriation classification conservation);

g. Language concept evaluation (an example is the Boehm test of basic concepts);

h. Morphological evaluation (examples are Bellugi-Klima grammatical comprehension tests, Michigan inventory, Miller-Yoder test);

i. Question evaluation;

j. Syntax evaluation;

k. Visual discrimination evaluation;

l. Visual memory evaluation;

m. Visual sequencing evaluation;

n. Visual processing evaluation;

o. Vocabulary evaluation (an example is the Peabody picture vocabulary test);

p. Zimmerman pre-school language scale; and

q. Illinois test of psycholinguistic abilities;

3. Pre-school speech skills:

a. Diadochokinetic rate evaluation; and

b. Oral peripheral evaluation; and

4. Hearing-auditory training:

a. Auditory screening;

b. Informal hearing evaluation;

c. Lip-reading evaluation;

d. Auditory training evaluation;

e. Hearing-aid orientation evaluation; and

f. Non-verbal evaluation.

(c) *Speech procedure treatments.* The following speech procedure treatments shall be performed by a certified speech and language pathologist or under the direct, immediate, on-premises supervision of a certified speech and language pathologist:

1. Expressive language:

a. Articulation;

b. Fluency;

c. Voice;

d. Language structure, including phonology, morphology, and syntax;

e. Language content, including range of abstraction in meanings and cognitive skills; and

f. Language functions, including verbal, non-verbal and written communication;

2. Receptive language:

a. Auditory processing — attention span, acuity or perception, recognition, discrimination, memory, sequencing and comprehension; and

b. Visual processing — attention span, acuity or perception, recognition, discrimination, memory, sequencing and comprehension;

3. Pre-speech skills:

a. Oral and peri-oral structure;

b. Vegetative function of the oral motor skills; and

c. Volitional oral motor skills; and

4. Hearing/auditory training:

a. Hearing screening and referral;

b. Auditory training;

c. Lip reading;

d. Hearing aid orientation; and

e. Non-verbal communication.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) *Definition.* In this subsection, "spell of illness" means a condition characterized by a demonstrated loss of functional ability to perform daily living skills, caused by a new disease, injury or medical condition or by an increase in the

severity of a pre-existing medical condition. For a condition to be classified as a new spell of illness, the recipient must display the potential to reachieve the skill level that he or she had previously.

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

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

(c) *Conditions justifying spell of illness designation.* The following conditions may justify designation of a new spell of illness:

1. An acute onset of a new disease, injury or condition such as:

a. Neuromuscular dysfunction, including stroke-hemiparesis, multiple sclerosis, Parkinson's disease and diabetic neuropathy;

b. Musculoskeletal dysfunction, including fracture, amputation, strains and sprains, and complications associated with surgical procedures; or

c. Problems and complications associated with physiologic dysfunction, including severe pain, vascular conditions, and cardio-pulmonary conditions;

2. An exacerbation of a pre-existing condition including but not limited to the following, which requires speech therapy intervention on an intensive basis:

a. Multiple sclerosis;

b. Rheumatoid arthritis; or

c. Parkinson's disease; or

3. A regression in the recipient's condition due to lack of speech therapy, as indicated by a decrease of functional ability, strength, mobility or motion.

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

(e) *Documentation.* The speech and language pathologist shall document the spell of illness in the patient plan of care, including measurable evidence that the recipient has incurred a demonstrated functional loss of ability to perform daily living skills.

(f) *Non-transferability of treatment days.* Unused treatment days from one spell of illness shall not be carried over into a new spell of illness.

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

(h) *Department expertise.* The department may have on its staff qualified speech and language pathologists to develop prior authorization criteria and perform other consultative activities.

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

(3) OTHER LIMITATIONS. (a) *Plan of care for therapy services.* Services shall be furnished to a recipient under a plan of care established and periodically reviewed by a physician. The plan shall be reduced to writing before treatment is begun, either by the physician who makes the plan available to the provider or by the provider of therapy when the provider makes a written record of the physician's oral orders. The plan shall be promptly signed by the ordering physician and incorporated into the provider's permanent record for the recipient. The plan shall:

1. State the type, amount, frequency, and duration of the therapy services that are to be furnished the recipient and shall indicate the diagnosis and anticipated goals. Any changes shall be made in writing and signed by the physician or by the provider of therapy services or physician on the staff of the provider pursuant to the attending physician's oral orders; and

2. Be reviewed by the attending physician, in consultation with the therapist providing services, at whatever intervals the severity of the recipient's condition requires but at least every 90 days. Each review of the plan shall contain the initials of the physician and the date performed. The plan for the recipient shall be retained in the provider's file.

(b) *Restorative therapy services.* Restorative therapy services shall be covered services except as provided under sub. (4) (b).

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

(d) *Maintenance therapy services.* Preventive or maintenance therapy services shall be covered services only when one or more of the following conditions are met:

1. The skills and training of a therapist are required to execute the entire preventive and maintenance program;

2. The specialized knowledge and judgment of a speech therapist are required to establish and monitor the therapy program, including the initial evaluation, the design of the program appropriate to the individual recipient, the instruction of nursing personnel, family or recipient, and the re-evaluations required; or

3. When, due to the severity or complexity of the recipient's condition, nursing personnel cannot handle the recipient safely and effectively.

(e) *Extension of therapy services.* Extension of therapy services shall not be approved in any of the following circumstances:

1. The recipient has shown no progress toward meeting or maintaining established and measurable treatment goals over a 6-month period, or the recipient has shown no ability within 6 months to carry over abilities gained from treatment in a facility to the recipient's home;

2. The recipient's chronological or developmental age, way of life or home situation indicates that the stated therapy goals are not appropriate for the recipient or serve no functional or maintenance purpose;

3. The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel;

4. The evaluation indicates that the recipient's abilities are functional for the person's present way of life;

5. The recipient shows no motivation, interest, or desire to participate in therapy, which may be for reasons of an overriding severe emotional disturbance;

6. Other therapies are providing sufficient services to meet the recipient's functioning needs; or

7. The procedures requested are not medical in nature or are not covered services. Inappropriate diagnoses for therapy services and procedures of questionable medical necessity may not receive departmental authorization, depending upon the individual circumstances.

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

(a) Services which are of questionable therapeutic value in a program of speech and language pathology. For example, charges by speech and language pathology providers for "language development — facial physical," "voice therapy — facial physical" or "appropriate outlets for reducing stress";

(b) Those services that can be performed by restorative nursing, as under s. HSS 132.60 (1) (b) to (d); and

(c) Activities such as end-of-the-day clean-up time, transportation time, consultations and required paper reports. These are considered components of the provider's overhead costs and are not covered as separately reimbursable items.

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

History: Cr Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (a), (b) (intro.), (c) (intro.) (2) (b), (d), (e), (h) and (4) (a), Register, February 1988, No. 386, eff. 3-1-88; emerg. am. (2) (b), (d), (g) and (3) (c), eff. 7-1-88; am. (2) (b), (d), (g), and (3) (c), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.19 Audiology services. (1) COVERED SERVICES. Covered audiology services are those medically necessary diagnostic, screening, preventive or corrective audiology services prescribed by a physician and provided by an audiologist certified pursuant to s. HSS 105.31. These services include:

(a) Audiological evaluation;

(b) Hearing aid evaluation;

(c) Hearing aid performance check;

(d) Audiological tests;

(e) Audiometric techniques;

(f) Impedance audiometry;

(g) Aural rehabilitation; and

(h) Speech and audiotherapy.

(2) PRIOR AUTHORIZATION. (a) *Services requiring prior authorization.* The following covered services require prior authorization from the department:

1. Speech and audiotherapy;

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(b) A surgical procedure under sub. (1) (a) which requires a second surgical opinion, as specified in s. HSS 104.04, is a covered service only when the requirements specified by the department and published in the MA provider handbook are followed.

(c) Reimbursement for ambulatory surgical center services shall include but is not limited to:

1. Nursing, technician, and related services;

2. Use of ambulatory surgical center facilities;

3. Drugs, biologicals, surgical dressings, supplies, splints, casts and appliances, and equipment directly related to the provision of a surgical procedure;

4. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

5. Administrative, recordkeeping and housekeeping items and services; and

6. Materials for anesthesia.

(4) NON-COVERED SERVICES. Ambulatory surgical center services and items for which payment may be made under other provisions of this chapter are not covered services. These include:

1. Physician services;

2. Laboratory services;

3. X-ray and other diagnostic procedures, except those directly related to performance of the surgical procedure;

4. Prosthetic devices;

5. Ambulance services;

6. Leg, arm, back and neck braces;

7. Artificial limbs; and

8. Durable medical equipment for use in the recipient's home.

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

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

HSS 107.31 Hospice care services. (1) DEFINITIONS. (a) "Attending physician" means a physician who is a doctor of medicine or osteopathy certified under s. HSS 105.05 and identified by the recipient as having the most significant role in the determination and delivery of his or her medical care at the time the recipient elects to receive hospice care.

(b) "Bereavement counseling" means counseling services provided to the recipient's family following the recipient's death.

(c) "Freestanding hospice" means a hospice that is not a physical part of any other type of certified provider.

(d) "Interdisciplinary group" means a group of persons designated by a hospice to provide or supervise care and services and made up of at

least a physician, a registered nurse, a medical worker and a pastoral counselor or other counselor, all of whom are employes of the hospice.

(e) "Medical director" means a physician who is an employe of the hospice and is responsible for the medical component of the hospice's patient care program.

(f) "Respite care" means services provided by a residential facility that is an alternate place for a terminally ill recipient to stay to temporarily relieve persons caring for the recipient in the recipient's home or caregiver's home from that care.

(g) "Supportive care" means services provided to the family and other individuals caring for a terminally ill person to meet their psychological, social and spiritual needs during the final stages of the terminal illness, and during dying and bereavement, including personal adjustment counseling, financial counseling, respite care and bereavement counseling and follow-up.

(h) "Terminally ill" means that the medical prognosis for the recipient is that he or she is likely to remain alive for no more than 6 months.

(2) COVERED SERVICES. (a) *General.* Hospice services covered by the MA program effective July 1, 1988 are, except as otherwise limited in this chapter, those services provided to an eligible recipient by a provider certified under s. HSS 105.50 which are necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided to the family and other individuals caring for the terminally ill recipient.

(b) *Conditions for coverage.* Conditions for coverage of hospice services are:

1. Written certification by the hospice medical director, the physician member of the interdisciplinary team or the recipient's attending physician that the recipient is terminally ill;

2. An election statement shall be filed with the hospice by a recipient who has been certified as terminally ill under subd. 1 and who elects to receive hospice care. The election statement shall designate the effective date of the election. A recipient who files an election statement waives any MA covered services pertaining to his or her terminal illness and related conditions otherwise provided under this chapter, except those services provided by an attending physician not employed by the hospice. However, the recipient may revoke the election of hospice care at any time and thereby have all MA services reinstated. A recipient may choose to reinstate hospice care services subsequent to revocation. In that event, the requirements of this section again apply;

3. A written plan of care shall be established by the attending physician, the medical director or physician designee and the interdisciplinary team for a recipient who elects to receive hospice service prior to care being provided. The plan shall include:

a. An assessment of the needs of the recipient;

b. The identification of services to be provided, including management of discomfort and symptom relief;

c. A description of the scope and frequency of services to the recipient and the recipient's family; and

d. A schedule for periodic review and updating of the plan; and

4. A statement of informed consent. The hospice shall obtain the written consent of the recipient or recipient's representative for hospice care on a consent form signed by the recipient or recipient's representative that indicates that the recipient is informed about the type of care and services that may be provided to him or her by the hospice during the course of illness and the effect of the recipient's waiver of regular MA benefits.

(c) *Core services.* The following services are core services which shall be provided directly by hospice employes unless the conditions of sub. (3) apply:

1. Nursing care by or under the supervision of a registered nurse;

2. Physician services;

3. Medical social services provided by a social worker under the direction of a physician. The social worker shall have at least a bachelor's degree in social work from a college or university accredited by the council of social work education; and

4. Counseling services, including but not limited to bereavement counseling, dietary counseling and spiritual counseling.

(d) *Other services.* Other services which shall be provided as necessary are:

1. Physical therapy;

2. Occupational therapy;

3. Speech pathology;

4. Home health aide and homemaker services;

5. Durable medical equipment and supplies;

6. Drugs; and

7. Short-term inpatient care for pain control, symptom management and respite purposes.

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

2. Inpatient care for respite purposes shall be provided by a facility under subd. 1 or by an intermediate care facility which meets the additional certification requirements regarding staffing, patient areas and 24 hour nursing service for skilled nursing facilities under subd. 1. An inpatient stay for respite care may not exceed 5 consecutive days at a time.

3. The aggregate number of inpatient days may not exceed 20% of the aggregate total number of hospice care days provided to all MA recipients enrolled in the hospice during the period beginning November 1 of

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

(b) *Care during periods of crisis.* Care may be provided 24 hours a day during a period of crisis as long as the care is predominately nursing care provided by a registered nurse. Other care may be provided by a home health aide or homemaker during this period. "Period of crisis" means a period during which an individual requires continuous care to achieve palliation or management of acute medical symptoms.

(c) *Sub-contracting for services.* 1. Services required under sub. (2) (c) shall be provided directly by the hospice unless an emergency or extraordinary circumstance exists.

2. A hospice may contract for services required under sub. (2) (d). The contract shall include identification of services to be provided, the qualifications of the contractor's personnel, the role and responsibility of each party and a stipulation that all services provided will be in accordance with applicable state and federal statutes, rules and regulations and will conform to accepted standards of professional practice.

3. When a resident of a skilled nursing facility or an intermediate care facility elects to receive hospice care services, the hospice shall contract with that facility to provide the recipient's room and board. Room and board includes assistance in activities of daily living and personal care, socializing activities, administration of medications, maintaining cleanliness of the recipient's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

(d) *Reimbursement for services.* 1. The hospice shall be reimbursed for care of a recipient at per diem rates set by the federal health care financing administration (HCFA).

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

3. The hospice shall reimburse any provider with whom it has contracted for service, including a facility providing inpatient care under par. (a).

4. Skilled nursing facilities and intermediate care facilities providing room and board for residents who have elected to receive hospice care services shall be reimbursed for that room and board by the hospice.

5. Bereavement counseling and services and expenses of hospice volunteers are not reimbursable under MA.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88; emerg. am. (2) (a) and (3) (d) 1., r. and recr. (3) (a) 3., renum. (3) (d) 2. to 4. to be 3. to 5. and cr. (3) (d) 2., eff. 7-1-88; am. (2) (a), (3) (a) 1. and (d) 1., r. and recr. (3) (a) 3., renum. (3) (d) 2 to 4. to be 3. to 5. and cr. (3) (d) 2., Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.32 Case management services. (1) COVERED SERVICES. (a) *General.* 1. Case management services covered by MA are services de-

scribed in this section and provided by an agency certified under s. HSS 105.51 or by a qualified person under contract to an agency certified under s. HSS 105.51 to help a recipient, and, when appropriate, the recipient's family gain access to, coordinate or monitor necessary medical, social, educational, vocational and other services.

2. Case management services under pars. (b) and (c) are provided under s. 49.45 (25), Stats., as benefits to those recipients in a county in which case management services are provided who are over age 64, are diagnosed as having Alzheimer's disease or other dementia, or are members of one or more of the following target populations: developmentally disabled, chronically mentally ill who are age 21 or older, alcoholic or drug dependent, physically or sensory disabled, or under the age of 21 and severely emotionally disturbed. In this subdivision, "severely emotionally disturbed" means having emotional and behavioral problems which:

a. Are expected to persist for at least one year;

b. Have significantly impaired the person's functioning for 6 months or more and, without treatment, are likely to continue for a year or more. Areas of functioning include: developmentally appropriate self-care; ability to build or maintain satisfactory relationships with peers and adults; self-direction, including behavioral controls, decisionmaking, judgment and value systems; capacity to live in a family or family equivalent; and learning ability, or meeting the definition of "child with exceptional educational needs" under ch. PI 1 and 115.76 (3), Stats.;

c. Require the person to receive services from 2 or more of the following service systems: mental health, social services, child protective services, juvenile justice and special education; and

d. Include mental or emotional disturbances diagnosable under DSM-III-R. Adult diagnostic categories appropriate for children and adolescents are organic mental disorders, psychoactive substance use disorders, schizophrenia, mood disorders, schizophreniform disorders, somatoform disorders, sexual disorders, adjustment disorder, personality disorders and psychological factors affecting physical condition. Disorders usually first evident in infancy, childhood and adolescence include pervasive developmental disorders (Axis II), conduct disorder, anxiety disorders of childhood or adolescence and tic disorders.

Note: DSM-111-R is the 1987 revision of the 3rd edition (1980) of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

3. Case management services under par. (d) are available as benefits to a recipient identified in subd. 2 if:

a. The recipient is eligible for and receiving services in addition to case management from an agency or through medical assistance which enable the recipient to live in a community setting; and

b. The agency has a completed case plan on file for the recipient.

4. The standards specified in s. 46.27, Stats., for assessments, case planning and ongoing monitoring and service coordination shall apply to all covered case management services.

(b) *Case assessment.* A comprehensive assessment of a recipient's abilities, deficits and needs is a covered case management service. The assess-

ment shall be made by a qualified employe of the certified case management agency or by a qualified employe of an agency under contract to the case management agency. The assessment shall be completed in writing and shall include face-to-face contact with the recipient. Persons performing assessments shall possess skills and knowledge of the needs and dysfunctions of the specific target population in which the recipient is included. Persons from other relevant disciplines shall be included when results of the assessment are interpreted. The assessment shall document gaps in service and the recipient's unmet needs, to enable the case management provider to act as an advocate for the recipient and assist other human service providers in planning and program development on the recipient's behalf. All services which are appropriate to the recipient's needs shall be identified in the assessment, regardless of availability or accessibility of providers or their ability to provide the needed service. The written assessment of a recipient shall include:

1. Identifying information;

2. A record of any physical or dental health assessments and consideration of any potential for rehabilitation;

3. A record of the multi-disciplinary team evaluation required for a recipient who is a severely emotionally disturbed child under s. 49.45 (25), Stats.;

4. A review of the recipient's performance in carrying out activities of daily living, including moving about, caring for self, doing household chores and conducting personal business, and the amount of assistance required;

5. Social status and skills;

6. Psychiatric symptomatology, and mental and emotional status;

7. Identification of social relationships and support, as follows:

a. Informal caregivers, such as family, friends and volunteers; and

b. Formal service providers;

8. Significant issues in the recipient's relationships and social environment;

9. A description of the recipient's physical environment, especially in regard to safety and mobility in the home and accessibility;

10. The recipient's need for housing, residential support, adaptive equipment and assistance with decision-making;

11. An in-depth financial resource analysis, including identification of insurance, veterans' benefits and other sources of financial and similar assistance;

12. If appropriate, vocational and educational status, including prognosis for employment, rehabilitation, educational and vocational needs, and the availability and appropriateness of educational, rehabilitation and vocational programs;

13. If appropriate, legal status, including whether there is a guardian and any other involvement with the legal system;

14. Accessibility to community resources which the recipient needs or wants; and

15. Assessment of drug and alcohol use and misuse, for AODA target population recipients.

(c) *Case planning.* Following the assessment with its determination of need for case management services, a written plan of care shall be developed to address the needs of the recipient. Development of the written plan of care is a covered case management service. To the maximum extent possible, the development of a care plan shall be a collaborative process involving the recipient, the family or other supportive persons and the case management provider. The plan of care shall be a negotiated agreement on the short and long term goals of care and shall include:

1. Problems identified during the assessment;

2. Goals to be achieved;

3. Identification of all formal services to be arranged for the recipient and their costs and the names of the service providers;

4. Development of a support system, including a description of the recipient's informal support system;

5. Identification of individuals who participated in development of the plan of care;

6. Schedules of initiation and frequency of the various services to be made available to the recipient; and

7. Documentation of unmet needs and gaps in service.

(d) *Ongoing monitoring and service coordination.* Ongoing monitoring of services and service coordination are covered case management services when performed by a single and identifiable employe of the agency or person under contract to the agency who meets the requirements under s. HSS 105.51 (2) (b). This person, the case manager, shall monitor services to ensure that quality service is being provided and shall evaluate whether a particular service is effectively meeting the client's needs. Where possible, the case manager shall periodically observe the actual delivery of services and periodically have the recipient evaluate the quality, relevancy and desirability of the services he or she is receiving. The case manager shall record all monitoring and quality assurance activities and place the original copies of these records in the recipient's file. Ongoing monitoring of services and service coordination include:

1. Face to face and phone contacts with recipients for the purpose of assessing or reassessing their needs or planning or monitoring services. Included in this activity are travel time to see a recipient and other allowable overhead costs that must be incurred to provide the service;

2. Face to face and phone contact with collaterals for the purposes of mobilizing services and support, advocating on behalf of a specific eligible recipient, educating collaterals on client needs and the goals and services specified in the plan, and coordinating services specified in the plan. In this paragraph, "collateral" means anyone involved with the recipient, including a paid provider, a family member, a guardian, a housemate, a school representative, a friend or a volunteer. Collateral contacts also include case management staff time spent on case-specific staffings

and formal case consultation with a unit supervisor and other professionals regarding the needs of a specific recipient. All contacts with collaterals shall be documented and may include travel time and other allowable overhead costs that must be incurred to provide the service; and

3. Recordkeeping necessary for case planning, service implementation, coordination and monitoring. This includes preparing court reports, updating case plans, making notes about case activity in the client file, preparing and responding to correspondence with clients and collaterals, gathering data and preparing application forms for community programs, and reports. All time spent on recordkeeping activities shall be documented in the case record. A provider, however, may not bill for recordkeeping activities if there was no client or collateral contact during the billable month.

(2) OTHER LIMITATIONS. (a) Reimbursement for assessment and case plan development shall be limited to no more than one each for a recipient in a calendar year unless the recipient's county of residence has changed, in which case a second assessment or case plan may be reimbursed.

(b) Reimbursement for ongoing monitoring and service coordination shall be limited to one claim for each recipient by county per month and shall be only for the services of the recipient's designated case manager.

(c) Ongoing monitoring or service coordination is not available to recipients residing in hospitals, intermediate care or skilled nursing facilities. In these facilities, case management is expected to be provided as part of that facility's reimbursement.

(d) Case management services are not reimbursable when rendered to a recipient who, on the date of service, is enrolled in a health maintenance organization under s. HSS 107.28.

(e) Persons who require institutional care and who receive services beyond those available under the MA state plan but which are funded by MA under a federal waiver are ineligible for case management services under this section. Case management services for these persons shall be reimbursed as part of the regular per diem available under federal waivers and included as part of the waiver fiscal report.

(f) A recipient receiving case management services, or the recipient's parents, if the recipient is a minor child, or guardian, if the recipient has been judged incompetent by a court, may choose a case manager to perform ongoing monitoring and service coordination, and may change case managers, subject to the case manager's or agency's capacity to provide services under this section.

(3) NON-COVERED SERVICES. Services not covered as case management services or included in the calculation of overhead charges are any services which:

a. Involve provision of diagnosis, treatment or other direct services, including:

1. Diagnosis of a physical or mental illness;

2. Monitoring of clinical symptoms;

3. Administration of medications;

4. Client education and training;

5. Legal advocacy by an attorney or paralegal;

6. Provision of supportive home care;

7. Home health care;

8. Personal care; and

9. Any other professional service which is a covered service under this chapter and which is provided by an MA certified or certifiable provider, including time spent in a staffing or case conference for the purpose of case management; or

b. Involve information and referral services which are not based on a plan of care.

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

HSS 107.33 Ambulatory prenatal services for recipients with presumptive eligibility. (1) COVERED SERVICES. Ambulatory prenatal care services are covered services. These services include treatment of conditions or complications that are caused by, exist or are exacerbated by a pregnant woman's pregnant condition.

(2) PRIOR AUTHORIZATION. An ambulatory prenatal service may be subject to a prior authorization requirement, when appropriate, as described in this chapter.

(3) OTHER LIMITATIONS. (a) Ambulatory prenatal services shall be reimbursed only if the recipient has been determined to have presumptive MA eligibility under s. 49.465, Stats., by a qualified provider under s. HSS 103.11.

(b) Services under this section shall be provided by a provider certified under ch. HSS 105.

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