(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.

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(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;

c. Removal of reaction-producing foreign bodies from the skin or subcutaneous tissue and the musculo-skeletal system; and

d. Maxillary sinusotomy for removal of tooth fragment or foreign body;

8. Treatment of fractures — simple (maxillae, mandible, malar, alveolus and facial);

9. Treatment of fractures — compound or comminuted (maxillae, mandible, malar, aveolus and facial);

10. Reduction of dislocation and management of temporomandibular joint dysfunctions; and

11. Other oral surgery — suture of soft tissue wound or injury apart from other surgical procedure.

(j) *Orthodontic records.* Orthodontic records applicable to orthodontic cases only are covered.

(k) *Adjunctive general services.* Covered adjunctive general services are:

1. Unclassified treatment, palliative (emergency) treatment, per visit; and

2. Annual oral examination for patients seen in a nursing home.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) The dental services listed under par. (c) require prior authorization. In addition, the department may require prior authorization for other covered dental services where necessary to meet the program objectives stated in s. HSS 107.02 (3). A request for prior authorization of dental services submitted to the department by a dentist or physician shall identify the items enumerated in s. HSS 107.02 (3) (d), and in addition:

1. The age and occupation of the recipient;

2. The service or procedure requested;

3. An estimate of the fee associated with the provision of the service, if requested by the department; and

4. Diagnostic casts, dentist's statement, physician's statement and radiographs if requested by the department.

(b) In determining whether to approve or disapprove a request for prior authorization, the department shall ensure consideration of criteria enumerated in s. HSS 107.02 (3) (e).

(c) The following dental services require prior authorization in order to be reimbursed under MA:

1. All covered dental services if provided out-of-state under nonemergency circumstances by non-border status providers;

2. Surgical or other dental procedures of a marginal dental 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;

3. Preventive procedures:

a. Fluoride treatments; and

b. Prophylaxis procedures for recipients who are physically handicapped, mentally handicapped or both, 4 times per year;

4. Space management therapy:

a. Fixed unilateral for first primary molars; and

b. Fixed bilateral type;

5. Restorative procedures:

a. Stainless steel, laterals and centrals, primary teeth;

b. Stainless steel crowns for the first permanent molars for children under age 21 only;

6. Endondontics, gutta percha or silver points only:

a. Molars excluding final restoration;

b. Root amputation/apicoectomy — anteriors only; and

c. Retrograde fillings;

7. Periodontics — surgical, including postoperative services:

a. Gingivectomy or gingivoplasty; and

b. Gingival curettage;

8. Prosthodontics — removable, complete dentures or relining complete dentures, including 6 months postdelivery care. If the request is approved, the recipient shall be eligible on the date the authorized prosthodontic treatment is started, which is the date the final impressions were taken. Once started, the service shall be reimbursed to completion, regardless of the recipient's eligibility;

9. Oral surgery, including anesthetics and routine postoperative care:

a. Surgical incision to remove a foreign body from skin or from subcutaneousareolar tissue, or to remove a foreign body from hard tissues;

b. Excision of hyperplastic tissue, by quadrant or sextant; sialolithotomy;

c. Obturator for surgically excised palate;

d. Palatal lift prosthesis;

e. Osteoplasty for orthognathic deformity if the case is an EPSDT referral;

f. Frenulectomy if the case is an EPSDT referral; and

g. Temporomandibular joint surgery when performed by a dentist who meets the specific qualifications established by the department in a provider bulletin for this type of surgery. The prior authorization request shall include documentation of all prior treatment of the recipient for the condition and evidence of necessity for the surgery;

10. Orthodontics. The diagnostic work-up shall be performed and submitted with the prior authorization request. If the request is approved, the recipient is required to be eligible on the date the authorized orthodontic treatment is started as demonstrated by the placement of bands for comprehensive orthodontia. Once started, the service shall be reimbursed to completion, regardless of the recipient's eligibility;

11. General services:

a. General anesthesia;

b. Nonemergency hospitalization; and

12. Adjunctive general services — hospital calls, limited to 2 calls per hospital stay.

(3) OTHER LIMITATIONS. (a) A full-mouth intra-oral series of radiographs, including bitewings, shall be reimbursed for children only once per patient per dentist during a 3-year period.

(b) Bitewing films shall be reimbursed only when required for review of a prior authorization request.

(c) Prophylaxis procedure shall be reimbursed for children only once per recipient per dentist during a 6-month period, and for adults only once per recipient per dentist during a 12-month period.

(d) Root canal therapy shall be limited to recipients under age 21.

(e) An initial oral examination shall be reimbursed only once during the lifetime of each recipient per dentist.

(f) Periodic oral examinations shall be reimbursed for children only once per recipient per dentist during a 6-month period, and for adults only once per recipient per dentist during a 12-month period.

(g) Oral examinations performed in the nursing home shall be allowed once a year per recipient per dentist.

(h) An orthodontia case shall be considered for prior approval only when the case is the result of an EPSDT referral.

(i) Amalgam restorations on primary teeth are allowed once in each 12-month period for each tooth.

(j) Amalgam, composite and acrylic restorations on permanent teeth are allowed once in each 36-month period for each tooth.

(k) Recementation of space maintainers shall be reimbursed for children under age 13.

(l) Surgical exposure of impacted or unerupted teeth performed for orthodontic reasons or to aid eruption is covered if the individual is under age 21 and the case is the result of an EPSDT referral.

(m) Surgical extraction of impacted teeth is covered, provided that an operation report is submitted, in the following circumstances:

1. If the impacted tooth is associated with pain, a cyst or tumor which may cause ill effects or a life-threatening condition if the tooth is not removed; or

2. If the impacted tooth is associated with fracture of the jaw.

(n) Diagnostic casts are covered only if the department's dental consultant requires them to review the case for prior authorization.

(o) Upper and lower acrylic partial dentures shall be reimbursed only if the recipient is under age 21 and the case is a result of an EPSDT referral.

(p) Panoramic x-rays shall be reimbursed only for diagnostic needs in cases of emergency which require oral surgery.

(q) Temporomandibular joint surgery is a covered service only when performed after all necessary non-surgical medical or dental treatment has been provided by a multidisciplinary temporomandibular joint evaluation program or clinic approved by the department, and that treatment has been determined unsuccessful.

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

(a) Dental implants and transplants;

(b) Fluoride mouth rinse;

(c) Services for purely esthetic or cosmetic purposes;

(d) Overlay dentures, partial dentures, duplicate dentures and adjustments;

(e) Cu-sil dentures;

(f) Panoramic radiographs which include bitewings;

(g) Training in preventive dental care;

(h) Cement bases as a separate item;

(i) Composite crowns (acid etch);

(j) Precious metal crowns, and plastic with non-precious or semi-precious metal;

(k) Professional visits, other than for the annual examination of a nursing home resident;

(l) Dispensing of drugs;

(m) Adult full-mouth x-ray series;

(n) Adjunctive periodontal services;

(o) Surgical removal of erupted teeth, except as otherwise stated in sub (3);

(p) Alveoplasty and stomatoplasty;

(q) All non-surgical medical or dental treatment for a temporomandibular joint condition;

(r) Osteoplasty, except as otherwise stated in sub. (2);

(s) Bitewing x-rays, except as otherwise stated in sub. (3); and

(t) Diagnostic casts, except as otherwise stated in sub. (3).

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

(5) UNUSUAL CIRCUMSTANCES. In certain unusual circumstances the department may request that a non-covered service be performed, including but not limited to diagnostic casts, in order to substantiate a prior authorization request. In these cases the service shall be reimbursed.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (c) 10. and (2) (c) 9. e. and f., cr. (2) (c) 9. g. and (3) (8), r. and recr. (4) (q), Register, February, 1988, No. 386, eff. 3-1-88.

HSS 107.08 Hospital services. (1) COVERED SERVICES. (a) *Inpatient hospital services.* Covered inpatient hospital services are those medically necessary services, excluding podiatry services provided by a podiatrist as defined in s. 448.01 (7) Stats., which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients, and which are provided under the direction of a physician or dentist in an institution which is a certified provider. Complementary services, such as physical and occupational therapy, shall be provided under the supervision of professionals who meet the appropriate certification standards specified in ch. HSS 105.

(b) *Outpatient hospital services.* Covered hospital outpatient services are limited to those preventive, diagnostic, rehabilitative or palliative items or services, furnished by or under the direction of a physician or dentist to an outpatient in a certified hospital, which are within one of the following categories:

1. Physician services, except mental health services, in accordance with s. HSS 107.06;

2. Early and periodic screening, diagnosis and treatment services for persons under 21 years of age, in accordance with s. HSS 107.22;

3. Rural health clinic services, in accordance with s. HSS 107.29;

4. Home health services, or nursing services if a home health agency is unavailable, in accordance with s. HSS 107.11;

5. Laboratory and x-ray services, in accordance with s. HSS 107.25;

6. Family planning services and supplies, in accordance with s. HSS 107.21; or

7. Nurse midwife services, in accordance with s. HSS 107.12.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. The following covered services require prior authorization:

(a) Covered hospital services if provided out-of-state under non-emergency circumstances by non-border status providers;

(b) Hospitalization for non-emergency dental services; and

(c) Hospitalization for any medical service noted in s. HSS 107.06 (2), 107.07 (2) (c), 107.10 (2), 107.13 (2) (b), 107.16 (2), 107.17 (2), 107.18 (2), 107.19 (2), 107.20 (2), or 107.24 (2). The admitting physician shall

either obtain the prior authorization directly or ensure that prior authorization has been obtained by the attending physician or dentist.

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

(3) OTHER LIMITATIONS. (a) Inpatient admission for nontherapeutic sterilization is a covered service only if the procedures specified in s. HSS 107.06 (3) are followed.

(b) Private room accommodations are covered services when the recipient has one or more of the following diagnoses:

1. Acquired immune deficiency;
2. Acute viral infection;
3. Agammaglobulinemia;
4. Amebiasis;
5. Anthrax;
6. Aplastic leukemia;
7. Bacillary dysentery;
8. Botulism;
9. Brucellosis;
10. Burn — third degree;
11. Cellulitis;
12. Cerebral concussion;
13. Cholera;
14. Conjunctivitis, inclusion;
15. Diarrhea enteropathic, E. coli;
16. Diptheria;
17. Encephalitis, viral;
18. Epidemic influenza;
19. Epiglottitis;
20. Gas gangrene due to costridium perfringens;
21. Gastroenteritis due to salmonella, shigella or E. coli.;
22. Giadiasis;
23. Gonococcal opthalmia neonatorum;
24. Granuloma inguinall;
25. Hepatitis, types A, B, non-A, non-B;
26. Herpes simplex & disseminated neonatal;
27. Histoplasmosis;

1. Collateral interviews and consultations, except as provided in s. HSS 107.06 (4) (d); and

2. Court appearances except when necessary to defend against commitment.

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

(4) DAY TREATMENT OR DAY HOSPITAL SERVICES. (a) *Covered services.* Day treatment or day hospital services are covered services when prescribed by a physician, when provided by a provider who meets the requirements of s. HSS 105.24, and when the following conditions are met:

1. Before becoming involved in a day treatment program, the recipient is evaluated through the use of the functional assessment scale provided by the department to determine the medical necessity for day treatment and the person's ability to benefit from it;

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

3. Up to 90 hours of day treatment services in a calendar year may be reimbursed without prior authorization if these services are authorized by the board in the county in which the recipient resides. Psychotherapy services or occupational therapy services provided as component parts of a person's day treatment package may not be billed separately, but shall be billed and reimbursed as part of the day treatment program;

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

5. Reimbursement is not made for day treatment services provided in excess of 5 hours in any day or in excess of 120 hours in any month;

6. Day treatment services are covered only for the chronically mentally ill and acutely mentally ill who have a need for day treatment and an ability to benefit from the service, as measured by the functional assessment scale authorized by the department. At the time of authorization, the board shall indicate on each claim form whether the recipient has been determined to be acutely or chronically mentally ill; and

7. Billing for day treatment is submitted by the provider. Day treatment services shall be billed as such, and not as psychotherapy, occupational therapy or any other service modality.

(b) *Services requiring prior authorization.* 1. Providers shall obtain authorization from the department before providing the following services, as a condition for coverage of these services:

a. Day treatment services provided beyond 90 hours of service in a calendar year;

b. All day treatment or day hospital services provided to recipients with inpatient status in a nursing home. Only those patients scheduled for discharge are eligible for day treatment. No more than 40 hours of

service in a calendar year may be authorized for a recipient residing in a nursing home;

c. All day treatment services provided to recipients who are concurrently receiving psychotherapy, occupational therapy or AODA services;

d. Day treatment services for all persons age 18 and under with psychotic disorders; and

e. All day treatment services in excess of 90 hours provided to recipients who are diagnosed as acutely mentally ill.

2. The prior authorization request shall include:

a. The name, address, and MA number of the recipient;

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

c. A photocopy of the physician's original prescription for treatment;

d. A copy of the treatment plan and the expected outcome of treatment;

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

f. The demographic and client information form from the initial and most recent functional assessment. The assessment shall have been conducted within 3 months prior to the authorization request.

3. The department's decision on a prior authorization request shall be communicated to the provider in writing. If the request is denied, the department shall provide the recipient with a separate notification of the denial.

(c) *Other limitations.* 1. All assessment hours beyond 6 hours in a calendar year shall be considered part of the treatment hours and shall become subject to the relevant prior authorization limits. Day treatment assessment hours shall be considered part of the 6 hour per 2-year mental health evaluation limit.

2. Reimbursement for day treatment services shall be limited to actual treatment time and may not include time devoted to meals, rest periods, transportation, recreation or entertainment.

3. Reimbursement for day treatment services shall be limited to no more than 2 series of day treatment services in one calendar year related to separate episodes of acute mental illness. All day treatment services in excess of 90 hours in a calendar year provided to a recipient who is acutely mentally ill shall be prior-authorized.

(d) *Non-covered services.* The following services are not covered services:

1. Day treatment services which are primarily recreation-oriented and which are provided in non-medically supervised settings such as 24 hour day camps, or other social service programs. These include sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities and tours;

2. Day treatment services which are primarily social or educational in nature, in addition to having recreational programming. These shall be considered non-medical services and therefore non-covered services regardless of the age group served;

3. Consultation with other providers or service agency staff regarding the care or progress of a recipient;

4. Prevention or education programs provided as an outreach service, case-finding, and reading groups;

5. Aftercare programs, provided independently or operated by or under contract to boards;

6. Day treatment for recipients with a primary diagnosis of alcohol or other drug abuse;

7. Day treatment provided in the recipient's home; and

8. Court appearances except when necessary to defend against commitment.

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) (f) 8., Register, February, 1988, No. 386, eff. 3-1-88.

HSS 107.15 Chiropractic services. (1) DEFINITION. In this section, "spell of illness" means a condition characterized by the onset of a spinal subluxation. "Subluxation" means the alteration of the normal dynamics, anatomical or physiological relationships of contiguous articular structures. A subluxation may have biomechanical, pathophysiological, clinical, radiologic and other manifestations.

(2) COVERED SERVICES. Chiropractic services covered by MA are manual manipulations of the spine used to treat a subluxation. These services shall be performed by a chiropractor certified pursuant to s. HSS 105.26.

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