CR 91-68

CERTIFICATE

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

I, Gerald Whitburn, Secretary of the Department of Health and Social Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to reimbursement of hospitals by diagnosis-related groups (DRGs) for inpatient care provided to Medical Assistance recipients were duly approved and adopted by this Department on August 19, 1991.

I further certify that this copy has been compared by me with the original on file in the Department and that this copy is a true copy of the original, and of the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 19th day of August, 1991.

SEAL:

Gerald Whitburn, Secretary
Department of Health and Social Services

10-1-91

8-8-91

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

To repeal HSS 105.24(2)(c), 107.02(2)(c), 107.06(2)(zh), (zk), (zo) and (zp), 107.06(4)(a), 107.13(4)(b)1d, and 108.03(4); to renumber HSS 107.06(2)(d) and (e) and (zi) to (zw) and (4)(b) to (h), 107.13(3)(c) and (4)(b)1e, and 108.03(5) and (6); to amend HSS 105.01(4)(c) and (d), 105.01(5)(b), 105.07(1) to (4), 105.23(1)(b) and (c) and (2)(a) 1, 105.24(2)(b), 106.04(3)(intro.), 107.02(2)(b), 107.03(10), (12), (16) and (17), 107.06(2)(zr) and (zs), as renumbered, 107.13(1)(title), (a) and (b)1 and 2, (c) and (f)5, 6 and 8, (2)(a)1, 3a and b, 4f, 6 and 7, (b)1 and 2 and (c)2, (3)(a)(intro.), 4, 5 and 7, (b)1 and 2, (c)1, as renumbered, (d)1 and 2 and (4)(a)3 and 6 and (d)6; to repeal and recreate HSS 105.07(intro.), 105.21(title) and (1)(intro.) and (a), 105.22, 105.24(1)(a), 105.48, 107.08, 107.13(1)(b)3 and (e) and 107.24(4)(a); and to create HSS 101.03(136m), 105.01(4)(e), 105.055, 105.07(5), 105.075, 106.03(5)(br), 107.02(2m), 107.03(18), 107.06(2)(zt), 107.065, 107.13(2)(c)6 and 107.13(3)(c)3 and 4 and (d)3, relating to the Medical Assistance (MA) program.

Analysis Prepared by the Department of Health and Social Services

On January 1, 1991, the Department converted to a new methodology for reimbursing hospitals for services provided to inpatients who are Medical Assistance (MA) recipients. For services provided on or after that date, the Department is reimbursing hospitals on the basis of diagnosis-related groups (DRGs) rather than patient discharges. This involves separately reimbursing specified health care professionals for the services they provide to hospital inpatients, and reimbursing hospitals on the basis of groupings of patient diagnoses for the remaining services provided to hospital inpatients. The new reimbursement methodology, unlike the old, is responsive to changing patient mixes and is in the aggregate fairer for hospitals providing services to MA recipients. An emergency order effective January 1, 1991 removed impediments in the MA rules to converting to the new reimbursement methodology. These are the permanent rules to replace the emergency rules.

This rulemaking order makes several other changes in the MA rules unrelated to reimbursement of hospitals by DRGs. The current rule language under s. HSS 107.13(1)(b)3 for certifying need for inpatient mental health services does not exactly comply with federal requirements. This is corrected. The requirements for out-of-state health care providers to become Wisconsin-certified border status providers are modified to delete as too restrictive the list of out-of-state cities in favor of documentation from a non-nursing home health care provider that recipients in a particular area of Wisconsin commonly go for medical services to the provider's area in the other state. Certification for hospital institutions for mental disease (IMDs) is revised to comply with federal requirements and conditions for participation in the MA program for this type of facility. Requirements relating to covered psychiatric services provided in general hospitals have been moved under hospitals (s. HSS 107.08), leaving s. HSS 107.13(1) to apply only to the 20 or so psychiatric hospitals in the state which for purposes of the rules are called hospital institutions for mental disease (IMDs). Nurse anesthetists and anesthesiologist assistants are made a separate certified provider group. Finally, prior

authorization requirements for mental health treatment and alcohol and other drug abuse (AODA) treatment services are clarified, and all references to the county 51.42 board "gatekeeper" authorization function for mental health and AODA services to be reimbursed by the MA program are dropped because the statutory requirement has been eliminated.

The Department's authority to repeal, renumber, amend and create these rules is found in s. 49.45(10), Stats. The rules interpret ss. 49.45(3)(e)3 and 49.46(2)(a)4a, Stats., as follows:

SECTION 1. HSS 101.03(136m) is created to read:

HSS 101.03(136m) "Professional services" means the covered services listed in s. HSS 107.08(4)(d) that are provided by health care professionals to MA recipients who are inpatients of a hospital.

SECTION 2. HSS 105.01(4)(c) and (d) are amended to read:

HSS 105.01(4)(c) Provider assistants; ~~and~~

(d) Group billing providers; and

SECTION 3. HSS 105.01(4)(e) is created to read:

HSS 105.01(4)(e) Providers performing professional services for hospital inpatients under s. HSS 107.08(4)(d). Hospitals which provide the setting for the performance of professional services to its inpatients shall ensure that the providers of those services are appropriately certified under s. HSS 105.07.

SECTION 4. HSS 105.01(5)(b) is amended to read:

HSS 105.01(5)(b) ~~Providers~~ Except for providers required to be separately certified under sub. (4)(b) to (e), providers employed by or under contract to certified institutional providers, including but not limited to physicians, therapists, nurses and provider assistants. These providers shall meet certification standards applicable to their respective provider type.

SECTION 5. HSS 105.055 is created to read:

HSS 105.055 CERTIFICATION OF NURSE ANESTHETISTS AND ANESTHESIOLOGIST ASSISTANTS. (1) CERTIFIED REGISTERED NURSE ANESTHETIST. For MA certification, a nurse anesthetist shall be licensed as a registered nurse pursuant to s. 441.06, Stats., and shall meet one of the following additional requirements:

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

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

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

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

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

SECTION 6. HSS 105.07 (intro.) is repealed and recreated to read:

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

SECTION 7. HSS 105.07(1) to (4) is amended to read:

HSS 105.07(1) ~~Hospitals~~ A hospital providing psychotherapy shall meet the requirements specified in s. HSS 105.22(1) and (2) ~~and (3)~~;

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

(3) ~~Hospitals~~ A hospital providing mental health day treatment services shall ~~meet the requirements specified in~~ be certified under s. HSS 105.24;

(4) ~~Hospitals~~ A hospital participating in ~~the peer review organization (PRO)~~ a PRO review program shall meet the requirements of 42 CFR ~~405.1035~~ 456.101 and any additional requirements established under state contract with the PRO~~.~~; and

SECTION 8. HSS 105.07(5) and 105.075 are created to read:

HSS 105.07(5) A hospital providing AODA day treatment services shall be certified under s. HSS 105.25.

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

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

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

SECTION 9. HSS 105.21 (title) and (1)(intro.) and (a) are repealed and recreated to read:

HSS 105.21 CERTIFICATION OF HOSPITAL IMDS. (1) REQUIREMENTS. (intro.) For MA certification, a hospital which is an institution for mental disease (IMD) shall:

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

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

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

SECTION 10. HSS 105.22 is repealed and recreated to read:

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

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

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

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

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

(2) STAFFING OF OUTPATIENT FACILITIES. (a) To provide psychotherapy reimbursable by MA, personnel employed by an outpatient facility deemed a provider under sub. (1)(d) shall be individually certified and shall work under the supervision of a physician or psychologist who meets the requirements of sub. (1)(a) or (b). Persons employed by a board-operated or hospital outpatient mental health facility need not be individually certified as providers but may provide psychotherapy services upon the department's issuance of certification to the facility by which they are employed. In this case, the facility shall maintain a list of the names of persons employed by the facility who are performing psychotherapy services for which reimbursement may be claimed under MA. This listing shall document the credentials possessed by the named persons which would qualify them for certification under the standards specified in this subsection and shall include the dates that the named persons began employment.

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

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

SECTION 11. HSS 105.23(1)(b) and (c) and (2)(a)1 are amended to read:

HSS 105.23(1)(b) An outpatient facility ~~under contract to a board,~~ or hospital outpatient AODA facility certified under ss. HSS 61.50 to 61.68; or

(c) A provider certified under s. HSS 105.05 (1) or 105.22(1)(b) ~~who has a written agreement with a board or a facility under sub. (1)(a) or (b), if the recipient being treated is enrolled in an AODA program at the facility~~.

(2)(a)1. Meet the requirements in s. HSS 105.22~~(3)~~(1)(b) or 105.05(1); or

SECTION 12. HSS 105.24(1)(a) is repealed and recreated to read:

HSS 105.24(1)(a) Be a medical program certified under s. HSS 61.75; and

SECTION 13. HSS 105.24(2)(b) is amended to read:

HSS 105.24(2)(b) Reimbursement payable under par. (a) shall be subject to reductions for third party recoupments. ~~For day treatment or day hospital services provided under MA, the board shall be responsible for 10 percent of the amount reimbursable under par. (a).~~

SECTION 14. HSS 105.24(2)(c) is repealed.

SECTION 15. HSS 105.48 is repealed and recreated to read:

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

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

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

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

(5)(a) A provider certified in another state for services not covered in Wisconsin shall be denied border status certification for these services in the Wisconsin program.

Note: Examples of providers whose services are not covered in Wisconsin are music therapists and art therapists.

(b) A provider denied certification in another state shall be denied certification in Wisconsin, except that a provider denied certification in another state because the provider's services are not MA-covered in that state may be eligible for Wisconsin border status certification if the provider's services are covered in Wisconsin.

SECTION 16. HSS 106.03(5)(br) is created to read:

HSS 106.03(5)(br) Providers of professional services to hospital inpatients. Notwithstanding pars. (a) and (b), in the case of a provider performing professional services to hospital inpatients, payment shall be made directly to the provider or to the hospital if it is separately certified to be reimbursed for the same professional services.

SECTION 17. HSS 106.04(3) (intro.) is amended to read:

HSS 106.04(3) NON-LIABILITY OF RECIPIENTS. (intro.) A provider shall accept payments made by the department in accordance with sub.(1) as payment in full for services provided a recipient. A provider may not attempt to impose a charge for an individual procedure or for overhead which is included in the reimbursement for services provided nor may the provider attempt to impose an unauthorized charge or receive payment from a recipient, relative or other person for services provided, or impose direct charges upon a

recipient in lieu of obtaining payment under the program, except under any of the following conditions:

SECTION 18. HSS 107.02(2)(b) is amended to read:

HSS 107.02(2)(b) Services which the ~~department's~~ department, the PRO review process or ~~its~~ the department fiscal agent's professional consultants determine to be ~~not~~ medically ~~necessary~~ unnecessary, inappropriate, ~~or~~ in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration;

SECTION 19. HSS 107.02(2)(c) is repealed.

SECTION 20. HSS 107.02(2)(d) and (e) are renumbered 107.02(2)(c) and (d).

SECTION 21. HSS 107.02(2m) is created to read:

HSS 107.02(2m) SERVICES REQUIRING A PHYSICIAN'S ORDER OR PRESCRIPTION. (a) The following services require a physician's order or prescription to be covered under MA:

1. Skilled nursing services provided in a nursing home;
2. Intermediate care services provided in a nursing home;
3. Home health care services;
4. Independent nursing services;
5. Respiratory care services for ventilator-dependent recipients;
6. Physical and occupational therapy services;
7. Mental health and alcohol and other drug abuse (AODA) services;
8. Speech pathology and audiology services;

9. Medical supplies and equipment, including rental of durable equipment, but not hearing aid batteries, hearing aid accessories or repairs;

10. Drugs, except when prescribed by a nurse practitioner under s. HSS 107.122, or a podiatrist under s. HSS 107.14;

11. Prosthetic devices;

12. Laboratory, diagnostic, radiology and imaging test services;

13. Inpatient hospital services;

14. Outpatient hospital services;

15. Inpatient hospital IMD services;

16. Hearing aids;

17. Specialized transportation services for persons not requiring a wheelchair, except when prescribed by a nurse practitioner under s. HSS 107.122;

18. Hospital private room accommodations;

19. Personal care services; and

20. Hospice services.

(b) Except as otherwise provided in federal or state statutes, regulations or rules, a prescription or order shall be in writing or be given orally and later be reduced to writing by the provider filling the prescription or order, and shall include the date of the prescription or order, the name and address of the prescriber, the prescriber's MA provider number, the name and address of the recipient, the recipient's MA eligibility number, an evaluation of the service to be provided, the estimated length of time required, the brand of drug or drug product equivalent medically required and the prescriber's signature. For hospital patients and nursing home patients, orders shall be entered into the medical and nursing charts and shall include the information required by this paragraph. Services prescribed or ordered shall be provided within one year of the date of the prescription.

(c) A prescription for specialized transportation services for a recipient not declared legally blind or not determined to be permanently disabled shall include an explanation of the reason the recipient is unable to travel in a private automobile, or a taxicab, bus or other common carrier. The prescription shall specify the length of time for which the recipient shall require the specialized transportation, which may not exceed 90 days.

SECTION 22. HSS 107.03(10), (12), (16) and (17) and are amended to read:

HSS 107.03(10) Services subject to review and approval pursuant to ~~ss.~~ s. 150.21, ~~and 150.61~~ Stats., but which have not yet received approval;

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

(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~~.~~ ; and

SECTION 23. HSS 107.03(18) is created to read:

HSS 107.03(18) Services provided by a hospital or professional services provided to a hospital inpatient are not covered services unless billed separately as hospital services under s. HSS 107.08 or 107.13(1) or as professional services under the appropriate provider type. No recipient may be billed for these services as non-covered.

SECTION 24. HSS 107.06(2)(zh), (zk), (zo) and (zp) are repealed.

SECTION 25. HSS 107.06(2)(zi) to (zw) are renumbered 107.06(2)(zh) to (zs), and HSS 107.06(2)(zr) and (zs), as renumbered, are amended to read:

HSS 107.06(2)(zr) Any other procedure not identified in the physicians' "current procedural terminology", fourth edition, published by the American medical association; ~~and~~

Note: The referenced publication may be reviewed in the department's Bureau of Health Care Financing, Room 250, 1 West Wilson Street, Madison, Wisconsin. Interested persons may obtain a copy by writing the American Medical Association, 535 N. Dearborn Avenue, Chicago, Illinois 60610.

(zs) Sterilizations~~.~~ ; and

SECTION 26. HSS 107.06(2)(zt) is created to read:

HSS 107.06(2)(zt) Transplants:

1. Heart;

2. Pancreas;

3. Bone marrow;

4. Liver;

5. Heart-lung; and

6. Lung.

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

SECTION 27. HSS 107.06(4)(a) is repealed.

SECTION 28. HSS 107.06(4)(b) to (h) are renumbered 107.06(4)(a) to (g).

SECTION 29. HSS 107.065 is created to read:

HSS 107.065 ANESTHESIOLOGY SERVICES (1) COVERED SERVICES. Anesthesiology services covered by the MA program are any medically necessary medical services applied to a recipient to induce the loss of sensation of pain associated with surgery, dental procedures or radiological services. These services are performed by an anesthesiologist certified under s. HSS 105.05, or by a nurse anesthetist or an anesthesiology assistant certified under s. HSS 105.055. Anesthesiology services shall include preoperative, intraoperative and postoperative evaluation and management of recipients as appropriate.

(2) OTHER LIMITATIONS. (a) A nurse anesthetist shall perform services in the presence of a supervising anesthesiologist or performing physician.

(b) An anesthesiology assistant shall perform services only in the presence of a supervising anesthesiologist.

SECTION 30. HSS 107.08 is repealed and recreated to read:

HSS 107.08 HOSPITAL SERVICES. (1) COVERED SERVICES. (a) Inpatient services. Covered hospital inpatient services are those medically necessary services 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 certified under s. HSS 105.07 or 105.21.

(b) Outpatient services. Covered hospital outpatient services are those medically necessary preventive, diagnostic, rehabilitative or palliative items or services provided by a hospital certified under s. HSS 105.07 or 105.21 and performed by or under the direction of a physician or dentist for a recipient who is not a hospital inpatient.

(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 the following transplants:

1. Heart;

2. Pancreas;

3. Bone marrow;

4. Liver;

5. Heart-lung;

6. Lung; and

(d) Hospitalization for any other medical service noted in s. HSS 107.06(2), 107.07(2)(c), 107.10(2), 107.16(2), 107.17(2), 107.18(2), 107.19(2), 107.20(2) or 107.24(3). 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 limitations. The following limitations apply to hospital inpatient services:

1. Inpatient admission for non-therapeutic sterilization is a covered service only if the procedures specified in s. HSS 107.06(3) are followed; and

2. A recipient's attending physician shall determine if private room accommodations are medically necessary. Charges for private room accommodations shall be denied unless the private room is medically necessary and prescribed by the recipient's attending physician. When a private room is not medically necessary, neither MA nor the recipient may be held responsible for the cost of the private room charge. If, however, a recipient requests a private room and the hospital informs the recipient at the time of admission of the cost differential,

and if the recipient understands and agrees to pay the differential, then the recipient may be charged for the differential.

(b) Outpatient limitations. The following limitations apply to hospital outpatient services:

1. For services provided by a hospital on an outpatient basis, the same requirements shall apply to the hospital as apply to MA-certified non-hospital providers performing the same services;

2. Outpatient services performed outside the hospital facility may not be reimbursed as hospital outpatient services; and

3. All covered outpatient services provided during a calendar day shall be included as one outpatient visit.

(c) General limitations. 1. MA-certified hospitals shall meet the requirements of ch. HSS 124.

2. If a hospital is certified and reimbursed as a type of provider other than a hospital, the hospital is subject to all coverage and reimbursement requirements for that type of provider.

3. On any given calendar day a patient in a hospital shall be considered either an inpatient or an outpatient, but not both. Emergency room services shall be considered outpatient services unless the patient is admitted as an inpatient and counted on the midnight census. Patients who are same day admission and discharge patients and who die before the midnight census shall be considered inpatients.

4. All covered services provided during an inpatient stay, except professional services which are separately billed, shall be considered hospital inpatient services.

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

1. Unnecessary or inappropriate inpatient admissions or portions of a stay;

2. Hospitalizations or portions of hospitalizations disallowed by the PRO;

3. Hospitalizations either for or resulting in surgeries which the department views as experimental due to questionable or unproven medical effectiveness;

4. Inpatient services and outpatient services for the same patient on the same date of service unless the patient is admitted to a hospital other than the facility providing the outpatient care;

5. Hospital admissions on Friday or Saturday, except for emergencies, accident or accident care and 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; and

6. Hospital laboratory, diagnostic, radiology and imaging tests not ordered by a physician, except in emergencies;

(b) Neither MA nor the recipient may be held responsible for charges or services identified in par. (a) as non-covered, except that a recipient may be billed for charges under par. (a)3, 5, or 7 if the recipient was notified in writing in advance of the hospital stay that the service was not a covered service.

(c) If hospital services for a patient are no longer medically necessary and an appropriate alternative care setting is available but the patient refuses discharge, the patient may be billed for continued services if he or she receives written notification prior to the time medically unnecessary services are provided.

(d) The following professional services are not covered as part of a hospital inpatient claim but shall be billed by an appropriately certified MA provider:

1. Services of physicians, including pathologists, radiologists and the professional-billed component of laboratory and radiology or imaging services, except that services by physician intern and residents services are included as hospital services;

2. Services of psychiatrists and psychologists, except when performing group therapy and medication management, including services provided to a hospital inpatient when billed by a hospital, clinic or other mental health or AODA provider;

3. Services of podiatrists;

4. Services of physician assistants;

5. Services of nurse midwives, nurse practitioners and independent nurses when functioning as independent providers;

6. Services of certified registered nurse anesthetists;

7. Services of anesthesia assistants;

8. Services of chiropractors;

9. Services of dentists;

10. Services of optometrists;

11. Services of hearing aid dealers;

12. Services of audiologists;

13. Any of the following provided on the date of discharge for home use:

a. Drugs;

b. Durable medical equipment; or

c. Disposable medical supplies;

14. Specialized medical vehicle transportation; and

15. Air, water and land ambulance transportation.

(e) Professional services provided to hospital inpatients are not covered hospital inpatient services but are rather professional services and subject to the requirements in ch. HSS 107 that apply to the services provided by the particular provider type.

(f) Neither a hospital nor a provider performing professional services to hospital inpatients may impose an unauthorized charge on recipients for services covered under ch. HSS 107.

(g) For provision of inpatient psychiatric care by a general hospital, the services listed under s. HSS 107.13(1)(f) are non-covered services.

SECTION 31. HSS 107.13(1) (title), (a) and (b)1 and 2 are amended to read:

(1) INPATIENT CARE IN A HOSPITAL IMD.

(a) Covered services. Inpatient ~~psychiatric~~ hospital mental health and AODA care shall be covered when prescribed by a physician and when provided within a ~~psychiatric hospital or by a psychiatric unit of a general hospital~~ hospital institution for mental disease (IMD) which ~~meets the requirements of~~ is certified under ss. HSS 105.07 and 105.21, except as provided in par. (b).

(b) Conditions for coverage of recipients under 21 years of age. 1. Definition. In this paragraph, "individual plan of care" or "plan of care" means a written plan developed for each recipient under 21 years of age who receives inpatient ~~psychiatric~~ hospital mental health or AODA care in a hospital IMD for the purpose of improving the recipient's condition to the extent that inpatient care is no longer necessary.

2. General conditions. Inpatient ~~psychiatric service~~ hospital mental health and AODA services provided in a hospital IMD for recipients under age 21 shall be provided under the direction of a physician~~, by a general hospital, a psychiatric facility or an inpatient program in a psychiatric facility,~~ and, if the recipient was receiving the services immediately before reaching age 21, ~~before~~ coverage shall extend to the earlier of the following:

a. The date the recipient no longer requires services; or

b. The date the recipient reaches age 22.

SECTION 32. HSS 107.13(1)(b)3 is repealed and recreated to read:

HSS 107.13(1)(b)3. Certification of need for services. a. For recipients under age 21 receiving services in a hospital IMD, a team specified in subpar. b. shall certify that ambulatory care resources do not meet the treatment needs of the recipient, proper treatment of the

recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will be needed in reduced amount or intensity or no longer be needed. The certification specified in this subdivision satisfies the requirement for physician certification in subd. 7. In this subparagraph, "ambulatory care resources" means any covered service except hospital inpatient care or care of a resident in a nursing home.

b. Certification under subpar. a. shall be made for a recipient when the person is admitted to a facility or program by an independent team that includes a physician. The team shall have competence in diagnosis and treatment of mental illness, preferably in child psychology, and have knowledge of the recipient's situation.

c. For a recipient who applies for MA eligibility while in a facility or program, the certification shall be made by the team described in subd. 5 b and shall cover any period before application for which claims are made.

d. For emergency admissions, the certification shall be made by the team specified in subd. 5 b within 14 days after admission.

SECTION 33. HSS 107.13(1)(c) is amended to read:

HSS 107.13(1)(c) Eligibility for non-institutional services. Recipients under age 22 or over age 64 who ~~reside in a psychiatric hospital~~ are inpatients in a hospital IMD are eligible for MA benefits for services not provided through that institution ~~and not reimbursed as part of the cost of care of that individual in the institution~~ and reimbursed to the hospital as hospital services under s. HSS 107.08 and this subsection.

SECTION 34. HSS 107.13(1)(e) is repealed and recreated to read:

HSS 107.13(1)(e) Professional services provided to hospital IMD inpatients. In addition to meeting the conditions for provision of services listed under s. HSS 107.08(4), including separate billing, the following conditions apply to professional services provided to hospital IMD inpatients:

1. Diagnostic interviews with the recipient's immediate family members shall be covered services. In this subdivision, "immediate family members" means parents, guardian, spouse and children or, for a child in a foster home, the foster parents;

2. The limitations specified in s. HSS 107.08(3) shall apply; and

3. Electroconvulsive therapy shall be a covered service only when provided by a certified psychiatrist in a hospital setting.

SECTION 35. HSS 107.13(1)(f)5, 6 and 8, and (2)(a)1, 3a and b, 4f, 6 and 7 and (b)1 and 2, and (c)2 are amended to read:

HSS 107.13(1)(f)5. Psychotherapy or ~~alcohol and other drug abuse~~ AODA treatment services when separately billed and performed by masters level therapists or AODA counsellors certified under s. HSS 105.22~~(3)~~ or 105.23;

6. Group therapy services or medication management for hospital inpatients whether separately billed by an IMD hospital or by any other provider as an outpatient claim for professional services;

8. Inpatient services for recipients between the ages of 21 and 64 when provided by a ~~psychiatric~~ hospital ~~or an institution for mental disease~~ IMD, except that services may be provided to a 21 year old resident of ~~a psychiatric hospital or an~~ a hospital IMD if the person was a resident of ~~one of these institutions~~ that institution immediately prior to turning 21 and

continues to be a resident after turning 21. A hospital IMD patient who is 21 to 64 years of age may be eligible for MA benefits while on convalescent leave from a hospital IMD.

(2)(a)1. A differential diagnostic examination is performed by a certified psychotherapy provider ~~pursuant to the approval of the board for the county in which the recipient resides~~. A physician's prescription is not necessary to perform the examination;

3.a. A provider who is a licensed physician or a licensed psychologist ~~defined~~ as provided under s. HSS 105.22(1)(a) or (b), and who is working in an outpatient facility ~~defined~~ under s. HSS 105.22(1)(c) or (d) ~~which is certified to participate in MA and which is operated by or under contract with the board,~~ or who is working in private practice ~~and has a contract with the board~~; or

b. A provider under s. HSS 105.22(3) who is working in an outpatient facility ~~defined in~~ under s. HSS 105.22(1)(c) or (d) which is certified to participate in MA ~~and which is operated by or under contract with the board~~;

4.f. A hospital~~, for services provided under sub. (1)(e)1~~;

6. Outpatient psychotherapy services of up to $500 per recipient in a calendar year for hospital outpatient service providers billing on the hospital claim form, or 15 hours or $500 per recipient in a calendar year for non-hospital outpatient providers, whichever limit is reached first, may be ~~authorized by the board for the county in which the recipient resides~~ provided without prior authorization by the department; and

7. If reimbursement is also made to any provider for ~~alcohol or other drug abuse~~ AODA treatment services under sub. (3) during the same year for the same recipient, the hours reimbursed for these services shall be considered part of the $500 or 15-hour psychotherapy treatment services limit before prior authorization ~~shall be~~ is required. For hospital outpatient providers billing on the hospital claim form, these services shall be included in the $500 limit before prior authorization is required. If several psychotherapy or AODA treatment service

providers are treating the same recipient during the year, all the psychotherapy and AODA treatment services shall be considered in the $500 or 15-hour total limit before prior authorization is required. However, if a recipient is hospitalized as an inpatient in an acute care general hospital or IMD with a diagnosis of, or for a procedure associated with, a psychiatric or alcohol or other drug abuse condition, reimbursement for any inpatient psychotherapy or AODA treatment services is not included in the $500, 15-hour limit before prior authorization is required for outpatient psychotherapy or AODA treatment services. For hospital inpatients, the differential diagnostic examination for psychotherapy and the medical evaluation for ~~alcoholism and other drug abuse~~ AODA treatment services also are not included in the limit before prior authorization is required.

(b)1. Reimbursement may be claimed for treatment services beyond 15 hours or $500, whichever limit is attained first, after receipt of ~~authorization by the recipient's board and~~ prior authorization from the department. Services reimbursed by any third party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified number of additional hours of non-hospital outpatient care or visits for hospital outpatient services to be provided to a recipient within the calendar year. The department shall require periodic progress reports and subsequent prior authorization requests ~~as well as authorization by the board~~ in instances where additional services are approved.

(c)2. ~~Not~~ No more than one provider may be reimbursed for the same psychotherapy session, unless the session involves a couple, a family group or is a group therapy session. In this subdivision, "group therapy session" means a session not conducted in a hospital for an inpatient recipient at which there are more than one but not more than 10 ~~recipients~~ individuals receiving psychotherapy services together from one or 2 providers. Under no circumstances may more than 2 providers be reimbursed for the same session.

SECTION 36. HSS 107.13(2)(c)6 is created to read:

HSS 107.13(2)(c)6. Professional psychotherapy services provided to hospital inpatients in general hospitals, other than group therapy and medication management, are not considered inpatient services. Reimbursement shall be made to the psychiatrist or psychologist billing providers certified under s. HSS 105.22(1)(a) or (b) who provide mental health professional services to hospital inpatients in accordance with requirements of this subsection.

SECTION 37. HSS 107.13(3)(a)(intro.), 4, 5 and 7, and (b)1 and 2 are amended to read:

HSS 107.13(3)(a) Covered services. (intro.) Outpatient alcohol and drug abuse treatment services shall be covered when prescribed by a physician, ~~authorized by the board for the county in which the recipient resides,~~ provided by a provider who meets the requirements of s. HSS 105.23 ~~and is employed by or is under contract to the recipient's board for provision of these services~~, and when the following conditions are met:

4. Outpatient ~~alcohol or other drug abuse~~ AODA treatment services of up to $500 or 15 hours per recipient in a calendar year, whichever limit is reached first, may be ~~authorized by the board of the county in which the recipient resides~~ provided without prior authorization by the department;

5. ~~Alcohol and other drug abuse~~ AODA treatment services are performed only in the office of the provider, a hospital or hospital outpatient clinic, an outpatient facility, a nursing home or a school;

7. If reimbursement is also made to any provider for psychotherapy or mental health services ~~outlined in~~ under sub. (2) during the same year for the same recipient, the hours reimbursed for these services shall be considered part of the $500 or 15-hour AODA treatment services limit before prior authorization ~~shall be~~ is required. For hospital outpatient service

providers billing on the hospital claim form, these services shall be included in the $500 limit before prior authorization is required. If several psychotherapy or AODA treatment service providers are treating the same recipient during the year, all the psychotherapy or AODA treatment services shall ~~also~~ be considered in the $500 or 15-hour total limit before prior authorization is required. However, if a recipient is hospitalized as an inpatient in an acute care general hospital or IMD with a diagnosis of, or for a procedure associated with, ~~an~~ a psychiatric or alcohol or other drug abuse ~~AODA~~ condition, reimbursement for any inpatient psychotherapy or AODA treatment services is not included in the $500, 15-hour limit before prior authorization is required. For hospital inpatients, the differential diagnostic examination for psychotherapy or AODA treatment services and the medical evaluation for psychotherapy or other mental health treatment or AODA treatment services are also not included in the limit before prior authorization is required.

(b) Prior authorization. 1. Reimbursement beyond 15 hours or $500 of service may be claimed for treatment services furnished after receipt of ~~authorization from the recipient's board and~~ prior authorization from the department. Services reimbursed by any third-party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified additional number of hours of ~~additional~~ outpatient AODA treatment services or visits for hospital outpatient services to be provided to a recipient in a calendar year. The department shall require periodic progress reports and subsequent prior authorization requests ~~as well as authorization by the county board~~ in instances where additional services are approved.

SECTION 38. HSS 107.13(3)(c) is renumbered 107.13(3)(c)1, and HSS 107.13(3)(c)1, as renumbered, is amended to read:

HSS 107.13(3)(c) Other limitations. 1. No more than one provider may be reimbursed for the same AODA treatment session, unless the session involves a couple, a family group or is a group session. In this paragraph, "group session" means a session not conducted in a hospital for an inpatient recipient at which there are more than one but not more than 10 recipients receiving services together from one or 2 providers. No more than 2 providers may be reimbursed for the same session. No recipient may be held responsible for charges for services in excess of MA coverage under this paragraph.

SECTION 39. HSS 107.13(3)(c)3 and 4 are created to read:

HSS 107.13(3)(c)3. Professional AODA treatment services other than group therapy and medication management provided to hospital inpatients in general or to inpatients in IMDs are not considered inpatient services. Reimbursement shall be made to the psychiatrist or psychologist billing provider certified under s. HSS 105.22(1)(a) or (b) or 105.23 who provides AODA treatment services to hospital inpatients in accordance with requirements under this subsection.

4. Medical detoxification services are not considered inpatient services if provided outside an inpatient general hospital or IMD.

SECTION 40. HSS 107.13(3)(d)1 and 2 are amended to read:

HSS 107.13(3)(d)1. Collateral interviews and consultations, except as provided in s. HSS 107.06(4)(d); ~~and~~

2. Court appearance~~,~~ except when necessary to defend against commitment~~,~~ ; and

SECTION 41. HSS 107.13(3)(d)3 is created to read:

HSS 107.13(3)(d)3. Detoxification provided in a social setting, as described in s. HSS 61.58, is not a covered service.

SECTION 42. HSS 107.13(4)(a)3 and 6 are amended to read:

HSS 107.13(4)(a)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;

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~~ provided 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

SECTION 43. HSS 107.13(4)(b)1d is repealed.

SECTION 44. HSS 107.13(4)(b)1e is renumbered 107.13(4)(b)1d.

SECTION 45. HSS 107.13(4)(d)6 is amended to read:

HSS 107.13(4)(d)6 ~~Day~~ Medical or AODA day treatment for recipients with a primary diagnosis of alcohol or other drug abuse;

SECTION 46. HSS 107.24(4)(a) is repealed and recreated to read:

HSS 107.24(4)(a) Payment for medical supplies ordered for a patient in a medical institution is considered part of the institution's cost and may not be billed directly to the program by a provider. Durable medical equipment and medical supplies provided to a hospital inpatient to take home on the date of discharge are reimbursed as part of the inpatient hospital services. No recipient may be held responsible for charges or services in excess of MA coverage under this paragraph.

SECTION 47. HSS 108.03(4) is repealed.

SECTION 48. HSS 108.03(5) and (6) are renumbered 108.03(4) and (5).

The rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s. 227.22(2), Stats.

Wisconsin Department of Health and Social Services

Dated: August 19, 1991

By: 

Gerald Whitburn
Secretary

SEAL: