Chapter HSS 107

COVERED SERVICES

Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.

HSS 107.01 General statement of coverage. (1) The department shall reimburse providers for medically necessary and appropriate health care services listed in ss. 49.46 (2) and 49.47 (6) (a), Stats., when provided to currently eligible medical assistance recipients, including emergency services provided by persons or institutions not currently certified. The department shall also reimburse providers certified to provide case management services as defined in s. HSS 107.32 to eligible recipients.

(2) Services provided by a student during a practicum are reimbursable under the following conditions:

(a) The services meet the requirements of this chapter;

(b) Reimbursement for the services is not reflected in prospective payments to the hospital, skilled nursing facility or intermediate care facility at which the student is providing the services;

(c) The student does not bill and is not reimbursed directly for his or her services;

(d) The student provides services under the direct, immediate on-premises supervision of a certified provider; and

(e) The supervisor documents in writing all services provided by the student.

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

HSS 107.02 General limitations. (1) PAYMENT. (a) The department shall reject payment for claims which fail to meet program requirements. However, claims rejected for this reason may be eligible for reimbursement if, upon resubmission, all program requirements are met.

(b) Medical assistance shall pay the deductible and coinsurance amounts for services provided under this chapter which are not paid by medicare under 42 USC 1395 to 1395zz, and shall pay the monthly premiums under 42 USC 1395v. Payment of the coinsurance amount for a service under medicare part B, 42 USC 1395j to 1395w, may not exceed the allowable charge for this service under MA minus the medicare payment, effective for dates of service on or after July 1, 1988.

(2) NON-REIMBURSABLE SERVICES. The department may reject payment for a service which ordinarily would be covered if the service fails to meet program requirements. Non-reimbursable services include:

(a) Services which fail to comply with program policies or state and federal statutes, rules and regulations, for instance, sterilizations performed without prior authorization and without following proper informed consent procedures, or controlled substances prescribed or dispensed illegally;

(b) Services which the department, the PRO review process or the department fiscal agent's professional consultants determine to be medically unnecessary, inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration;

(c) Non-emergency services provided by a person who is not a certified provider;

(d) Services provided to recipients who were not eligible on the date of the service, except as provided under a prepaid health plan or HMO;

(e) Services for which records or other documentation were not prepared or maintained, as required under s. HSS 106.02 (9);

(f) Services provided by a provider who fails or refuses to prepare or maintain records or other documentation as required under s. HSS 106.02 (9);

(g) Services provided by a provider who fails or refuses to provide access to records as required under s. HSS 106.02 (9) (e) 4;

(h) Services for which the provider failed to meet any or all of the requirements of s. HSS 106.03, including but not limited to the requirements regarding timely submission of claims;

(i) Services provided inconsistent with an intermediate sanction or sanctions imposed by the department under s. HSS 106.08; and

cephalelgia and migraine, pelvic inflammatory disease, gynecologic disease and venereal disease;

3. History of previous contraceptive use;

4. Family, social, physical health, and mental health history, including chronic illnesses, genetic aberrations and mental depression;

5. Physical examination. Recommended procedures for examination are:

a. Thyroid palpation;

b. Examination of breasts and axillary glands;

c. Auscultation of heart and lungs;

d. Blood pressure measurement;

e. Height and weight measurement;

f. Abdominal examination;

g. Pelvic examination; and

h. Examination of extremities.

(c) *Laboratory and other diagnostic services.* Laboratory and other diagnostic services are covered services as indicated in this paragraph. These services may be performed in conjunction with an initial examination with health history, and are the following:

1. Routinely performed procedures:

a. CBC, or hematocrit or hemoglobin;

b. Urinalysis;

c. Papanicolaou smear for females between the ages of 12 and 65;

d. Bacterial smear or culture (gonorrhea, trichomonas, yeast, etc.) including VDRL — syphilis serology with positive gonorrhea cultures; and

e. Serology;

2. Procedures covered if indicated by the recipient's health history:

a. Skin test for TB;

b. Vaginal smears and wet mounts for suspected vaginal infection;

c. Pregnancy test;

d. Rubella titer;

e. Sickle-cell screening;

f. Post-prandial blood glucose; and

g. Blood test for cholesterol, and triglycerides when related to oral contraceptive prescription;

3. Procedures relating to fertility and infertility:

a. Semen analysis, including pelvic exam as necessary;

b. Endometrial biopsy when performed after a hormone blood test;

c. Hysterosalpingogram;

d. Laparoscopy;

e. Cervical mucus exam;

f. Vasectomies;

g. Culdoscopy; and

h. Colposcopy;

4. Procedures relating to genetics, including:

a. Ultrasound;

b. Amniocentesis;

c. Tay-Sachs screening;

d. Hemophilia screening;

e. Muscular dystrophy screening; and

f. Sickle-cell screening; and

5. Colposcopy, culdoscopy, and laparoscopy procedures which may be either diagnostic or treatment procedures.

(d) *Counseling services.* Counseling services in the clinic are covered as indicated in this paragraph. These services may be performed or supervised by a physician, registered nurse or licensed practical nurse. Counseling services may be provided as a result of request by a recipient or when indicated by exam procedures and health history. These services are limited to the following areas of concern:

1. Instruction on reproductive anatomy and physiology;

2. Overview of available methods of contraception, including natural family planning. An explanation of the medical ramifications and effectiveness of each shall be provided;

3. Counseling about venereal disease;

4. Counseling about sterility;

5. Counseling about sterilization accompanied by a full explanation of sterilization procedures including associated discomfort and risks, benefits, and irreversibility;

6. Genetic counseling accompanied by a full explanation of procedures utilized in genetic assessment, including information regarding the medical ramifications for unborn children and planning of care for unborn children with either diagnosed or possible genetic abnormalities;

7. Information regarding teratologic evaluations; and

8. Information and education regarding pregnancies at the request of the recipient, including pre-natal counseling and referral.

(e) *Contraceptive methods.* Procedures related to the prescription of a contraceptive method are covered services. The contraceptive method

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.

HSS 107.34 Prenatal care coordination services. (1) COVERED SERVICES. (a) *General.* 1. Prenatal care coordination services covered by MA are services described in this section that are provided by an agency certified under s. HSS 105.52 or by a qualified person under contract with an agency certified under s. HSS 105.52 to help a recipient and, when appropriate, the recipient's family gain access to medical, social, educational and other services needed for a successful pregnancy outcome. Nutrition counseling and health education are covered services when medically necessary to ameliorate identified high-risk factors for the pregnancy. In this subdivision, "successful pregnancy outcome" means the birth of a healthy infant to a healthy mother.

2. Prenatal care coordination services are available as an MA benefit to recipients who are pregnant, from the beginning of the pregnancy up to the sixty-first day after delivery, and who are at high risk for adverse pregnancy outcomes. In this subdivision, "high risk for adverse pregnancy outcome" means that a pregnant woman requires additional prenatal care services and follow-up because of medical or nonmedical factors, such as psychosocial, behavioral, environmental, educational or nutritional factors that significantly increase her probability of having a low birth weight baby, a preterm birth or other negative birth outcome. "Low birth weight" means a birth weight less than 2500 grams or 5.5 pounds and "preterm birth" means a birth before the gestational age of 37 weeks. The determination of high risk for adverse pregnancy outcome shall be made by use of the risk assessment tool under sub. (c).

(b) *Outreach.* Outreach is a covered prenatal care coordination service. Outreach is activity which involves implementing strategies for identifying and informing low-income pregnant women who otherwise might not be aware of or have access to prenatal care and other pregnancy-related services.

(c) *Risk assessment.* A risk assessment of a recipient's pregnancy-related needs is a covered prenatal care coordination service. The assessment shall be performed by an employe of the certified prenatal care coordination agency or by an employe of an agency under contract with the prenatal care coordination agency. The assessment shall be completed in writing and shall be reviewed and finalized in a face-to-face contact with the recipient. All assessments performed shall be reviewed by a qualified professional under s. HSS 105.52 (2) (a). The risk assessment shall be performed with the risk assessment tool developed and approved by the department.

(d) *Care planning.* Development of an individualized plan of care for a recipient is a covered prenatal care coordination service when performed by a qualified professional as defined in s. HSS 105.52 (2) (a), whether that person is an employe of the agency or under contract with the agency under s. HSS 105.52 (2). The recipient's individualized written plan of care shall be developed with the recipient. The plan shall identify the recipient's needs and problems and possible services which will reduce the probability of the recipient having a preterm birth, low birth weight baby or other negative birth outcome. The plan of care shall include all possible needed services regardless of funding source. Services in the plan shall be related to the risk factors identified in the assessment. To the maximum extent possible, the development of a plan of care shall be done in collaboration with the family or other supportive persons. The plan shall be signed by the recipient and the employe responsible for the development of the plan and shall be reviewed and, if necessary, updated by the employe in consultation with the recipient at least every 60 days. Any updating of the plan of care shall be in writing and shall be signed by the recipient. The plan of care shall include:

1. Identification and prioritization of all risks found during the assessment, with an attached copy of the risk assessment under par. (c);

2. Identification and prioritization of all services to be arranged for the recipient by the care coordinator under par. (e) 2 and the names of the service providers including medical providers;

3. Description of the recipient's informal support system, including collaterals as defined in par. (e) 1, and any activities to strengthen it;

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

5. Arrangements made for and frequency of the various services to be made available to the recipient and the expected outcome for each service;

6. Documentation of unmet needs and gaps in service; and

7. Responsibilities of the recipient.

(e) *Ongoing care coordination.* 1. In this paragraph, "collaterals" means anyone who is in direct supportive contact with the recipient dur-

ing the pregnancy such as a service provider, a family member, the prospective father or any person acting as a parent, a guardian, a medical professional, a housemate, a school representative or a friend .

2. Ongoing coordination is a covered prenatal care coordination service when performed by an employe of the agency or person under contract to the agency who serves as care coordinator and who is supervised by the qualified professional required under s. HSS 105.52 (2) (b) 2. The care coordinator shall follow-up the provision of services to ensure that quality service is being provided and shall evaluate whether a particular service is effectively meeting the recipient's needs as well as the goals and objectives of the care plan. The amount of service provided shall be commensurate with the specific risk factors addressed in the plan of care and the overall level of risk. Ongoing care coordination services include:

a. Face-to-face and phone contacts with recipients for the purpose of determining if arranged services have been received and are effective. This shall include reassessing needs and revising the written plan of care. Face-to-face and phone contact with collaterals are included for the purposes of mobilizing services and support, advocating on behalf of a specific eligible recipient, informing collateral of client needs and the goals and services specified in the care plan and coordinating services specified in the care plan. Covered contacts also include prenatal care coordination staff time spent on case-specific staffings regarding the needs of a specific recipient. All billed contacts with a recipient or a collateral and staffings related to the recipient shall be documented in the recipient prenatal care coordination file; and

b. Recordkeeping documentation necessary and sufficient to maintain adequate records of services provided to the recipient. This may include verification of the pregnancy, updating care plans, making notes about the recipient's compliance with program activities in relation to the care plan, maintaining copies of written correspondence to and for the recipient, noting of all contacts with the recipient and collateral, ascertaining and recording pregnancy outcome including the infant's birth weight and health status and preparation of required reports. All plan of care management activities shall be documented in the recipient's record including the date of service, the person contacted, the purpose and result of the contact and the amount of time spent. A care coordination provider shall not bill for recordkeeping activities if there was no client contact during the billable month.

(f) *Health education.* Health education, either individually or in a group setting, is a covered prenatal care coordination service when provided by an individual who is a qualified professional under s. HSS 105.52 (2) (a) and who by education or at least one year of work experience has the expertise to provide health education. Health education is a covered service if the medical need for it is identified in the risk assessment and the strategies and goals for it are part of the care plan to ameliorate a pregnant woman's identified risk factors in areas including, but not limited to, the following:

1. Education and assistance to stop smoking;

2. Education and assistance to stop alcohol consumption;

3. Education and assistance to stop use of illicit or street drugs;

4. Education and assistance to stop potentially dangerous sexual practices;

5. Education on environmental and occupational hazards related to pregnancy;

6. Lifestyle management consultation;

8. Reproductive health education;

9. Parenting education; and

10. Childbirth education.

(g) *Nutrition counseling.* Nutrition counseling is a covered prenatal care coordination service if provided either individually or in a group setting by an individual who is a qualified professional under s. HSS 105.52 (2) (a) with expertise in nutrition counseling based on education or at least one year of work experience. Nutrition counseling is a covered prenatal care coordination service if the medical need for it is identified in the risk assessment and the strategies and goals for it are part of the care plan to ameliorate a pregnant woman's identified risk factors in areas including, but not limited to, the following:

1. Weight and weight gain ;

2. A biochemical condition such as gestational diabetes;

3. Previous nutrition-related obstetrical complications;

4. Current nutrition-related obstetrical complications;

5. Psychological problems affecting nutritional status;

6. Dietary factors affecting nutritional status; and

7. Reproductive history affecting nutritional status.

(2) LIMITATIONS. (a) Reimbursement for risk assessment and development of a care plan shall be limited to no more than one each for a recipient per pregnancy.

(b) Reimbursement of a provider for on-going prenatal care coordination and health education and nutrition counseling provided to a recipient shall be limited to one claim for each recipient per month and only if the provider has had contact with the recipient during the month for which services are billed.

(c) Prenatal care coordination is available to a recipient residing in an intermediate care facility or skilled nursing facility or as an inpatient in a hospital only to the extent that it is not included in the usual reimbursement to the facility.

(d) Reimbursement of a provider for prenatal care coordination services provided to a recipient after delivery shall only be made if that provider provided prenatal care coordination services to that recipient before the delivery.

(e) A prenatal care coordination service provider shall not terminate provision of services to a recipient it has agreed to provide services for during the recipient's pregnancy unless the recipient initiates or agrees to

the termination. If services are terminated prior to delivery of the child, the termination shall be documented in writing and the recipient shall sign the statement to indicate agreement. If the provider cannot contact a recipient in order to obtain a signature for the termination of services, the provider will document all attempts to contact the recipient through telephone logs and certified mail.

(f) Reimbursement for prenatal care coordination services shall be limited to a maximum amount per pregnancy as established by the department.

(3) NON-COVERED SERVICES. Services not covered as prenatal care coordination services are the following:

(a) Diagnosis and treatment, including:

1. Diagnosis of a physical or mental illness;

2. Follow-up of clinical symptoms;

3. Administration of medications; and

4. Any other professional service, except nutrition counseling or health education, which is a covered service by an MA certified or certifiable provider under this chapter;

(b) Client vocational training;

(c) Legal advocacy by an attorney or paralegal;

(d) Care monitoring, nutrition counseling or health education not based on a plan of care;

(e) Care monitoring, nutrition counseling or health education which is not reasonable and necessary to ameliorate identified prenatal risk factors; and

(f) Transportation.

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