Chapter HSS 107

MEDICAL ASSISTANCE: 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Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.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's or its fiscal agent's professional consultants determine to be not medically necessary, inappropriate or in excess of accepted standards of reasonableness;

(c) Inpatient hospital services or lengths of stay which are not approved by the department, the PRO review process or, pursuant to s. 49.46 (2) (b)7, Stats., by the appropriate board;

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

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

(3) PRIOR AUTHORIZATION. (a) *Procedures for prior authorization.* The department may require prior authorization for covered services. In addition to services designated for prior authorization under each service category in this chapter, the department may require prior authorization for any other covered service for any reason listed in par. (b). The department shall notify in writing all affected providers of any additional services for which it has decided to require prior authorization. The department or its fiscal agent shall act on 95% of requests for prior authorization within 10 working days and on 100% of requests for prior authorization within 20 working days from the receipt of all information necessary to make the determination. The department or its fiscal agent shall make a reasonable attempt to obtain from the provider the information necessary for timely prior authorization decisions. When prior authorization decisions are delayed due to the department's need to seek further information from the provider, the recipient shall be notified by the provider of the reason for the delay.

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

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

2. To safeguard against excess payments;

3. To assess the quality and timeliness of services;

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

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

6. To curtail misutilization practices of providers and recipients.

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

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

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

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

3. The person or provider requesting prior authorization;

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

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

6. Justification for the provision of the service.

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

1. The medical necessity of the service;

2. The appropriateness of the service;

3. The cost of the service;

4. The frequency of furnishing the service;

5. The quality and timeliness of the service;

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

7. The effective and appropriate use of available services;

8. The misutilization practices of providers and recipients;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Recipients who are nursing home residents;

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

3. Recipients who are under age 18;

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

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

6. Family planning services and related supplies;

7. Transportation services by a specialized medical vehicle;

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

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

10. Laboratory and x-ray services prescribed by a physician;

11. Physician office visits over 6 visits per recipient per physician per calendar year;

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

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

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. (1) and am. (14) (c) 12. and 13., Register, February, 1988, No. 386, eff. 3-1-88.

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

(1) Charges for telephone calls;

(2) Charges for missed appointments;

(3) Sales tax on items for resale;

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

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

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

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

(8) Autopsies;

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

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

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

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

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

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

(15) Expenditures for any services to individuals who are inmates of public institutions or patients in psychiatric hospitals, except for those services provided during the calendar month of admission to the facility. An individual on conditional release or convalescent leave from a psychiatric hospital is not considered to be a patient in that facility. However, such an individual who is under age 22 and has been receiving inpatient psychiatric service shall be considered a patient in the facility until either unconditionally discharged or the age of 22 is reached;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(cm) Temporomandibular joint surgery when performed by a physician 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;

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

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

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

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

2. Perirenal insufflation; and

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

(h) Circumcision, female;

(i) Hysterotomy, non-obstetrical or vaginal;

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

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

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

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

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

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

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

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

(q) Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as treatment for hypertension;

(r) Splanchnicectomy, unilateral or bilateral, when used as treatment for hypertension;

(s) Bronchoscopy with injection of contrast medium for bronchography or with injection of radioactive substance;

(t) Basal metabolic rate (BMR);

(u) Protein bound iodine (PBI);

(v) Ballistocardiogram;

(w) Icterus index;

(x) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study;

(y) 1. Angiocardiography, utilizing $C0_2$ method, supervision and interpretation only;

2. Angiocardiography, either single plane, supervision and interpretation in conjunction with cineradiography or multi-plane, supervision and interpretation in conjunction with cineradiography;

(z) 1. Angiography — coronary: unilateral, selective injection, supervision and interpretation only, single view unless emergency;

2. Angiography — extremity: unilateral, supervision and interpretation only, single view unless emergency;

(za) Fabric wrapping of abdominal aneurysm;

(zb) Reversal of tubal ligation or tubal anastamosis;

(zc) Reversal of vasectomy;

(zd) 1. Mammoplasty, reduction or repositioning, one-stage — bilateral;

2. Mammoplasty, reduction or repositioning, two-stage — bilateral;

3. Mammoplasty augumentation, unilateral and bilateral;

(ze) 1. Rhinoplasty, primary;

2. Rhinoplasty, complete;

3. Rhinoplasty, including major septal repair;

(zf) Cingulotomy;

(zg) Dermabrasion;

(zh) Heart transplant;

(zi) Lipectomy;

(zj) Mandibular osteotomy;

(zk) Pancreas transplant;

(zl) Excision or surgical planning for rhinophyma;

(zm) Rhytidectomy;

(zn) Tattoo removal;

(zo) Bone marrow transplant;

(zp) 1. Gastric bypass;

2. Gastric stapling;

(zq) Constructing artificial vagina;

(zr) Plastic operation for insertion of inflatable penile prosthesis, including placement of pump or reservoir;

(zs) Repair blepharoptosis, lid retraction;

(zt) Transsexual surgery;

(zu) Any other surgical or diagnostic procedure identified in the blue cross and blue shield medical necessity project;

Note: Persons interested in obtaining a copy of these procedures may write the Blue Cross and Blue Shield Associations, 211 East Chicago Avenue, Chicago, Illinois 60610. Changes to the list will be published in updates to the Wisconsin Medical Assistance physician provider handbook.

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

Note: The referenced publication is on file and may be reviewed in the department's bureau of health care financing. Interested persons may obtain a copy by writing American Medical Association, 535 N. Dearborn Avenue, Chicago, Illinois 60610.

(zw) Sterilizations.

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

(3) LIMITATIONS ON STERILIZATION. (a) *Conditions for coverage.* Sterilization is covered only if:

1. The individual is at least 21 years old at the time consent is obtained;

2. The individual has not been declared mentally incompetent by a federal, state or local court of competent jurisdiction to consent to sterilization;

3. The individual has voluntarily given informed consent in accordance with all the requirements prescribed in subd. 4 and par. (d); and

4. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(b) *Sterilization by hysterectomy.* 1. A hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing or which would not have been performed except to render the

individual permanently incapable of reproducing is a covered service only if:

a. The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; and

b. The individual or her representative, if any, has signed and dated a written acknowledgment of receipt of that information prior to the hysterectomy being performed.

2. A hysterectomy may be a covered service if it is performed on an individual:

a. Already sterile prior to the hysterectomy and whose physician has provided written documentation, including a statement of the reason for sterility, with the claim form; or

b. Requiring a hysterectomy due to a life-threatening situation in which the physician determines that prior acknowledgment is not possible. The physician performing the operation shall provide written documentation, including a clear description of the nature of the emergency, with the claim form.

Note: Documentation may include an operative note, or the patient's medical history and report of physical examination conducted prior to the surgery.

3. If a hysterectomy was performed for a reason stated under subd. 1 or 2 during a period of the individual's retroactive eligibility for MA under s. HSS 103.08, the hysterectomy shall be covered if the physician who performed the hysterectomy certifies in writing that:

a. The individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing; or

b. The condition in subd. 2. was met. The physician shall supply the information specified in subd. 2.

(c) *Documentation.* Before reimbursement will be made for a sterilization or hysterectomy, the department shall be given documentation showing that the requirements of this subsection were met. This documentation shall include a consent form, an acknowledgment of receipt of hysterectomy information or a physician's certification form for a hysterectomy performed without prior acknowledgment of receipt of hysterectomy information.

Note: Copies of the consent form and the physician's certification form are reproduced in the Wisconsin medical assistance physician provider handbook.

(d) *Informed consent.* For purposes of this subsection, an individual has given informed consent only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had concerning the procedure, provided a copy of the consent form and provided orally all of the following information or advice to the individual to be sterilized:

a. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the

right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled;

b. A description of available alternative methods of family planning and birth control;

c. Information that the sterilization procedure is considered to be irreversible;

d. A thorough explanation of the specific sterilization procedure to be performed;

e. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

f. A full description of the benefits or advantages that may be expected as a result of the sterilization; and

g. Advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in par. (a) 4.

2. Suitable arrangements were made to ensure that the information specified in subd. 1. was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

3. An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;

4. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

5. The consent form requirements of par. (e) were met;

6. Any additional requirement of state or local law for obtaining consent, except a requirement for spousal consent, was followed; and

7. Informed consent is not obtained while the individual to be sterilized is:

a. In labor or childbirth;

b. Seeking to obtain or obtaining an abortion; or

c. Under the influence of alcohol or other substances that affect the individual's state of awareness.

(e) *Consent form.* 1. Consent shall be registered on a form prescribed by the department.

Note: A copy of the informed consent form can be found in the Wisconsin medical assistance physician provider handbook.

2. The consent form shall be signed and dated by:

a. The individual to be sterilized;

b. The interpreter, if one is provided;

c. The person who obtains the consent; and

d. The physician who performs the sterilization procedure.

3. The person securing the consent and the physician performing the sterilization shall certify by signing the consent form that:

a. Before the individual to be sterilized signed the consent form, they advised the individual to be sterilized that no federally funded program benefits will be withdrawn because of the decision not to be sterilized;

b. They explained orally the requirements for informed consent as set forth on the consent form; and

c. To the best of their knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

4. a. Except in the case of premature delivery or emergency abdominal surgery, the physician shall further certify that at least 30 days have passed between the date of the individual's signature on the consent form and the date upon which the sterilization was performed, and that to the best of the physician's knowledge and belief, the individual appeared mentally competent and knowingly and voluntarily consented to be sterilized.

b. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician shall certify that the sterilization was performed less than 30 days but not less than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery. In the case of premature delivery, the physician shall state the expected date of delivery. In the case of abdominal surgery, the physician shall describe the emergency.

5. If an interpreter is provided, the interpreter shall certify that the information and advice presented orally was translated, that the consent form and its contents were explained to the individual to be sterilized and that to the best of the interpreter's knowledge and belief, the individual understood what the interpreter said.

(4) OTHER LIMITATIONS. (a) *Physician's order or prescription.* 1. The following services require a physician's order or prescription in order to be covered under MA:

a. Skilled nursing facility services;

b. Intermediate care facility services;

c. Home health care services, including personal care, and other nursing services;

d. Physical and occupational therapy services;

e. Mental health services;

f. Speech pathology and audiology services;

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

h. Drugs;

i. Prosthetic devices;

j. Diagnostic, screening, preventive and rehabilitative services;

k. Inpatient hospital services;

l. Outpatient hospital services;

m. Inpatient psychiatric hospital services;

n. Long-term private duty nursing services;

o. Hearing aids;

p. Specialized transportation services for persons not requiring a wheelchair; and

q. Hospital private room accommodations.

2. Except as otherwise provided in federal or state statutes, regulations or rules, a prescription or order shall be in writing or given orally and later reduced to writing by the provider filling the prescription, and shall include the date of the 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, and the prescriber's signature. In the case of 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 ordered by prescription shall be provided within one year of the date of the prescription.

3. Prescriptions 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, but shall not exceed 90 days.

(b) *Physician's visits.* A maximum of one physician's visit per month to a recipient confined to a nursing home is covered unless the recipient has an acute condition which warrants more frequent care, in which case the recipient's medical record shall document the necessity of additional visits. The attending physician of a nursing home recipient, or the physician's assistant, or a nurse practitioner under the supervision of a physician, shall reevaluate the recipient's need for nursing home care in accordance with s. HSS 107.09 (3) (m).

(c) *Services of a surgical assistant.* The services of a surgical assistant are not covered for procedures which normally do not require assistance at surgery.

(d) *Consultations.* Certain consultations shall be covered if they are professional services furnished to a recipient by a second physician at the request of the attending physician. Consultations shall include a written report which becomes a part of the recipient's permanent medical record. The name of the attending physician shall be included on the consultant's claim for reimbursement. The following consultations are covered:

1. Consultation requiring limited physical examination and evaluation of a given system or systems;

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

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

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

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

a. Diabetes mellitus;

b. Arteriosclerosis obliterans evidenced by claudication; or

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

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

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

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

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

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

1. Cataract extraction, with or without lens implant;

2. Cholecystectomy;

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

4. Hemorrhoidectomy;

5. Hernia repair, inguinal;

6. Hysterectomy;

7. Joint replacement, hip or knee;

8. Tonsillectomy or adenoidectomy, or both; and

9. Varicose vein surgery.

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

(h) 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.

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

(a) Artificial insemination;

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

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

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

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

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

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

(h) Ear piercing;

(i) Electrolysis;

(j) Tattooing;

(k) Hair transplants;

(l) Vitamin C injections;

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

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

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

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

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

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

(s) Liver injections;

(t) Acupuncture;

(u) Phonocardiogram with interpretation and report;

(v) Vector cardiogram;

(w) Intestinal bypass for obesity;

(x) Separate charges for pump technician services; and

(y) All non-surgical medical or dental treatment for a temporomandibular joint condition.

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.

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

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

1. Clinical oral examinations; and

2. Radiographs:

a. Intraoral — occlusal, single film;

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

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

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

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

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

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

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

2. Pin retention, exclusive of restoration;

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

4. Crowns:

a. Stainless steel — primary cuspid and posteriors only;

b. Stainless steel — primary lateral and centrals; and

c. Recement crowns; and

5. Recement inlays and facings.

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

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

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

a. Anterior exclusion of final restoration;

b. Bicuspids exclusion of final restoration;

c. Apexification or therapeutic apical closure; and

d. Molar, exclusive of final restoration; and

3. Replantation and splinting of traumatically avulsed tooth.

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

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

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

3. Relining upper complete denture;

4. Relining lower complete denture; and

5. Repair damaged complete or partial dentures.

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

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

1. Gingivectomy or gingivoplasty; and

2. Gingival curettage for each quadrant.

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

1. Simple extractions, including sutures;

2. Extraction of impacted teeth under emergency circumstances;

3. Oral antral fistual closure and antral root recovery;

4. Biopsy of oral tissue, hard or soft;

5. Excision of tumors, but not hyperplastic tissue;

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

7. Surgical incision:

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

b. Sequestrectomy for osteomyelitis;

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;

28. Homicidal tendencies;
29. Immunocompromised patient;
30. Intestinal parasitism;
31. Kawaski disease;
32. Laryngotracheobronchitis;
33. Lassa fever, Marburg virus disease;
34. Legionnaires' disease;
35. Leprosy;
36. Listeriosis;
37. Lymphogranuloma venereum;
38. Lyme disease;
39. Malaria;
40. Measles;
41. Melioidosis;
42. Meningitis, aseptic;
43. Meningitis, meningoccoccal;
44. Mumps;
45. Nontuberculous, mycobacterial disease;
46. Plague;
47. Poliomyelitis;
48. Pneumonia with staphylococcus or streptococcus;
49. Pregnancy with infectious diagnosis;
50. Pregnancy, pre-eclampsia;
51. Premature infant with respiratory diagnosis;
52. Psittacosis;
53. Psychosis-acute;
54. Q fever;
55. Rabies;
56. Rat bite fever;
57. Reyes syndrome;
58. Rheumatic fever;
59. Rocky Mountain spotted fever;
60. Rubella and congenital rubella syndrome;
61. Salmonellosis;

62. Scarlet fever;

63. Shigellosis;

64. Smallpox;

65. Staphyloccocal infection;

66. Suicidal tendencies;

67. Tetanus;

68. Toxoplasmosis;

69. Trichinosis;

70. Tuberculosis;

71. Tularemia;

72. Typhoid fever;

73. Uncontrolled seizures;

74. Vaccinia (cowpox); or

75. Vericella or chicken pox.

(c) The attending physician shall determine the need for private room accommodations. Any claim for private room accommodations with a diagnosis not listed in par. (b) shall be suspended and submitted to the medical consultant of the department for postpayment review and shall be denied unless necessity is documented and certified by the 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.

(d) Ambulatory day services shall be considered outpatient services in all cases. Emergency room services shall be considered outpatient services unless the patient is admitted and counted in the midnight census. Patients who are same day admission/discharge patients and who die before the midnight census shall be considered inpatients. On any given day a patient shall be considered either an inpatient or an outpatient, but not both.

(e) The department may identify hospital-provided optional services to which the same coverage policies shall apply as to other MA-certified providers performing similar or comparable services.

(f) Inpatient psychiatric services provided in a general hospital certified pursuant to s. HSS 105.07 shall meet the requirements of s. HSS 107.13 (1). The hospital shall maintain records which reflect authorizations of payment pursuant to s. 49.46 (2) (e), Stats., by the board for the county in which the recipient resides and the financial liability which is due the performing provider by the authorizing 51.42 board.

(g) MA-certified hospitals shall meet the requirements of s. H 24.12 [HSS 124.20].

(h) All covered benefits provided by the hospital during an inpatient stay shall be covered as inpatient services.

(i) Acute general hospitals providing outpatient psychotherapy, AODA or day treatment services shall be certified as providers pursuant to s. HSS 105.22, 105.23 or 105.24.

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

(a) Unnecessary or inappropriate inpatient admissions;

(b) Hospitalizations or portions of hospitalizations disallowed by the peer review organization or the PRO-approved review process;

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

(d) Claims for inpatient services and outpatient services for the same patient on the same date of service;

(e) Hospital admissions on Friday or Saturday, except for emergencies, 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;

(f) Standard hospital laboratory tests not ordered by a physician, except in emergencies; and

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

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. (4) (e) and (f), cr. (4) (g), Register, February, 1988, No. 388, eff. 3-1-88.

HSS 107.09 Nursing home services. (1) DEFINITION. In this section, "active treatment" means an ongoing, organized effort to help each resident attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

(2) COVERED SERVICES. Covered nursing home services are medically necessary services provided by a certified nursing home to an inpatient and prescribed by a physician in a written plan of care. The costs of all routine, day-to-day health care services and materials provided to recipients by a nursing home shall be reimbursed within the daily rate determined for MA in accordance with s. 49.45 (6m), Stats. These services are the following:

(a) Routine services and costs, namely:

1. Nursing services;

2. Special care services, including activity therapy, recreation, social services and religious services;

3. Supportive services, including dietary, housekeeping, maintenance, institutional laundry and personal laundry services, but excluding personal dry cleaning services;

4. Administrative and other indirect services;

5. Physical plant, including depreciation, insurance and interest on plant;

6. Property taxes; and

7. Transportation services provided on or after July 1, 1986;

(b) Personal comfort items, medical supplies and special care supplies. These are items reasonably associated with normal and routine nursing home services which are listed in the nursing home payment formula. If a recipient specifically requests a brand name which the nursing home does not routinely supply and for which there is no equivalent or close substitute included in the daily rate, the recipient, after having been informed in advance that the equivalent or close substitute is not available without charge, will be expected to pay for that brand item at cost out of personal funds; and

(c) Indirect services provided by independent providers of service.

Note #1: Copies of the Nursing Home Payment Formula may be obtained from Records Custodian, Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701.

Note #2: Examples of indirect services provided by independent providers of services are services performed by a pharmacist reviewing prescription services for a facility and services performed by an occupational therapist developing an activity program for a facility.

(3) SERVICES REQUIRING PRIOR AUTHORIZATION. The rental or purchase of a specialized wheelchair for a recipient in a nursing home, regardless of the purchase or rental cost, requires prior authorization from the department.

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

(4) OTHER LIMITATIONS. (a) *Ancillary costs.* 1. Treatment costs which are both extraordinary and unique to individual recipients in nursing homes shall be reimbursed separately as ancillary costs, subject to any modifications made under sub. (1) (b). The following items are not included in calculating the daily nursing home rate but may be reimbursed separately:

a. Oxygen in liters, tanks, or hours, including tank rentals and monthly rental fees for concentrators;

b. Tracheostomy and ventilatory supplies and related equipment, subject to guidelines and limitations published by the department in the provider handbook;

c. Transportation of a recipient to obtain health treatment or care if the treatment or care is prescribed by a physician as medically necessary and is performed at a physician's office, clinic, or other recognized medical treatment center, if the transportation service is provided by the nursing home, in its controlled equipment and by its staff, or by common carrier such as bus or taxi, and if the transportation service was provided

prior to July 1, 1986. Transportation shall not be reimbursed as an ancillary service on or after July 1, 1986; and

Note: Effective July 1, 1986, reimbursement for transportation services is included in the nursing home payment formula.

d. Direct services provided by independent providers of service only if the nursing home can demonstrate to the department that to pay for the service in question as an add-on adjustment to the nursing home's daily rate is equal in cost or less costly than to reimburse the independent service provider through a separate billing. The nursing home may receive an ancillary add-on adjustment to its daily rate in accordance with s. 49.45 (6m) (b), Stats. The independent service provider may not claim direct reimbursement if the nursing home receives an ancillary add-on adjustment to its daily rate for the service.

2. The costs of services and materials identified in subd. 1. which are provided to recipients shall be reimbursed in the following manner:

a. Claims shall be submitted under the nursing home's provider number, and shall appear on the same claim form used for claiming reimbursement at the daily nursing home rate;

b. The items identified in subd. 1. shall have been prescribed in writing by the attending physician, or the physician's entry in the medical records or nursing charts shall make the need for the items obvious;

c. The amounts billed shall reflect the fact that the nursing home has taken advantage of the benefits associated with quantity purchasing and other outside funding sources;

d. Reimbursement for questionable materials and services shall be decided by the department;

e. Claims for transportation shall show the name and address of any treatment center to which the patient recipient was transported, and the total number of miles to and from the treatment center; and

f. The amount charged for transportation may not include the cost of the facility's staff time, and shall be for an actual mileage amount.

(b) *Independent providers of service.* Whenever an ancillary cost is incurred under this subsection by an independent provider of service, reimbursement may be claimed only by the independent provider on its provider number. The procedures followed shall be in accordance with program requirements for that provider specialty type.

(c) *Services covered in a Christian Science sanatorium.* Services covered in a Christian Science sanatorium shall be services ordinarily received by inpatients of a Christian Science sanitorium, but only to the extent that these services are the Christian Science equivalent of services which constitute inpatient services furnished by a hospital or skilled nursing facility.

(d) *Wheelchairs.* Wheelchairs shall be provided by skilled nursing and intermediate care facilities in sufficient quantity to meet the health needs of patients who are recipients. Nursing homes which specialize in providing rehabilitative services and treatment for the developmentally or physically disabled, or both, shall provide the special equipment, including commodes, elevated toilet seats, grab bars, wheelchairs adapted to

the recipient's disability, and other adaptive prosthetics, orthotics and equipment necessary for the provision of these services. The facility shall provide replacement wheelchairs for recipients who have changing wheelchair needs.

(e) *Determination of services as skilled.* In determining whether a nursing service is skilled, the following criteria shall be applied:

1. Where the inherent complexity of a service prescribed for a patient is such that it can be safely and effectively performed only by or under the direct supervision of technical or professional personnel, the service shall constitute a skilled service;

2. The restoration potential of a patient shall not be the deciding factor in determining whether a service is to be considered skilled or nonskilled. Even where full recovery or medical improvement is not possible, skilled care may be needed to prevent, to the extent possible, deterioration of the condition or to sustain current capacities. For example, even though no potential for rehabilitation exists, a terminal cancer patient may require skilled services as defined in this paragraph and par. (f); and

3. A service that is ordinarily nonskilled shall be considered a skilled service where, because of medical complications, its performance or supervision or the observation of the patient necessitates the use of skilled nursing or skilled rehabilitation personnel. For example, the existence of a plaster cast on an extremity generally does not indicate a need for skilled care, but a patient with a preexisting acute skin problem or with a need for special traction of the injured extremity might need to have technical or professional personnel properly adjust traction or observe the patient for complications. In these cases, the complications and special services involved shall be documented by physician's orders and nursing or therapy notes.

(f) *Skilled nursing services or skilled rehabilitation services.* 1. A nursing home shall provide either skilled nursing services or skilled rehabilitation services on a 7-day-a-week basis. If, however, skilled rehabilitation services are not available on a 7-day-a-week basis, the nursing home would meet the requirement in the case of a patient whose inpatient stay is based solely on the need for skilled rehabilitation services if the patient needs and receives these services on at least 5 days a week.

Note: For example, where a facility provides physical therapy on only 5 days a week and the patient in the facility requires and receives physical therapy on each of the days on which it is available, the requirement that skilled rehabilitation services be provided on a daily basis would be met.

2. Examples of services which could qualify as either skilled nursing or skilled rehabilitation services are:

a. Overall management and evaluation of the care plan. The development, management and evaluation of a patient care plan based on the physician's orders constitute skilled services when, in terms of the patient's physical or mental condition, the development, management and evaluation necessitate the involvement of technical or professional personnel to meet needs, promote recovery and actuate medical safety. This includes the management of a plan involving only a variety of personal care services where in light of the patient's condition the aggregate of the services necessitates the involvement of technical or professional personnel. Skilled planning and management activities are not always specifi-

cally identified in the patient's clinical record. In light of this, where the patient's overall condition supports a finding that recovery or safety can be assured only if the total care required is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided;

b. Observation and assessment of the patient's changing condition. When the patient's condition is such that the skills of a nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until the patient's condition is stabilized, the services constitute skilled nursing or rehabilitation services. Patients who in addition to their physical problems exhibit acute psychological symptoms such as depression, anxiety or agitation may also require skilled observation and assessment by technical or professional personnel for their safety and the safety of others. In these cases, the special services required shall be documented by a physician's orders or nursing or therapy notes; and

c. Patient education. In cases where the use of technical or professional personnel is necessary to teach a patient self-maintenance, the teaching services constitute skilled nursing or rehabilitative services.

(g) *Intermediate care facility services (ICF).* 1. Intermediate care services include services that are:

a. Considered appropriate by the department and provided by a Christian Science sanatorium either operated by or listed and certified by the First Church of Christ Scientist, Boston, Mass.; or

b. Provided by a facility located on an Indian reservation that furnishes, on a regular basis, health-related services and is licensed pursuant to s. 50.03, Stats., and ch. HSS 132.

2. Intermediate care services may include services provided in an institution for developmentally disabled persons if:

a. The primary purpose of the institution is to provide health or rehabilitation services for developmentally disabled persons;

b. The institution meets the standards in s. HSS 105.12; and

c. The developmentally disabled recipient for whom payment is requested is receiving active treatment and meeting the requirements of 42 CFR 442.445 and 442.464, s. HSS 132.695 and ch. HSS 134.

3. Intermediate care services may include services provided in a distinct part of a facility other than an intermediate care facility if the distinct part:

a. Meets all requirements for an intermediate care facility;

b. Is an identifiable unit, such as an entire ward or contiguous ward, a wing, a floor, or a building;

c. Consists of all beds and related facilities in the unit;

d. Houses all recipients for whom payment is being made for intermediate care facility services, except as provided in subd. 4;

e. Is clearly identified; and

f. Is approved in writing by the department.

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

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

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

1. At the time of admission; or

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

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

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

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

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

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

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

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

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

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

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

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

HSS 107.10 Drugs. (1) COVERED SERVICES. Drugs and drug products covered by MA include legend and non-legend drugs and supplies listed

in the Wisconsin medicaid drug index, which are prescribed by a physician licensed pursuant to s. 448.04, Stats., by a dentist licensed pursuant to s. 447.05, Stats., or by a podiatrist licensed pursuant to s. 448.04, Stats. The department may determine whether or not drugs judged by the U.S. food and drug administration to be "less than effective" shall be reimbursable under the program.

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

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

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

(b) All schedule III and IV stimulant drugs;

(c) Methaqualone;

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

(e) Decubitex; and

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

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

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

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

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

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

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

1. Digoxin, digitoxin, digitalis;

2. Hydrochlorothiazide and chlorothiazide;

3. Prenatal vitamins;

4. Fluoride;

5. Levothyroxine, liothyronine, thyroid extract;

6. Phenobarbital; and

7. Phenytoin.

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

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

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

1. Antacids;

2. Analgesics;

3. Insulins;

4. Contraceptives;

5. Cough preparations; and

6. Opthalmic lubricants.

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

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

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

(b) Refills of schedule II drugs;

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

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

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

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

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

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

(i) Uneconomically small package sizes;

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

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

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

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

HSS 107.11 Home health services. (1) COVERED SERVICES. (a) Services provided by an agency certified under s. HSS 105.16 which are covered by MA are part-time or intermittent nursing, home health aide and personal care services, medical supplies, equipment and appliances suitable for use in the home, and therapy services which the agency is certified to provide, when provided upon prescription of a physician to a recipient confined to a place of residence other than a hospital, skilled nursing facility or intermediate care facility.

(b) Covered personal care services are:

1. Household services related to maintaining a comfortable and healthy environment in the areas of the home used by the recipient, such as changing the bed, light cleaning, rearrangements to ensure that the recipient can safely reach necessary supplies or medication and laundering essential to the comfort and cleanliness of the recipient;

2. Dietary services related to the nutritional needs of the recipient, such as purchasing food, assisting in meal preparation and washing utensils; and

3. Supplemental assistance to the home health aide in helping with activities of daily living. This assistance may be given either concurrently or subsequently.

(c) Personal care worker services shall be covered by MA only if they are provided by a home health agency which provided personal care workers services as of March 1, 1986.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) In this subsection and in sub. (3), "home health visit" means a period of time during which home health services are provided through personal contact in the recipient's place of residence for the purpose of providing a covered home health service, by a health worker on the staff of the home health agency or by a health worker under contract or by another arrangement with the home health agency. The visit includes time spent on record-keeping, travel time to and from the recipient's residence and actual in-home service time. One home health visit may range from:

1. For home health aides and personal care workers, 15 minutes to 1 hour;

2. For registered nurses and licensed practical nurses, 15 minutes to 4 hours; and

3. For physical therapists, occupational therapists and speech pathologists, 15 minutes to 90 minutes.

(b) No more than one home health visit may be billed within the maximum time period defined as a visit.

Note: For example, a home health agency providing 8 hours of nursing services per day can bill for a maximum of 2 visits, each visit being 4 hours in duration. Twelve hours of nursing services are billed as 3 visits; 10 hours of nursing services are also billed as 3 visits. Two hours of nursing services or other periods of nursing services comprising more than 15 minutes but less than 4 hours are billed as 1 visit. More than one category of practitioner may provide services to a recipient simultaneously; for example, if a therapist and a home health aide are both in a recipient's home for 1 hour, a total of 2 visits (1 home health aide visit and 1 therapist visit) would be counted for that hour.

(c) Prior authorization shall be required for:

1. Home health visits in excess of 160 home health visits per calendar year;

2. Home health visits in excess of 60 home health visits per calendar month;

3. All medical supplies and equipment for which prior authorization is required under s. HSS 107.24 (3); and

4. Nursing services, home health aide services or personal care services, and any combination of these services in excess of 8 hours a day, and all other home health services provided to a recipient who is receiving nursing, home health aide, personal care services or any combination of these services in excess of 8 hours a day.

Note 1: To determine the number of home health visits received by a recipient, add the number of visits received from all categories of home health worker. For example, if a recipient received 20 home health aide visits, 5 nursing visits and 10 therapist visits, the recipient would have receive a total of 35 home health visits.

Note 2: For more information about prior authorization, see s. HSS 107.02 (3).

(3) OTHER LIMITATIONS. (a) All services provided by a certified home health agency shall be provided upon a physician's orders as part of a written plan of care which is reviewed by the physician at least every 60 days. The plan of care shall include diagnosis, specific medical orders, specific types of services required, rehabilitation potential of the recipient and any other appropriate items.

(b) The registered nurse shall reevaluate the recipient's condition at least every 60 days. The reevaluations shall include at least one visit to the recipient's home, a review of the home health aide or personal care worker's daily written record, a review of the plan of care, and contact with the physician as necessary. If a change in level of care is necessary, an appropriate referral shall be made.

(c) Each type of home health service shall be reported and billed as a separate service on the designated MA claim form provided by the department, and shall meet the requirements of chs. HSS 101 to 108.

(d) All therapy and personal care services contracted by the home health agency are considered services provided by the home health agency and shall meet the requirements of this section as well as ss. HSS 107.16, 107.17, and 107.18. These services shall be billed to MA by the home health agency; they may not be separately billed by the contracting agency.

(e) Services covered by another payment source for which the recipient is eligible are not covered by MA unless the provider has received a rejection of coverage from the other payment source and has documented this fact on the MA billing.

(f) All durable medical equipment shall meet the requirements of s. HSS 107.24.

(4) NON-COVERED SERVICES. (a) Home health services provided in a hospital or nursing home are not covered by MA.

(b)Medical social services are not covered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) NON-COVERED SERVICES. (a) Private duty nursing services provided in a hospital or nursing home are not covered services.

(b) Christian Science nursing services rendered in connection with treatment by prayer or spiritual means alone are not covered services.

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

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

HSS 107.13 Mental health services. (1) INPATIENT PSYCHIATRIC SERVICES. (a) *Covered services.* Inpatient psychiatric 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 which meets the requirements of 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 care 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 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 the earlier of the following:

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

b. The date the recipient reaches age 22.

3. Certification of need for services. a. Before a recipient is admitted for inpatient care or, in the case of a person who already is receiving inpatient care before that care may be reimbursed by MA, the team specified under subpar. b., c. or d., as appropriate, shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. The certification specified in this subdivision satisfies the requirement for physician certification in subd. 7.

b. Certification under subpar. a. for an individual who is a recipient when admitted to a facility or program shall be made by the team responsible for the plan of care in subd. 5.

c. Certification under subpar. a. for an individual who applies for MA while in the facility or program shall be made by the team responsible for the plan of care in subd. 5., and may cover any period before application for which claims are made.

d. Certification under subpar. a. for an emergency admission shall be made within 14 days after admission by the team responsible for the plan of care.

4. Active treatment. Inpatient psychiatric services shall involve active treatment. An individual plan of care described in subd. 5. shall be developed and implemented no later than 14 days after admission and shall be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

5. Individual plan of care. a. The individual plan of care shall be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care; be developed by a team of professionals specified under subpar. b. in consultation with the recipient and parents, legal guardians or others into whose care the recipient will be released after discharge; specify treatment objectives; prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

b. The individual plan of care shall be developed by an interdisciplanary team that includes a board-eligible or board-certified psychiatrist; a clinical psychologist who has a doctorate and a physician licensed to practice medicine or osteopathy; or a physician licensed to practice medicine or osteopathy who has specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who is certified by the state. The team shall also include a psychiatric social worker, a registered nurse with specialized training or one year's experience in treating mentally ill individuals, an occupational therapist who is certified by the American occupation therapy association and who has specialized training or one year of experience in treating mentally ill individuals, or a psychologist who has a master's degree in clinical psychology or who has been certified by the state. Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

c. The plan shall be reviewed every 30 days by the team specified in subpar. b. to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

d. The development and review of the plan of care under this subdivision shall satisfy the utilization control requirements for physician certification and establishment and periodic review of the plan of care.

6. Evaluation. a. Before a recipient is admitted to a psychiatric hospital or before payment is authorized for a patient who applies for MA, the attending physician or staff physician shall make a medical evaluation of each applicant's or recipient's need for care in the hospital, and appropriate professional personnel shall make a psychiatric and social evaluation of the applicant's or recipient's need for care.

b. Each medical evaluation shall include a diagnosis, a summary of present medical findings, medical history, the mental and physical status

and functional capacity, a prognosis, and a recommendation by a physician concerning admission to the psychiatric hospital or concerning continued care in the psychiatric hospital for an individual who applies for MA while in the hospital.

7. Physician certification. a. A physician shall certify and recertify for each applicant or recipient that inpatient services in a psychiatric hospital are or were needed.

b. The certification shall be made at the time of admission or, if an individual applies for assistance while in a psychiatric hospital, before the agency authorizes payment.

c. Recertification shall be made at least every 60 days after certification.

8. Physician's plan of care. a. Before a recipient is admitted to a psychiatric hospital or before payment is authorized, the attending physician or staff physician shall document and sign a written plan of care for the recipient or applicant. The physician's plan of care shall include diagnosis, symptoms, complaints and complications indicating the need for admission; a description of the functional level of the individual; objectives; any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet or special procedures recommended for the health and safety of the patient; plans for continuing care, including review and modification to the plan of care; and plans for discharge.

b. The attending or staff physician and other personnel involved in the recipient's care shall review each plan of care at least every 30 days.

9. Record entries. A written report of each evaluation under subd. 6 and the plan of care under subd. 8 shall be entered in the applicant's or recipient's record at the time of admission or, if the individual is already in the facility, immediately upon completion of the evaluation or plan.

(c) *Eligibility for non-institutional services.* Recipients under age 22 or over age 64 who reside in a psychiatric hospital 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.

(d) *Patient's account.* Each recipient who is a patient in a state, county, or private psychiatric hospital shall have an account established for the maintenance of earned or unearned money payments received, including social security and SSI payments. The account for a patient in a state mental health institute shall be kept in accordance with s. 46.07, Stats. The payee for the account may be the recipient, if competent, or a legal representative or bank officer except that a legal representative employed by a county department of social services or the department may not receive payments. If the payee of the resident's account is a legally authorized representative, the payee shall submit an annual report on the account to the U.S. social security administration if social security or SSI payments have been paid into the account.

(e) *Separately billable outpatient services to hospital inpatients.* 1. a. Diagnostic interviews with immediate family members of the recipient 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. A maximum of 5 hours of these interviews shall be covered during the recipient's lifetime.

b. Psychotherapy shall be a covered service when provided to a general hospital inpatient for whom the therapy is prescribed as a component of the plan of care, and when given by a provider certified under s. HSS 105.22 (1) (a) or (b) who is not an employe of the hospital.

c. One diagnostic work-up is allowed per admission.

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

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

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

1. Activities which are primarily diversional in nature such as services which act as social or recreational outlets for the recipient;

2. Mild tranquilizers or sedatives provided solely for the purpose of relieving the recipient's anxiety or insomnia;

3. Consultation with other providers about the recipient's care;

4. Conditional leave, convalescent leave or transfer days from psychiatric hospitals for recipients under the age of 21;

5. Psychotherapy or alcohol and other drug abuse treatment services performed by masters-level therapists certified under s. HSS 105.22 (3);

6. Group therapy services for hospital inpatients;

7. Court appearances, except when necessary to defend against commitment; and

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

Note: Subdivision 8 applies only to services for recipients 21 to 64 years of age who are actually residing in a psychiatric hospital or an IMD. Services provided to a recipient who is a patient in one of these facilities but temporarily hospitalized elsewhere for medical treatment or temporarily residing at a rehabilitation facility or another type of medical facility are covered services.

Note: For more information on non-covered services, see ss. HSS 107.03 and 107.08 (4).

(2) OUTPATIENT PSYCHOTHERAPY SERVICES. (a) *Covered services.* Outpatient psychotherapy services shall be covered services when prescribed by a physician, when provided by a provider who meets the requirements of s. HSS 105.22, and when the following conditions are met:

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;

2. Before the actual provision of psychotherapy services, a physician prescribes psychotherapy in writing;

3. Psychotherapy is furnished by:

a. A provider who is a licensed physician or a licensed psychologist defined 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 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. Psychotherapy is performed only in:

a. The office of a provider;

b. A hospital outpatient clinic;

c. An outpatient facility;

d. A nursing home;

e. A school; or

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

5. The provider who performs psychotherapy shall engage in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed under MA;

6. Outpatient psychotherapy 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 for the county in which the recipient resides without prior authorization by the department; and

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

(b) *Prior authorization.* 1. Reimbursement may be claimed for treatment services beyond 15 hours or $500, whichever limit is obtained 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 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.

3. Persons who review prior authorization requests for the department shall meet the same minimum training that providers are expected to meet.

4. A prior authorization request shall include the following information:

a. The names, addresses and MA provider or identifier numbers of the providers conducting the diagnostic examination or medical evaluation and performing psychotherapy services;

b. A copy of the physician's prescription for treatment;

c. A detailed summary of the differential diagnostic examination, setting forth the severity of the mental illness or medically significant emotional or social dysfunction, the medical necessity for psychotherapy and the expected outcome of treatment;

d. A copy of the treatment plan which shall relate to the findings of the diagnostic examination or medical evaluation and specify behavior and personality changes being sought; and

e. A statement of the estimated frequency of treatment sessions, the estimated cost of treatment and the anticipated location of treatment.

5. The department's decision on a prior authorization request shall be communicated to the provider in writing.

(c) *Other limitations.* 1. Collateral interviews shall be limited to members of the recipient's immediate family. These are parents, spouse and children or, for children in foster care, foster parents.

2. Not 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 at which there are more than one but not more than 10 recipients receiving psychotherapy services together from one or 2 providers. Under no circumstances may more than 2 providers be reimbursed for the same session.

3. Emergency psychotherapy may be performed by a provider for a recipient without a prescription for treatment or prior authorization when the provider has reason to believe that the recipient may immediately injure himself or herself or any other person. A prescription for the emergency treatment shall be obtained within 48 hours of the time the emergency treatment was provided, excluding weekends and holidays. Services shall be incorporated within the limits described in par.(b) and this paragraph, and subsequent treatment may be provided if par. (b) is followed.

4. Diagnostic testing and evaluation for mental health, day treatment and AODA services shall be limited to 6 hours every 2 years per recipient as a unique procedure. Any diagnostic testing and evaluation in excess of

6 hours shall be counted toward the therapy prior authorization limits and may, therefore, be subject to prior authorization.

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

1. Collateral interviews with persons not stipulated in par. (c) 1., and consultations, except as provided in s. HSS 107.06 (4) (d);

2. Psychotherapy for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention;

3. Psychotherapy provided in a person's home;

4. Self-referrals. For purposes of this paragraph, "self-referral" means that a provider refers a recipient to an agency in which the provider has a direct financial interest, or to himself or herself acting as a practitioner in private practice; and

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

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

(3) ALCOHOL AND OTHER DRUG ABUSE TREATMENT SERVICES. (a) *Covered services.* 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:

1. The treatment services furnished are AODA treatment services;

2. Before being enrolled in an alcohol or drug abuse treatment program, the recipient receives a complete medical evaluation, including diagnosis, summary of present medical findings, medical history and explicit recommendations by the physician for participation in the alcohol or other drug abuse treatment program. A medical evaluation performed for this purpose within 60 days prior to enrollment shall be valid for reenrollment;

3. The supervising physician or psychologist develops a treatment plan which relates to behavior and personality changes being sought and to the expected outcome of treatment;

4. Outpatient alcohol or other drug abuse 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 without prior authorization by the department;

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

6. The provider who provides alcohol and other drug abuse treatment services engages in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed; and

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

(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 number of hours of additional outpatient AODA treatment 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 county board in instances where additional services are approved.

3. Persons who review prior authorization requests for the department shall meet the same minimum training requirements that providers are expected to meet.

4. A prior authorization request shall include the following information:

a. The names, addresses and MA provider or identifier numbers of the providers conducting the medical evaluation and performing AODA services;

b. A copy of the physician's prescription for treatment;

c. A copy of the treatment plan which shall relate to the findings of the medical evaluation and specify behavior and personality changes being sought; and

d. A statement of the estimated frequency of treatment sessions, the estimated cost of treatment and the anticipated location of treatment.

5. The department's decision on a prior authorization request shall be communicated to the provider in writing.

(c) *Other limitations.* 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 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.

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

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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dures of questionable medical necessity may not receive departmental authorization, depending upon the individual circumstances.

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

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

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

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

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

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

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

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

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

1. Expressive language:

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

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

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

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

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

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

g. Stuttering evaluation;

h. Syntax evaluation;

i. Vocabulary evaluation;

j. Voice evaluation;

k. Zimmerman pre-school language scale; and

1. Illinois test of psycholinguistic abilities;

2. Receptive language:

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

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

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

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

e. Auditory processing evaluation;

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

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

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

i. Question evaluation;

j. Syntax evaluation;

k. Visual discrimination evaluation;

l. Visual memory evaluation;

m. Visual sequencing evaluation;

n. Visual processing evaluation;

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

p. Zimmerman pre-school language scale; and

q. Illinois test of psycholinguistic abilities;

3. Pre-school speech skills:

a. Diadochokinetic rate evaluation; and

b. Oral peripheral evaluation; and

4. Hearing-auditory training:

a. Auditory screening;

b. Informal hearing evaluation;

c. Lip-reading evaluation;

d. Auditory training evaluation;

e. Hearing-aid orientation evaluation; and

f. Non-verbal evaluation.

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

1. Expressive language:

a. Articulation;

b. Fluency;

c. Voice;

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

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

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

2. Receptive language:

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

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

3. Pre-speech skills:

a. Oral and peri-oral structure;

b. Vegetative function of the oral motor skills; and

c. Volitional oral motor skills; and

4. Hearing/auditory training:

a. Hearing screening and referral;

b. Auditory training;

c. Lip reading;

d. Hearing aid orientation; and

e. Non-verbal communication.

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

(b) *Requirement.* Prior authorization is required under this subsection for speech and language pathology services provided to an MA recipient in excess of 45 treatment days per spell of illness, except that speech and language pathology services provided to an MA recipient who is a hospital inpatient or who is receiving speech therapy services provided by a home health agency are not subject to prior authorization under this subsection.

Note: Speech and language pathology services provided by a home health agency are subject to prior authorization under s. HSS 107.11 (2).

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

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

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

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

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

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

a. Multiple sclerosis;

b. Rheumatoid arthritis; or

c. Parkinson's disease; or

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

(d) *Onset and termination of spell of illness.* The spell of illness begins with the first day of treatment or evaluation following the onset of the new disease, injury or medical condition or increased severity of a pre-existing medical condition and ends when the recipient improves so that treatment by a speech and language pathologist for the condition causing the spell of illness is no longer required, or after 45 treatment days, whichever comes first.

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

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

(g) *Other coverage.* Treatment days covered by medicare or other third-party insurance shall be included in computing the 45-day per spell of illness total.

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

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

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

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

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

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

(c) *Evaluations.* Evaluations shall be covered services. The need for an evaluation or re-evaluation shall be documented in the plan of care. Evaluations shall be counted toward the 45-day per spell of illness prior authorization threshold.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Audiological evaluation;

(b) Hearing aid evaluation;

(c) Hearing aid performance check;

(d) Audiological tests;

(e) Audiometric techniques;

(f) Impedance audiometry;

(g) Aural rehabilitation; and

(h) Speech and audiotherapy.

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

1. Speech and audiotherapy;

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6. From a nursing home to another nursing home. This shall be considered non-emergency transportation;

7. From a recipient's residence or nursing home to a physician's or dentist's office, if the transportation is to obtain a physician's or dentist's services which require special equipment for diagnosis or treatment that cannot be obtained in the nursing home or recipient's residence. This shall be considered non-emergency transportation; or

8. In an isolette. This shall be considered non-emergency transportation.

(c) *Transport by non-emergency vehicle.* Specialized medical vehicle (SMV) transportation shall be a covered service if the recipient is legally blind or permanently disabled as documented by a physician with the documentation maintained by the provider, or if the recipient's condition contraindicates transportation by a common carrier and the recipient's physician has prescribed specialized medical vehicle transportation. This type of transportation service, and the return trip, is covered only if the transportation is to a facility at which the recipient primarily receives MA-covered medical services. SMV trips by cot or stretcher are covered if they have been prescribed by a physician and meet the prescription requirements of s. HSS 107.06 (4) (a) 3. In this paragraph, "permanent disability" means a chronic debilitating physical or mental impairment which includes an inability to ambulate without personal assistance or requires the use of mechanical walking aids such as a wheelchair, a walker or crutches.

(d) *More than one passenger.* A provider of transportation service may carry more than one recipient at a time.

(e) *Transport provided by the county agency.* County agencies shall pay for necessary transportation to MA-covered medical services by public carrier or private motor vehicle when this transportation is provided as an administrative service in accordance with sub. (3).

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

(a) *Air or water ambulance.* All non-emergency transportation of a recipient by air or water ambulance to receive medical services; and

(b) *Long distance transports.* Non-emergency transportation of a recipient to a provider in another state unless the non-emergency transportation is for the purpose of receiving services from a provider who is a certified Wisconsin border-status provider.

(3) COUNTY APPROVAL OF TRANSPORT BY PUBLIC CARRIER OR PRIVATE MOTOR VEHICLE. (a) *Covered service.* 1. Transportation by a non-certified public carrier, that is, by bus, taxi, train or airplane, or by private motor vehicle to a Wisconsin provider or a border-status provider to receive covered MA services shall be a covered administrative service if approved by the county agency under par. (b) or (c). The transportation costs shall include the cost of the public carrier or mileage expenses.

2. When the necessary transportation is more than routine, such as transportation to receive a service that is only available in another county or state, the travel time may warrant coverage of related travel expenses. These expenses may include the cost of meals and commercial

lodging enroute to medical care, while receiving the care and when returning from the care, and the cost of an attendant to accompany the recipient if necessary. The cost of an attendant may include the attendant's transportation, lodging, meals and salary, except that no reimbursement may be paid to a member of the recipient's family.

3. The transportation service shall be reimbursed directly to the recipient or to the vendor by the county agency if the service is not provided directly by the county agency.

(b) *Non-emergency transportation.* 1. Non-emergency transportation of a recipient by public carrier or private motor vehicle is subject to approval by the county agency before departure.

2. The county agency may require documentation by the medical services provider of the service received at the specific location.

(c) *Emergency transportation.* If a recipient for emergency reasons beyond that person's control is unable to obtain the county agency's authorization for necessary transportation prior to the transportation, such as for a trip to a hospital emergency room on a weekend, the county agency may provide retroactive authorization. The county agency may require documentation from the medical services provider or the transportation provider, or both, to establish that the transportation was necessary.

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

(4) OTHER LIMITATIONS. (a) *Ambulance transportation for inter-facility transfers.* When hospital-to-hospital or nursing home-to-nursing home transfers are made by ambulance, the ambulance provider shall obtain a written certification from the recipient's physician that the discharging institution was not an appropriate facility for the patient's condition and that the admitting institution was the nearest one appropriate for that condition. This certification shall contain the reasons for which the discharging institution was considered inappropriate and the reasons for which the admitting institution was considered appropriate. The certification document shall be signed by the recipient's physician and shall also contain details pertinent to the recipient's condition. A checkoff form is not acceptable. This document shall be kept by the ambulance provider.

(b) *Prescription requirements for nonemergency transportation.* For nonemergency ambulance transport:

1. The ambulance provider shall obtain a statement, signed by a physician or dentist. The statement shall include the recipient's name, the date of transport, the details about the recipient's condition that preclude transport by any other means, the specific circumstances requiring that the recipient be transported to the office or clinic to obtain a service and the services performed, and an explanation of why the service could not be performed in the nursing home or recipient's residence. The signature of the physician or dentist performing the service shall be dated. This statement shall be maintained by the provider of the transportation service;

2. The services obtained shall be performed by a physician or dentist or under the direct supervision of a physician or dentist; and

3. Trips by ambulance to obtain physical therapy, occupational therapy, speech therapy, audiology, chiropractic or psychotherapy are not covered.

(c) *Transportation to a non-medical facility.* If specialized medical vehicle (SMV) transportation is provided to a facility whose function is not primarily medical, the transportation shall be covered if the primary purpose of the trip is to receive medical services. The provider shall obtain from the provider of services at the destination a written statement of the medical services provided. This statement shall be maintained by the provider of transportation service.

(d) *Non-emergency transportation for nursing home outpatient services.* If ambulance or SMV transportation is to a nursing home for the provision of outpatient services, a statement of services received shall be obtained from the nursing home. This statement shall be maintained by the provider of transportation service.

(e) *Waiting time charges.* Charges for waiting time are covered charges. For non-emergency services, waiting time is allowable only when a continuous trip is being billed. In this paragraph, "waiting time" means time when the transportation provider is waiting for the recipient to receive medical services and return to the vehicle.

(f) *Specialized medical vehicle transportation of ambulatory recipients.* When the recipient has not been declared legally blind or has not been determined to be permanently disabled by a physician, a physician's prescription for SMV transportation stating the specific medical problem preventing the use of public-carrier transportation and the specific period of time the service should be provided, shall be obtained. A check-off form is not acceptable. This prescription shall be obtained prior to the transport and shall be valid for a maximum of 90 days from the physician's signature date. The provider shall indicate on the claim form that a prescription is on file with the provider, and shall indicate the name and provider number of the prescribing physician.

(g) *Attendant services.* 1. Services of a second SMV transportation attendant are covered only if the recipient's condition requires the physical presence of another person for purposes of restraint or lifting. Only recipients evidencing violent behavior shall be considered to require restraints.

2. Services of a second ambulance attendant are covered only if the recipient's condition requires the physical presence of another person for purposes of restraint or lifting. Medical personnel who care for the recipient in transit shall bill the program separately.

(h) *Recipient's death before ambulance arrival.* 1. If a recipient is pronounced dead by a legally authorized person after an ambulance is called out but before the ambulance arrives at the pick-up site, emergency service to the point of pick-up is covered.

2. If ambulance service is provided to a recipient who is pronounced dead enroute or dead on arrival by a legally authorized person, the entire ambulance service is covered as an emergency service.

(i) *County transportation services.* Transportation provided by county agencies shall involve the least expensive means of transportation which the recipient is capable of using and which is reasonably available at the

time the service is required. Reimbursement to the recipient may be limited to mileage to the nearest MA provider if the recipient has reasonable access to health care of adequate quality from that provider.

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

(a) Charges for reusable devices and equipment;

(b) Transportation of a recipient's personal belongings only;

(c) Transportation of a lab specimen only;

(d) Charges for sterilization of a vehicle after carrying a recipient with a contagious disease;

(e) Additional charges for services provided at night or on weekends, or on holidays;

(f) Emergency transportation of a recipient who is pronounced dead by a legally authorized person before an ambulance is called;

(g) Excessive mileage charges resulting from the use of indirect routes to and from medical destinations;

(h) Transport of a recipient's relatives;

(i) Unloaded ambulance or specialized medical vehicle mileage; and

(j) Additional charges by an ambulance provider for drugs used in transit, or for starting intravenous solutions or EKG monitoring.

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) (c) and (4) (5), Register, February, 1988, No. 386, eff. 3-1-88.

HSS 107.24 Durable medical equipment and medical supplies. (1) DEFINITION. In this chapter, "medical supplies" means disposable, consumable, expendable or nondurable medically necessary supplies which have a very limited life expectancy. Examples are plastic bed pans, catheters, electric pads, hypodermic needles, syringes, continence pads and oxygen administration circuits.

(2) COVERED SERVICES. (a) *Prescription and provision.* Durable medical equipment (DME) and medical supplies are covered services only when prescribed by a physician and when provided by a certified physician, clinic, hospital outpatient department, nursing home, pharmacy, home health agency, therapist, orthotist, prosthetist, hearing aid dealer or medical equipment vendor.

(b) *Items covered.* Covered services are limited to items contained in the Wisconsin durable medical equipment (DME) and medical supplies indices. Items prescribed by a physician which are not contained in one of these indices or in the listing of non-covered services in sub. (5) require submittal of a DME additional request. Should the item be deemed covered, a prior authorization request may be required.

(c) *Categories of durable medical equipment.* The following are categories of durable medical equipment covered by MA:

1. Occupational therapy assistive or adaptive equipment. This is medical equipment used in a recipient's home to assist a disabled person to adapt to the environment or achieve independence in performing daily personal functions. Examples are adaptive hygiene equipment, adaptive positioning equipment and adaptive eating utensils.

2. Orthopedic or corrective shoes. These are any shoes attached to a brace for prosthesis; mismatched shoes involving a difference of a full size or more; or shoes that are modified to take into account discrepancy in limb length or a rigid foot deformation. Arch supports are not considered a brace. Examples of orthopedic or corrective shoes are supinator and pronator shoes, surgical shoes for braces, and custom-molded shoes.

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

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

1. Nursing, technician, and related services;

2. Use of ambulatory surgical center facilities;

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

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

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

6. Materials for anesthesia.

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

1. Physician services;

2. Laboratory services;

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

4. Prosthetic devices;

5. Ambulance services;

6. Leg, arm, back and neck braces;

7. Artificial limbs; and

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

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

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

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

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

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

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

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

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

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

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

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

(2) COVERED SERVICES. (a) *General.* Hospice services covered by the MA program effective July 1, 1988 are, except as otherwise limited in this chapter, those services provided to an eligible recipient by a provider certified under s. HSS 105.50 which are necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided to the family and other individuals caring for the terminally ill recipient. Hospice services shall be provided only to those medical assistance recipients residing in a skilled nursing or intermediate care facility who are entitled, under medicare, to receive hospice care.

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

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

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

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

a. An assessment of the needs of the recipient;

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

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

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

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

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

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

2. Physician services;

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

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

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

1. Physical therapy;

2. Occupational therapy;

3. Speech pathology;

4. Home health aide and homemaker services;

5. Durable medical equipment and supplies;

6. Drugs; and

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

(3) OTHER LIMITATIONS. (a) *Short-term inpatient care.* 1. General inpatient care necessary for pain control and symptom management shall be provided by a hospital or skilled nursing facility certified under this chapter.

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

3. Use of inpatient care for a recipient may not exceed 20% of the total number of hospice care days of all MA recipients enrolled in the recipient's hospice.

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

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

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

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

(d) *Reimbursement for services.* 1. The hospice shall be reimbursed for care of a recipient at per diem rates set by the department. A maximum amount shall be established by the department for care of a recipient, to be applied to all recipients participating in the hospice's program.

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

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

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

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

HSS 107.32 Case management services. (1) COVERED SERVICES. (a) *General.* 1. Case management services covered by MA are services described in this section and provided by an agency certified under s. HSS 105.51 or by a qualified person under contract to an agency certified under s. HSS 105.51 to help a recipient, and, when appropriate, the recipient's family gain access to, coordinate or monitor necessary medical, social, educational, vocational and other services.

2. Case management services under pars. (b) and (c) are provided under s. 49.45 (25), Stats., as benefits to those recipients in a county in which case management services are provided who are over age 64, are diagnosed as having Alzheimer's disease or other dementia, or are mem-

bers of one or more of the following target populations: developmentally disabled, chronically mentally ill who are age 21 or older, alcoholic or drug dependent, physically or sensory disabled, or under the age of 21 and severely emotionally disturbed. In this subdivision, "severely emotionally disturbed" means having emotional and behavioral problems which:

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

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

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

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

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

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

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

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

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

(b) *Case assessment.* A comprehensive assessment of a recipient's abilities, deficits and needs is a covered case management service. The assessment shall be made by a qualified employe of the certified case management agency or by a qualified employe of an agency under contract to the case management agency. The assessment shall be completed in writing and shall include face-to-face contact with the recipient. Persons performing assessments shall possess skills and knowledge of the needs and dysfunctions of the specific target population in which the recipient is included. Persons from other relevant disciplines shall be included when results of the assessment are interpreted. The assessment shall document gaps in service and the recipient's unmet needs, to enable the case management provider to act as an advocate for the recipient and assist other

human service providers in planning and program development on the recipient's behalf. All services which are appropriate to the recipient's needs shall be identified in the assessment, regardless of availability or accessibility of providers or their ability to provide the needed service. The written assessment of a recipient shall include:

1. Identifying information;

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

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

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

5. Social status and skills;

6. Psychiatric symptomatology, and mental and emotional status;

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

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

b. Formal service providers;

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

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

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

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

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

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

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

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

(c) *Case planning.* Following the assessment with its determination of need for case management services, a written plan of care shall be developed to address the needs of the recipient. Development of the written plan of care is a covered case management service. To the maximum extent possible, the development of a care plan shall be a collaborative pro-

cess involving the recipient, the family or other supportive persons and the case management provider. The plan of care shall be a negotiated agreement on the short and long term goals of care and shall include:

1. Problems identified during the assessment;

2. Goals to be achieved;

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

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

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

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

7. Documentation of unmet needs and gaps in service.

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

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

2. Face to face and phone contact with collaterals for the purposes of mobilizing services and support, advocating on behalf of a specific eligible recipient, educating collaterals on client needs and the goals and services specified in the plan, and coordinating services specified in the plan. In this paragraph, "collateral" means anyone involved with the recipient, including a paid provider, a family member, a guardian, a housemate, a school representative, a friend or a volunteer. Collateral contacts also include case management staff time spent on case-specific staffings and formal case consultation with a unit supervisor and other professionals regarding the needs of a specific recipient. All contacts with collaterals shall be documented and may include travel time and other allowable overhead costs that must be incurred to provide the service; and

3. Recordkeeping necessary for case planning, service implementation, coordination and monitoring. This includes preparing court reports, updating case plans, making notes about case activity in the client file, preparing and responding to correspondence with clients and collaterals, gathering data and preparing application forms for community programs, and reports. All time spent on recordkeeping activities shall be

documented in the case record. A provider, however, may not bill for recordkeeping activities if there was no client or collateral contact during the billable month.

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

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

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

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

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

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

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

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

1. Diagnosis of a physical or mental illness;

2. Monitoring of clinical symptoms;

3. Administration of medications;

4. Client education and training;

5. Legal advocacy by an attorney or paralegal;

6. Provision of supportive home care;

7. Home health care;

8. Personal care; and

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

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

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

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

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

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

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

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