.eplaced Register April, 1988 No. 388

Chapter HSS 107

MEDICAL ASSISTANCE: COVERED SERVICES

HSS 107.01 General statement of coverage (p. 109)
HSS 107.02 General limitations (p. 110)
HSS 107.03 Services not covered (p. 113)
HSS 107.035 Definition and identification of experimental services (p. 114)
HSS 107.04 Coverage of out-of-state services (p. 115)
HSS 107.05 Coverage of emergency services provided by a person not a certified provider (p. 115)
HSS 107.06 Physician services (p. 115)
HSS 107.07 Dental services (p. 125)
HSS 107.08 Hospital services (p. 131)
HSS 107.09 Nursing home services (p. 135)
HSS 107.10 Drugs (p. 143)
HSS 107.11 Home health services (p. 146)
HSS 107.12 Independent nursing and nurse-midwife services (p. 148)
HSS 107.13 Mental health services (p. 149)
HSS 107.15 Chiropractic services (p. 158-1)
HSS 107.16 Physical therapy (p. 160)
HSS 107.17 Occupational therapy (p. 169)
HSS 107.18 Speech and language pathology services (p. 175)
HSS 107.19 Audiology services (p. 180)
HSS 107.20 Vision care services (p. 183)
HSS 107.21 Family planning services (p. 184)
HSS 107.22 Early and periodic screening, diagnosis and treatment (EPSDT) services (p. 187)
HSS 107.23 Transportation (p. 188)
HSS 107.24 Durable medical equipment and medical supplies (p. 192)
HSS 107.25 Diagnostic testing services (p. 196)
HSS 107.26 Dialysis services (p. 196)
HSS 107.27 Blood (p. 196)
HSS 107.28 Health maintenance organization and prepaid health plan services (p. 196)
HSS 107.29 Rural health clinic services (p. 198)
HSS 107.30 Ambulatory surgical center services (p. 199)
HSS 107.31 Hospice care services (p. 201)
HSS 107.32 Case management services (p. 202-2)
HSS 107.33 Ambulatory prenatal services for recipients with presumptive eligibility (p. 202-7)

Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.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

(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.