(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. Services to any recipient enrolled in a hospice under s. HSS 107.31;

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

7. Family planning services and related supplies;

8. Transportation services by a specialized medical vehicle;

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

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

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

12. 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;

13. Personal care services provided by a certified personal care provider; or

14. Case management services.

(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; cr. (4) (c) 14., Register, April, 1988, No. 388, eff. 7-1-88; r. and recr. (4) (c), Register, December, 1988, No. 396, eff. 1-1-89.

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 service to an individual who is an inmate of a public institution or for any service to a person 21 to 64 years of age who is a resident of an institution for mental diseases (IMD), unless the person is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, except that expenditures for a service to an individual on convalescent leave from an IMD may be reimbursed by MA.

(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; emerg. r. and recr. (15), eff. 8-1-88; r. and recr. (15), Register, December, 1988, No. 396, eff. 1-1-89; emerg. am. (15), eff. 6-1-89; am. (15), Register, February, 1990, No. 410, eff. 3-1-90.

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;

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.

(3m) ALCOHOL AND OTHER DRUG ABUSE DAY TREATMENT SERVICES. (a) *Covered services.* Alcohol and other drug abuse day treatment services shall be covered when prescribed by a physician, provided by a provider certified under s. HSS 105.25 and performed according to the recipient's treatment program in a non-residential, medically supervised setting, and when the following conditions are met:

1. An initial assessment is performed by qualified medical professionals under s. HSS 61.61 (6) for a potential participant. Services under this section shall be covered if the assessment concludes that AODA day treatment is medically necessary and that the recipient is able to benefit from treatment;

2. A treatment plan based on the initial assessment is developed by the interdisciplinary team in consultation with the medical professionals who conducted the initial assessment and in collaboration with the recipient;

3. The supervising physician or psychologist approves the recipient's written treatment plan;

4. The treatment plan includes measureable individual goals, treatment modes to be used to achieve these goals and descriptions of expected treatment outcomes; and

5. The interdisciplinary team monitors the recipient's progress, adjusting the treatment plan as required.

(b) *Prior authorization.* 1. All AODA day treatment services except the initial assessment shall be prior authorized.

2. Any recommendation by the county human services department under s. 46.23, Stats., or the county community programs department

under s. 51.42, Stats., shall be considered in review and approval of the prior authorization request.

3. Department representatives who review and approve prior authorization requests shall meet the same minimum training requirements as those mandated for AODA day treatment providers under s. HSS 105.25.

(c) *Other limitations.* 1. AODA day treatment services in excess of 5 hours per day are not reimbursable under MA.

2. AODA day treatment services may not be billed as psychotherapy, AODA outpatient treatment, case management, occupational therapy or any other service modality except AODA day treatment.

3. Reimbursement for AODA day treatment services may not include time devoted to meals, rest periods, transportation, recreation or entertainment.

4. Reimbursement for AODA day treatment assessment for a recipient is limited to 3 hours in a calendar year. Additional assessment hours shall be counted towards the mental health outpatient dollar or hour limit under sub. (2) (a) 6 before prior authorization is required or the AODA outpatient dollar or hour limit under sub. (3) (a) 4 before prior authorization is required.

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

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

2. Time spent in the AODA day treatment setting by affected family members of the recipient;

3. AODA day treatment services which are primarily recreation-oriented or which are provided in non-medically supervised settings. These include but are not limited to sports activities, exercise groups, and activities such as crafts, leisure time, social hours, trips to community activities and tours;

4. Services provided to an AODA day treatment recipient which are primarily social or only educational in nature. Educational sessions are covered as long as these sessions are part of an overall treatment program and include group processing of the information provided;

5. Prevention or education programs provided as an outreach service or as case-finding; and

6. AODA day treatment provided in the recipient's home.

(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; emerg. cr. (3m), eff. 3-9-89; cr. (3m), Register, December, 1989, No. 408, eff. 1-1-90.

emerg cr 107.14 eff 7/1/90

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.

(3) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) *Requirement.* 1. Prior authorization is required for services beyond the initial visit and 20 spinal manipulations per spell of illness. The prior authorization request shall include a justification of why the condition is chronic and why it warrants the scope of service being requested.

2. Prior authorization is required for spinal supports which have been prescribed by a physician or chiropractor if the purchase or rental price of a support is over $75. Rental costs under $75 shall be paid for one month without prior approval.

(b) *Conditions justifying spell of illness designation.* The following conditions may justify designation of a new spell of illness if treatment for the condition is medically necessary:

1. An acute onset of a new spinal subluxation;

2. An acute onset of an aggravation of pre-existing spinal subluxation by injury; or

3. An acute onset of a change in pre-existing spinal subluxation based on objective findings.

(c) *Onset and termination of spell of illness.* The spell of illness begins with the first day of treatment or evaluation following the onset of a condition under par. (b) and ends when the recipient improves so that treatment by a chiropractor for the condition causing the spell of illness is no longer medically necessary, or after 20 spinal manipulations, whichever comes first.

(d) *Documentation.* The chiropractor shall document the spell of illness in the patient plan of care.

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

(f) *Other coverage.* Treatment days covered by medicare or other third-party insurance shall be included in computing the 20 spinal manipulation per spell of illness total.

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

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

(4) OTHER LIMITATIONS. (a) An x-ray or set of x-rays, such as anterior-posterior and lateral, is a covered service only for an initial visit if the x-ray is performed either in the course of diagnosing a spinal subluxation or in the course of verifying symptoms of other medical conditions beyond the scope of chiropractic.

(b) A diagnostic urinalysis is a covered service only for an initial office visit when related to the diagnosis of a spinal subluxation, or when verifying a symptomatic condition beyond the scope of chiropractic.

(c) The billing for an initial office visit shall clearly describe all procedures performed to ensure accurate reimbursement.

(5) NON-COVERED SERVICES. Consultations between providers regarding a diagnosis or treatment 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 107.16 Physical therapy. (1) COVERED SERVICES. (a) *General.* Covered physical therapy services are those medically necessary modalities, procedures and evaluations enumerated in pars. (b) to (d), when prescribed by a physician and performed by a qualified physical therapist (PT) or a certified physical therapy assistant under the direct, immediate, on-premises supervision of a physical therapist. Specific services performed by a physical therapy aide under par. (e) are covered when provided in accordance with supervision requirements under par. (e) 3.

(b) *Evaluations.* Covered evaluations, the results of which shall be set out in a written report to accompany the test chart or form in the recipient's medical record, are the following:

1. Stress test;

2. Orthotic check-out;

3. Prosthetic check-out;

4. Functional evaluation;

5. Manual muscle test;

6. Isokinetic evaluation;

7. Range-of-motion measure;

8. Length measurement;

9. Electrical testing:

a. Nerve conduction velocity;

b. Strength duration curve — chronaxie;

c. Reaction of degeneration;

d. Jolly test (twitch tetanus); and