Chapter HSS 107

COVERED SERVICES

Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.

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

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

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

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

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

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

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

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

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

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

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

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

(b) Services which the department'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.

11. Meal preparation, food purchasing and meal serving;

12. Simple transfers including bed to chair or wheelchair and reverse; and

13. Accompanying the recipient to obtain medical diagnosis and treatment.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) Prior authorization is required for personal care services in excess of 250 hours per calendar year.

(b) Prior authorization is required for specific services listed in s. HSS 107.11 (2) (a) to (j), under the conditions cited in s. HSS 107.11 (3) (f).

(3) OTHER LIMITATIONS. (a) Personal care services shall be performed under the supervision of a registered nurse by a personal care worker who meets the requirements of s. HSS 105.17 (3) and who is employed by or is under contract to a provider certified under s. HSS 105.17.

(b) Services shall be performed according to a written plan of care for the recipient developed by a registered nurse for purposes of providing necessary and appropriate services, allowing appropriate assignment of a personal care worker and setting standards for personal care activities, giving full consideration to the recipient's preferences for service arrangements and choice of personal care workers. The plan shall be based on the registered nurse's visit to the recipient's home and shall include:

1. Review and interpretation of the physician's orders;

2. Frequency and anticipated duration of service;

3. Evaluation of the recipient's needs and preferences; and

4. Assessment of the recipient's social and physical environment, including family involvement, living conditions, the recipient's level of functioning and any pertinent cultural factors such as language.

(c) Review of the plan of care, evaluation of the recipient's condition and supervisory review of the personal care worker shall be made by a registered nurse at least every 60 days. The review shall include a visit to the recipient's home, review of the personal care worker's daily written record and discussion with the physician of any necessary changes in the plan of care.

(d) Reimbursement for registered nurse supervisory visits is limited to one visit per month.

(e) No more than one-third of the time spent by a personal care worker may be in performing housekeeping activities.

(f) Home health aide services may not include personal care services under sub. (1) (b) unless the recipient is ill and is bed-bound as defined in s. HSS 107.11 (2) (k).

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

(a) Personal care services provided in a hospital or a nursing home or in a community-based residential facility, as defined in s. 50.01 (1), Stats., with more than 20 beds;

(b) Homemaking services and cleaning of areas not used during personal care service activities, unless directly related to the care of the person and essential to the recipient's health;

(c) Personal care services not documented in the plan of care;

(d) Personal care services provided by a responsible relative under s. 49.90, Stats.;

(e) Personal care services provided in excess of 250 hours per calendar year without prior authorization;

(f) Services other than those listed in sub. (1) (b);

(g) Skilled nursing services, including:

1. Insertion and sterile irrigation of catheters;

2. Giving of injections;

3. Application of dressings involving prescription medication and use of aseptic techniques; and

4. Administration of medicine that is not usually self-administered; and

(h) Therapy services.

History: Cr. Register, April, 1988, No. 388, eff. 7-1-88; renum. (2) to be (2) (a), cr. (2) (b), am. (3) (e), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.12 Independent nursing services. (1) DEFINITIONS. In this section:

(a) "Extended care" means home nursing services provided for 8 or more hours in a calendar day.

(b) "Part-time, intermittent care" means home nursing services provided for less than 8 hours in a calendar day.

(2) COVERED SERVICES. (a) Services provided by a certified registered nurse (RN) in independent practice are those services prescribed by a physician which comprise the practice of professional nursing as described under s. 441.11 (3), Stats., and s. N 6.03. Services provided by a certified licensed pracitical nurse (LPN) are those services which comprise the practice of practical nursing under s. 441.11 (4), Stats., and s. N 6.04. An LPN may provide nursing services delegated by an RN as delegated nursing acts under the requirements of s. N 6.03 and guidelines established by the board of nursing. The following services are available only when documentation is provided to the department that an existing home health agency cannot provide the services and if the prescription calls for a level of care which the nurse is licensed to provide:

1. Nursing services provided in the home on a part-time, intermittent basis when prescribed by a physician; and

2. Extended care home nursing services provided in the home when prescribed by a physician and if the prescription calls for a level of care which the nurse is licensed to provide. These extended care services are available for recipients who need more continuous care in the home than can be provided on a part-time, intermittent basis.

(b) 1. A plan of care including physician's orders shall be established for every recipient accepted for care and shall be incorporated in the recipient's medical record. An initial plan of care shall be developed within 72 hours after acceptance, which shall include the physician's orders and preliminary treatment goals and methods for delivering needed care. The total plan of care shall be developed in consultation with the recipient and the recipient's physician and shall be signed by the physician within 20 working days following the recipient's admission for care. The total plan of care shall include, besides the physician's order:

a. Measurable time-specific goals, with benchmark dates for review; and

b. The methods for delivering needed care, and an indication of which, if any, other professional disciplines are responsible for delivering the care.

2. The total plan of care shall be reviewed by the attending physician as often as required by the recipient's condition, but not less often than every 62 days. The RN or LPN shall promptly notify the physician of any change in the recipient's condition that suggests a need to modify the plan of care.

(c) Drugs and treatment shall be administered by the RN or LPN only as ordered by the attending physician. The nurse shall immediately record and sign oral orders and shall obtain the physician's countersignature within 10 working days.

(d) Reasonable time spent on recordkeeping, travel time to and from the recipient's residence to provide needed care and medically necessary actual service time in the recipient's residence are covered services under this section.

(3) PRIOR AUTHORIZATION. (a) Prior authorization is required for:

1. Part-time, intermittent home nursing services beyond 50 hours per recipient per calendar year; and

2. All extended care home nursing services.

(b) Part-time intermittent care or extended home nursing for which prior authorization is requested is limited to no more than 12 continuous hours in each 24 hours, no more than 60 hours per week, for the number of weeks care continues to be medically necessary, when provided by a single provider for a recipient.

(c) A request for prior authorization of part-time intermittent care or extended home nursing services performed by an LPN shall include the name and license number of the registered nurse supervising the LPN.

(4) OTHER LIMITATIONS. Documentation and recordkeeping. Each independent RN or LPN shall document the care and services provided. Documentation required under sub. (2) (a) of the unavailability of a home health agency shall include names of agencies contacted, dates of contact and any other information pertinent to this requirement under sub. (2) (a).

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; emerg. r. and recr. eff. 7-1-90; r. and recr. Register, January, 1991, No. 421, eff. 2-1-91.

HSS 107.121 Nurse-midwife services. (1) COVERED SERVICES. Covered services provided by a certified nurse-midwife 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 4.

(2) LIMITATION. Coverage for nurse-midwife services for management and care of the mother and newborn child shall end after the sixth week of postpartum care.

HSS 107.122 Independent nurse practitioner services. (1) COVERED SERVICES. Services provided by a nurse practicioner, including a clinical nurse specialist, which are covered by the MA program are those medical services delegated by a licensed physician by a written protocol developed with the nurse practitioner pursuant to the requirements set forth in s. N 6.03 (2) and guidelines set forth by the medical examining board and the board of nursing. General nursing procedures are covered services when performed by a certified nurse practitioner or clinical nurse specialist in accordance with the requirements of s. N 6.03 (1). These services may include those medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative services provided in a medical setting, the recipient's home or elsewhere. Specific reimbursable delegated medical acts and nursing services are the following:

(a) Under assessment and nursing diagnosis:

1. Obtaining a recipient's complete health history and recording the findings in a systematic, organized manner;

2. Evaluating and analyzing a health history critically;

3. Performing a complete physical assessment using techniques of observation, inspection, auscultation, palpation and percussion, ordering appropriate laboratory and diagnostic tests and recording findings in a systematic manner;

4. Performing and recording a developmental or functional status evaluation and mental status examination using standardized procedures; and

5. Identifying and describing behavior associated with developmental processes, aging, life style and family relationships;

(b) Under analysis and decision-making:

1. Discriminating between normal and abnormal findings associated with growth and development, aging and pathological processes;

2. Discriminating between normal and abnormal patterns of behavior associated with developmental processes, aging, life style, and family relationships as influenced by illness;

3. Exercising clinical judgment in differentiating between situations which the nurse practitioner can manage and those which require consultations or referral; and

4. Interpreting screening and selected diagnostic tests;

(c) Under management, planning, implementation and treatment:

1. Providing preventive health care and health promotion for adults and children;

2. Managing common self-limiting or episodic health problems in recipients according to protocol and other guidelines;

3. Managing stabilized illness problems in colloration with physicians and other health care providers according to protocol;

4. Prescribing, regulating and adjusting medications as defined by protocol;

5. Recommending symptomatic treatments and non-prescription medicines;

6. Counseling recipients and their families about the process of growth and development, aging, life crises, common illnesses, risk factors and accidents;

7. Helping recipients and their families assume greater responsibility for their own health maintenance and illness care by providing instruction, counseling and guidance;

8. Arranging refferrals for recipients with health problems who need further evaluation or additional services; and

9. Modifying the therapeutic regimen so that it is appropriate to the developmental and functional statuses of the recipient and the recipient's family;

(d) Under evaluation:

1. Predicting expected outcomes of therapeutic regimens;

2. Collecting systematic data for evaluating the response of a recipient and the recipient's family to a therapeutic regimen;

3. Modifying the plan of care according to the response of the recipient;

4. Collecting systematic data for self-evaluation and peer review; and

5. Utilizing an epidemiological approach in examining the health care needs of recipients in the nurse practitioner's caseload;

(e) Physician services described under s. HSS 107.06 that are under protocol;

(f) Services under s. HSS 107.08 performed for an inpatient in a hospital;

(g) Outpatient hospital services, as described in s. HSS 107.08 (1) (b);

(h) Family planning services, as described in s. HSS 107.21;

(i) Early and periodic screening, diagnosis and treatment (EPSDT) services, as described in s. HSS 107.22;

(j) Prescriptions for drugs and recipient transportation; and

(k) Disposable medical supplies, as described in s. HSS 107.24.

(2) PRIOR AUTHORIZATION. (a) Services under sub. (1) (e) to (k) are subject to applicable prior authorization requirements for those services.

(b) Requests for prior authorization shall be accompanied by the written protocol.

(3) OTHER LIMITATIONS. (a) No services under this section may be reimbursed without a written protocol developed and signed by the nurse practitioner and the delegating physician, except for general nursing procedures described under s. N 6.03 (1). The physician shall review a protocol according to the requirements of s. 448.03 (2) (e), Stats., and guidelines established by the medical examining board and the board of nursing, but no less than once each calendar year. A written protocol shall be organized as follows:

1. Subjective data;

2. Objective data;

3. Assessment;

4. Plan of care; and

5. Evaluation.

(b) Prescriptions for drugs are limited to those drugs allowed under protocol for prescription by a nurse practitioner, except that controlled substances may not be prescribed by a nurse practitioner.

(4) NON-COVERED SERVICES. Non-covered services are:

(a) Mental health and alcohol and other drug abuse services;

(b) Services provided to nursing home residents or hospital inpatients which are included in the daily rates for a nursing home or hospital;

(c) Rural health clinic services;

(d) Dispensing durable medical equipment; and

(e) Medical acts for which the nurse practitioner or clinical nurse specialist does not have written protocols as specified in this section. In this paragraph, "medical acts" means acts reserved by professional training and licensure to physicians, dentists and podiatrists.

History: Emerg. cr. eff. 7-1-90; cr. Register, Jnauary, 1991, No. 421, eff. 2-1-91.

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

Next page is numbered 163

1. Case management services provided under s. HSS 107.32 by a provider not certified under s. HSS 105.255 to provide CSP services;

2. Services provided to a resident of an intermediate care facility, skilled nursing facility or an institution for mental diseases, or to a hospital patient unless the services are performed to prepare the recipient for discharge form the facility to reside in the community;

3. Services related to specific job-seeking, job placement and work activities;

4. Services performed by volunteers;

5. Services which are primarily recreation-oriented; and

6. Legal advocacy performed by an attorney or paralegal.

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. (2) (c) 5., (3) (c) 2., (4) (c) 4. and (6), eff. 1-1-90; cr. (2) (c) 5., (3) (c) 2., (4) (c) 4. and (6), Register, September, 1990, No. 417, eff. 10-1-90.

HSS 107.14 Podiatry services. (1) COVERED SERVICES. (a) Podiatry services covered by medical assistanace are those medically necessary services for the diagnosis and treatment of the feet and ankles, within the limitations described in this section, when provided by a certified podiatrist.

(b) The following categories of services are covered services when performed by a podiatrist:

1. Office visits;

2. Home visits;

3. Nursing home visits;

4. Physical medicine;

5. Surgery;

6. Mycotic conditions and nails;

7. Laboratory;

8. Radiology;

9. Plaster or other cast material used in cast procedures and strapping or tape casting for treating fractures, dislocations, sprains and open wounds of the ankle, foot and toes;

10. Unna boots; and

11. Drugs and injections.

(2) OTHER LIMITATIONS. (a) Podiatric services pertaining to the cleaning, trimming and cutting of toenails, often referred to as palliative or maintenance care, shall be reimbursed once per 61 day period only if the recipient is under the active care of a physician and the recipient's condition is one of the following:

1. Diabetes mellitus;

2. Arteriosclerosis obliterans evidenced by claudication;

3. Peripheral neuropathies involving the feet, which are associated with:

a. Malnutrition or vitamin deficiency;

b. Diabetes mellitus;

c. Drugs and toxins;

d. Multiple sclerosis; or

e. Uremia;

4. Cerebral palsy;

5. Multiple sclerosis;

6. Spinal cord injuries;

7. Blindness;

8. Parkinson's disease;

9. Cerebrovascular accident; or

10. Scleroderma.

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

(c) Initial diagnostic services are covered when performed in connection with a specfic symptom or complaint if it seems likely that treatment would be covered even though the resulting diagnosis may be one requiring non-covered care.

(d) Physical medicine modalities may include, but are not limited to, hydrotherapy, ultrasound, iontophoresis, transcutaneous neurostimulator (TENS) prescription, and electronic bone stimulation. Physical medicine is limited to 10 modality services per calendar year for the following diagnoses only:

1. Osteoarthritis;

2. Tendonitis;

3. Enthesopathy;

4. Sympathetic reflex dystrophy;

5. Subclacaneal bursitis; and

6. Plantar fascitis, as follows:

a. Synovitis;

b. Capsulitis;

c. Bursitis; or

d. Edema.

(e) Services provided during a nursing home visit to cut, clean or trim toenails, corns, callouses or bunions of more than one resident shall be reimbursed at the nursing home single visit rate for only one of the res-

idents seen on that day of service. All other claims for residents seen at the nursing home on the same day of service shall be reimbursed up to the multiple nursing home visit rate. The podiatrist shall identify on the claim form the single resident for whom the nursing home single visit rate is applicable, and the residents for whom the multiple nursing home visit rate is applicable.

(f) Debridement of mycotic conditions and mycotic nails is a covered service provided that utilization guidelines established by the department are followed.

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

(a) Procedures which do not relate to the diagnosis or treatment of the ankle or foot;

(b) Palliative or maintenance care, except under sub. (2);

(c) All orthopedic and orthotic services except plaster and other material cast procedures and strapping or tape casting for treating fractures, dislocations, sprains or open wounds of the ankle, foot or toes;

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

(e) Physical medicine exceeding the limits specfied under sub. (2) (d);

(f) Repairs made to orthopedic and orthotic appliances;

(g) Dispensing and repairing corrective shoes;

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

(i) Treatment of subluxation of the foot; and

(j) All other services not specifially identified as covered in this section.

History: Emerg. cr. eff. 7-1-90; cr. Register, January, 1991, No. 421, eff. 2-1-91.

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 per-

formed 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

Next page is numbered 175