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Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.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

(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. Cost-sharing requirements for providers are described under s. HSS 106.04 (2), and services and recipients exempted from cost-sharing requirements are listed under s. HSS 104.01 (12) (a).

(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.

(d) *Limitation on copayments for prescription drugs.* Providers may not collect copayments in excess of $5 a month from a recipient for prescrip-

tion 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; emerg. am. (4) (a), r. (4) (c), eff. 1-1-90; am. (4) (a) r. (4) (c), Register, September, 1990, No. 417, eff. 10-1-90.

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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Perirenal insufflation; and

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

(h) Circumcision, female;

(i) Hysterotomy, non-obstetrical or vaginal;

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

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

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

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

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

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

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

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

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

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

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

(t) Basal metabolic rate (BMR);

(u) Protein bound iodine (PBI);

(v) Ballistocardiogram;

(w) Icterus index;

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

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

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

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

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

(za) Fabric wrapping of abdominal aneurysm;

(zb) Reversal of tubal ligation or tubal anastamosis;

(zc) Reversal of vasectomy;

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

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

3. Mammoplasty augumentation, unilateral and bilateral;

(ze) 1. Rhinoplasty, primary;

2. Rhinoplasty, complete;

3. Rhinoplasty, including major septal repair;

(zf) Cingulotomy;

(zg) Dermabrasion;

(zh) Heart transplant;

(zi) Lipectomy;

(zj) Mandibular osteotomy;

(zk) Pancreas transplant;

(zl) Excision or surgical planning for rhinophyma;

(zm) Rhytidectomy;

(zn) Tattoo removal;

(zo) Bone marrow transplant;

(zp) 1. Gastric bypass;

2. Gastric stapling;

(zq) Constructing artificial vagina;

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

(zs) Repair blepharoptosis, lid retraction;

(zt) Transsexual surgery;

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

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

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

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

(zw) Sterilizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled;

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

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

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

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

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

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

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

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

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

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

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

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

a. In labor or childbirth;

b. Seeking to obtain or obtaining an abortion; or

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

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

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

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

a. The individual to be sterilized;

b. The interpreter, if one is provided;

c. The person who obtains the consent; and

d. The physician who performs the sterilization procedure.

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

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

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

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

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

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

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

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

a. Skilled nursing facility services;

b. Intermediate care facility services;

c. Home health care services 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;

q. Hospital private room accommodations; and

r. Personal care services

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) *Dental services.* Dental services performed by a physician shall be subject to all requirements for MA dental services described in s. HSS 107.07.

(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; and

(x) Separate charges for pump technician services; and

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; am. (4) (a) 1. c., p. and q., cr. (4) (a) 1. r., Register, April, 1988, No. 388, eff. 7-1-88; r. (2) (cm) and (5) (y), r. and recr. (4) (h), Register, December, 1988, No. 396, eff. 1-1-89.

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.* Covered fixed prosthodontic procedures are:

1. Recement bridges;

2. Metallic, inlay, onlaying cusps retainer;

3. Crown bridge retainers;

4. Bridge pontics;

5. Cast or prefabricated post and core for bridge retainers only;

6. Stress breakers.

(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;

(n) Dispensing of drugs;

(o) Adult full-mouth x-ray series;

(p) Adjunctive periodontal services;

(q) Surgical removal of erupted teeth, except as otherwise stated in sub (3);

(r) Alveoplasty and stomatoplasty;

(s) All non-surgical medical or dental treatment for a temporomandibular joint condition;

(t) Osteoplasty, except as otherwise stated in sub. (2);

(u) Bitewing x-rays, except as otherwise stated in sub. (3); and

(v) Diagnostic casts, except as otherwise stated in sub. (3).

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

(5) UNUSUAL CIRCUMSTANCES. In certain unusual circumstances the department may request that a non-covered service be performed, including but not limited to diagnostic casts, in order to substantiate a prior authorization request. In these cases the service shall be reimbursed.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (c) 10. and (2) (c) 9. e. and f., cr. (2) (c) 9. g. and (3) (8), r. and recr. (4) (q), Register, February, 1988, No. 386, eff. 3-1-88; r. and recr. (1) (g) and (4) (j), renum. (2) (c) 9. to 12. and (4) (k) to (t) to be (2) (c) 10. to 13. and (4) (m) to (v), cr. (2) (c) 9., (4) (k) and (l), Register, December, 1989, No. 408, eff. 1-1-90; correction in (4) (j) made under s. 13.93 (2m) (b) 7, Stats., Register, December, 1989, No. 408.

HSS 107.08 Hospital services. (1) COVERED SERVICES. (a) *Inpatient hospital services.* Covered inpatient hospital services are those medically necessary services, excluding podiatry services provided by a podiatrist as defined in s. 448.01 (7) Stats., which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients, and which are provided under the direction of a physician or dentist in an institution which is a certified provider. Complementary services, such as physical and occupational therapy, shall be provided under the supervision of professionals who meet the appropriate certification standards specified in ch. HSS 105.

(b) *Outpatient hospital services.* Covered hospital outpatient services are limited to those preventive, diagnostic, rehabilitative or palliative items or services, furnished by or under the direction of a physician or dentist to an outpatient in a certified hospital, which are within one of the following categories:

1. Physician services, except mental health services, in accordance with s. HSS 107.06;

2. Early and periodic screening, diagnosis and treatment services for persons under 21 years of age, in accordance with s. HSS 107.22;

3. Rural health clinic services, in accordance with s. HSS 107.29;

4. Home health services, or nursing services if a home health agency is unavailable, in accordance with s. HSS 107.11;

5. Laboratory and x-ray services, in accordance with s. HSS 107.25;

6. Family planning services and supplies, in accordance with s. HSS 107.21; or

7. Nurse midwife services, in accordance with s. HSS 107.12.

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

(a) Covered hospital services if provided out-of-state under non-emergency circumstances by non-border status providers;

(b) Hospitalization for non-emergency dental services; and

(c) Hospitalization for any medical service noted in s. HSS 107.06 (2), 107.07 (2) (c), 107.10 (2), 107.13 (2) (b), 107.16 (2), 107.17 (2), 107.18 (2), 107.19 (2), 107.20 (2), or 107.24 (2). The admitting physician shall either obtain the prior authorization directly or ensure that prior authorization has been obtained by the attending physician or dentist.

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

(3) OTHER LIMITATIONS. (a) Inpatient admission for nontherapeutic sterilization is a covered service only if the procedures specified in s. HSS 107.06 (3) are followed.

(b) Private room accommodations are covered services when the recipient has one or more of the following diagnoses:

1. Acquired immune deficiency;

2. Acute viral infection;

3. Agammaglobulinemia;

4. Amebiasis;

5. Anthrax;

6. Aplastic leukemia;

7. Bacillary dysentery;

8. Botulism;

9. Brucellosis;

10. Burn — third degree;

11. Cellulitis;

12. Cerebral concussion;

13. Cholera;

14. Conjunctivitis, inclusion;

15. Diarrhea enteropathic, E. coli;

16. Diptheria;

17. Encephalitis, viral;

18. Epidemic influenza;

19. Epiglottitis;
20. Gas gangrene due to costridium perfringens;
21. Gastroenteritis due to salmonella, shigella or E. coli.;
22. Giadiasis;
23. Gonococcal opthalmia neonatorum;
24. Granuloma inguinall;
25. Hepatitis, types A, B, non-A, non-B;
26. Herpes simplex & disseminated neonatal;
27. Histoplasmosis;
28. Homicidal tendencies;
29. Immunocompromised patient;
30. Intestinal parasitism;
31. Kawaski disease;
32. Laryngotracheobronchitis;
33. Lassa fever, Marburg virus disease;
34. Legionnaires' disease;
35. Leprosy;
36. Listeriosis;
37. Lymphogranuloma venereum;
38. Lyme disease;
39. Malaria;
40. Measles;
41. Melioidosis;
42. Meningitis, aseptic;
43. Meningitis, meningoccoccal;
44. Mumps;
45. Nontuberculous, mycobacterial disease;
46. Plague;
47. Poliomyelitis;
48. Pneumonia with staphylococcus or streptococcus;
49. Pregnancy with infectious diagnosis;
50. Pregnancy, pre-eclampsia;
51. Premature infant with respiratory diagnosis;
52. Psittacosis;

53. Psychosis-acute;

54. Q fever;

55. Rabies;

56. Rat bite fever;

57. Reyes syndrome;

58. Rheumatic fever;

59. Rocky Mountain spotted fever;

60. Rubella and congenital rubella syndrome;

61. Salmonellosis;

62. Scarlet fever;

63. Shigellosis;

64. Smallpox;

65. Staphyloccocal infection;

66. Suicidal tendencies;

67. Tetanus;

68. Toxoplasmosis;

69. Trichinosis;

70. Tuberculosis;

71. Tularemia;

72. Typhoid fever;

73. Uncontrolled seizures;

74. Vaccinia (cowpox); or

75. Vericella or chicken pox.

(c) The attending physician shall determine the need for private room accommodations. Any claim for private room accommodations with a diagnosis not listed in par. (b) shall be suspended and submitted to the medical consultant of the department for postpayment review and shall be denied unless necessity is documented and certified by the attending physician. When a private room is not medically necessary, neither MA nor the recipient may be held responsible for the cost of the private room charge. If, however, a recipient requests a private room and the hospital informs the recipient at the time of admission of the cost differential, and if the recipient understands and agrees to pay the differential, then the recipient may be charged for the differential.

(d) Ambulatory day services shall be considered outpatient services in all cases. Emergency room services shall be considered outpatient services unless the patient is admitted and counted in the midnight census. Patients who are same day admission/discharge patients and who die before the midnight census shall be considered inpatients. On any given

day a patient shall be considered either an inpatient or an outpatient, but not both.

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

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

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

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

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

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

(a) Unnecessary or inappropriate inpatient admissions;

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

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

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

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

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

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

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (4) (e) and (f), cr. (4) (g), Register, February, 1988, No. 388, eff. 3-1-88; correction in (3) (g) made under s. 13.93 (2m) (b) 7, Stats., Register, June, 1990, No. 414.

HSS 107.09 Nursing home services. (1) DEFINITION. In this section, "active treatment" means an ongoing, organized effort to help each resi-

dent attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

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

(a) Routine services and costs, namely:

1. Nursing services;

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

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

4. Administrative and other indirect services;

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

6. Property taxes; and

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

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

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

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

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

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

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

(4) OTHER LIMITATIONS. (a) *Ancillary costs.* 1. Treatment costs which are both extraordinary and unique to individual recipients in nursing homes shall be reimbursed separately as ancillary costs, subject to any

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

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the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

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

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

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

b. Each medical evaluation shall include a diagnosis, a summary of present medical findings, medical history, the mental and physical status and functional capacity, a prognosis, and a recommendation by a physician concerning admission to the psychiatric hospital or concerning continued care in the psychiatric hospital for an individual who applies for MA while in the hospital.

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

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

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

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

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

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

(c) *Eligibility for non-institutional services.* Recipients under age 22 or over age 64 who reside in a psychiatric hospital are eligible for MA benefits for services not provided through that institution and not reimbursed as part of the cost of care of that individual in the institution.

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

(e) *Separately billable outpatient services to hospital inpatients.* 1. a. Diagnostic interviews with immediate family members of the recipient shall be covered services. In this subdivision, "immediate family members" means parents, guardian, spouse and children or, for a child in a foster home, the foster parents. A maximum of 5 hours of these interviews shall be covered during the recipient's lifetime.

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

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

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

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

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

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

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

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

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

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

6. Group therapy services for hospital inpatients;

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

8. Inpatient services for recipients between the ages of 21 and 64 when provided by a psychiatric hospital or an institution for mental disease,

except that services may be provided to a 21 year old resident of a psychiatric hospital or IMD if the person was a resident of one of those institutions immediately prior to turning 21 and continues to be a resident after turning 21.

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

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

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

1. A differential diagnostic examination is performed by a certified psychotherapy provider pursuant to the approval of the board for the county in which the recipient resides. A physician's prescription is not necessary to perform the examination;

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

3. Psychotherapy is furnished by:

a. A provider who is a licensed physician or a licensed psychologist defined under s. HSS 105.22 (1) (a) or (b), and who is working in an outpatient facility defined under s. HSS 105.22 (1) (c) or (d) which is certified to participate in MA and which is operated by or under contract with the board, or who is working in private practice and has a contract with the board; or

b. A provider under s. HSS 105.22 (3) who is working in an outpatient facility defined in s. HSS 105.22 (1) (c) or (d) which is certified to participate in MA and which is operated by or under contract with the board;

4. Psychotherapy is performed only in:

a. The office of a provider;

b. A hospital outpatient clinic;

c. An outpatient facility;

d. A nursing home;

e. A school; or

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

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

6. Outpatient psychotherapy services of up to $500 or 15 hours per recipient in a calendar year, whichever limit is reached first, may be authorized by the board for the county in which the recipient resides without prior authorization by the department; and

7. If reimbursement is also made to any provider for alcohol or other drug abuse treatment services under sub. (3) during the same year for the same recipient, the hours reimbursed for these services shall be considered part of the $500 or 15-hour psychotherapy limit before prior authorization shall be required. If several psychotherapy providers are treating the same recipient during the year, all the psychotherapy shall also be considered in the $500 or 15-hour total. However, if a recipient is hospitalized as an inpatient in an acute care general hospital with a diagnosis of, or for a procedure associated with, a psychiatric condition, reimbursement for any inpatient psychotherapy services is not included in the $500, 15-hour limit for outpatient psychotherapy. For hospital inpatients, the differential diagnostic examination for psychotherapy and the medical evaluation for alcoholism or other drug abuse treatment services also are not included.

(b) *Prior authorization.* 1. Reimbursement may be claimed for treatment services beyond 15 hours or $500, whichever limit is obtained first, after receipt of authorization by the recipient's board and prior authorization from the department. Services reimbursed by any third-party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified number of additional hours of outpatient services to be provided to a recipient within the calendar year. The department shall require periodic progress reports and subsequent prior authorization requests as well as authorization by the board in instances where additional services are approved.

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

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

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

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

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

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

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

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

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

2. Not more than one provider may be reimbursed for the same psychotherapy session, unless the session involves a couple, a family group or is a group therapy session. In this subdivision, "group therapy session" means a session at which there are more than one but not more than 10 recipients receiving psychotherapy services together from one or 2 providers. Under no circumstances may more than 2 providers be reimbursed for the same session.

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

4. Diagnostic testing and evaluation for mental health, day treatment and AODA services shall be limited to 6 hours every 2 years per recipient as a unique procedure. Any diagnostic testing and evaluation in excess of 6 hours shall be counted toward the therapy prior authorization limits and may, therefore, be subject to prior authorization.

5. Services under this subsection are not reimbursable if the recipient is receiving community support program services under sub. (6).

(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.* 1. 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.

2. Services under this subsection are not reimbursable if the recipient is receiving community support program services under sub. (6).

(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 pre-

scribed 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.

4. Services under this subsection are not reimbursable if the recipient is receiving community support program services under sub. (6).

(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.

(6) COMMUNITY SUPPORT PROGRAM (CSP) SERVICES. *Covered services.* Community support program (CSP) services shall be covered services when prescribed by a physician and provided by a provider certified under s. HSS 105.255 for recipients who can benefit from the services. These non-institutional services make medical treatment and related care and rehabilitative services available to enable a recipient to better manage the symptoms of his or her illness, to increase the likelihood of the recipient's independent, effective functioning in the community and to reduce the incidence and duration of institutional treatment otherwise brought about by mental illness. Services covered are as follows:

1. Initial assessment. At the time of admission, the recipient, upon a psychiatrist's order, shall receive an initial assessment conducted by a psychiatrist and appropriate professional personnel to determine the need for CSP care;

2. In-depth assessment. Within one month following the recipient's admission to a CSP, a psychiatrist and a treatment team shall perform an in-depth assessment to include all of the following areas:

a. Evaluation of psychiatric symptomology and mental status;

b. Use of drugs and alcohol;

c. Evaluation of vocational, educational and social functioning;

d. Ability to live independently;

e. Evaluation of physical health, including dental health;

f. Assessment of family relationaships; and

g. Identification of other specific problems or needs;

3. Treatment plan. A comprehensive written treatment plan shall be developed for each recipient and approved by a psychiatrist. The plan shall be developed by the treatment team with the participation of the recipient or recipient's guardian and, as appropriate, the recipient's family. Based on the initial and in-depth assessments, the treatment plan shall specify short-term and long-term treatment and restorative goals, the services required to meet these goals and the CSP staff or other agencies providing treatment and psychosocial rehabilitation services. The treatment plan shall be reviewed by the psychiatrist and the treatment

team at least every 30 days to monitor the recipient's progress and status;

4. Treatment services, as follows:

a. Family, individual and group psychotherapy;

b. Symptom management or supportive psychotherapy;

c. Medication prescription, administration and monitoring;

d. Crisis intervention on a 24-hour basis, including short-term emergency care at home or elsewhere in the community; and

e. Psychiatric and psychological evaluations;

5. Psychological rehabilitation services as follows;

a. Employment-related services. These services consist of counseling the recipient to identify behaviors which interfere with seeking and maintaining employment; development of interventions to alleviate problem behaviors; and supportive services to assist the recipient with grooming, personal hygiene, acquiring appropriate work clothing, daily preparation for work, on-the-job support and crisis assistance;

b. Social and recreational skill training. This training consists of group or individual counseling and other activities to facilitate appropriate behaviors, and assistance given the recipient to modify behaviors which interfere with family relationships and making friends;

c. Assistance with and supervision of activities of daily living. These services consist of aiding the recipient in solving everyday problems; assisting the recipient in performing household tasks such as cleaning, cooking, grocery shopping and laundry; assisting the recipient to develop and improve money management skills; and assisting the recipient in using available tranaportation;

d. Other support services. These services consist of helping the recipient obtain necessary medical, dental, legal and financial services and living accomodations; providing direct assistance to ensure that the recipient obtains necessary government entitlements and services, and counseling the recipient in appropriately relating to neighbors, landlords, medical personnel and other personal contacts; and

6. Case management in the form of ongoing monitoring and service coordination activities described in s. HSS 107.32 (1) (d).

(b) *Other limitations.* 1. Mental health services under s. HSS 107.13 (2) and (4) are not reimbursable for recipients receiving CSP services.

2. An initial assessment shall be reimbursed only when the recipient is first admitted to the CSP and following discharge from a hospital after a short-term stay.

3. Group therapy is limited to no more than 10 persons in a group. No more than 2 professionals shall be reimbursed for a single session of group therapy. Mental health technicians shall not be reimbused for group therapy.

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

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

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c. The recipient has no special need which would necessitate either the diagnostic tools of an audiologist or a comprehensive evaluation requiring the expertise of an audiologist;

2. After a new or replacement hearing aid or other ALD has been worn for a 30-day trial period, the recipient shall obtain a performance check from a certified audiologist, a certified hearing aid dealer or at a certified speech and hearing center. The department shall provide reimbursement for the cost of the hearing aid or other ALD after the performance check has shown the hearing aid or ALD to be satisfactory, or 45 days has elapsed with no response from the recipient;

3. Special modifications other than those listed in the MA speech and hearing provider handbook shall require prior authorization; and

4. Provision of services in excess of the life expectancies of equipment enumerated in the MA speech and hearing provider handbook require prior authorization, except for hearing aid or other ALD batteries and repair services.

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

(4) OTHER LIMITATIONS. (a) The services covered under this section are not covered for recipients who are inpatients in hospitals. Payment for medical supplies ordered for a patient in a medical institution is considered part of the institution's cost and may not be billed directly to the program by a provider.

(b) Prescriptions shall be provided in accordance with s. HSS 107.06 (4) (a) 2. and may not be filled more than one year from the date the medical equipment or supply is ordered.

(c) The services covered under this section are not covered for recipients who are nursing home residents except for:

1. Oxygen. Prescriptions for oxygen shall provide the required amount of oxygen flow in liters;

2. Durable medical equipment which is personalized in nature or custom-made for a recipient and is to be used by the recipient on an individual basis for hygienic or other reasons. These items are orthoses, prostheses including hearing aids or other assistive listening devices, orthopedic or corrective shoes, special adaptive positioning wheelchairs and electric wheelchairs. Coverage of a special adaptive positioning wheelchair or electric wheelchair shall be justified by the diagnosis and prognosis and the occupational or vocational activities of the resident recipient; and

3. A wheelchair prescribed by a physician if the wheelchair will contribute towards the rehabilitation of the resident recipient through maximizing his or her potential for independence, and if the recipient has a long-term or permanent disability and the wheelchair requested constitutes basic and necessary health care for the recipient consistent with a plan of health care, or the recipient is about to transfer from a nursing home to an alternate and more independent setting.

(d) The provider shall weigh the costs and benefits of the equipment and supplies when considering purchase or rental of DME and medical supplies.

Note: The program's listing of covered services and the maximum allowable reimbursement schedules are based on basic necessity. Although the program does not intend to exclude

any manufacturer of equipment, reimbursement is based on the cost-benefit of equipment when comparable equipment is marketed at less cost. Several medical supply items are reimbursed according to generic pricing.

(e) The department may determine whether an item is to be rented or purchased on behalf of a recipient. In most cases equipment shall be purchased; however, in those cases where short-term use only is needed or the recipient's prognosis is poor, only rental of equipment shall be authorized.

(f) Orthopedic or corrective shoes or foot orthoses shall be provided only for postsurgery conditions, gross deformities, or when attached to a brace or bar. These conditions shall be described in the prior authorization request.

(g) Provision of hearing aid accessories shall be limited as follows:

1. For recipients under age 18: 3 earmolds per hearing aid, 2 single cords per hearing aid and 2 Y-cords per recipient per year;

2. For recipients over age 18: one earmold per hearing aid, one single cord per hearing aid and one Y-cord per recipient per year; and

3. For all recipients: one harness, one contralateral routing of signals (CROS) fitting, one new receiver per hearing aid and one bone-conduction receiver with headband per recipient per year.

(h) If a prior authorization request is approved, the person shall be eligible for MA reimbursement for the service on the date the final ear mold is taken.

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

(a) Foot orthoses or orthopedic or corrective shoes for the following conditions:

1. Flattened arches, regardless of the underlying pathology;

2. Incomplete dislocation or subluxation metatarsalgia with no associated deformities;

3. Arthritis with no associated deformities; and

4. Hypoallergenic conditions;

(b) Services denied by medicare for lack of medical necessity;

(c) Items which are not primarily medical in nature, such as dehumidifiers and air conditioners;

(d) Items which are not appropriate for home usage, such as oscillating beds;

(e) Items which are not generally accepted by the medical profession as being therapeutically effective, such as a heat and massage foam cushion pad;

(f) Items which are for comfort and convenience, such as cushion lift power seats or elevators, or luxury features which do not contribute to the improvement of the recipient's medical condition;

(g) Repair, maintenance or modification of rented durable medical equipment;

(h) Delivery or set-up charges for equipment as a separate service;

(i) Fitting, adapting, adjusting or modifying a prosthetic or orthotic device or corrective or orthopedic shoes as a separate service;

(j) All repairs of a hearing aid or other assistive listening device performed by a dealer within 12 months after the purchase of the hearing aid or other assistive listening device. These are included in the purchase payment and not as separate services; and

(k) Hearing aid or other assistive listening device batteries which are provided in excess of the guidelines enumerated in the MA speech and hearing provider handbook.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; emerg. r. and recr. (3) (h) 1. and 2., eff. 7-1-89; am. (2) (d) 6., (3) (e), (h) 4., (4) (c) 2., (5) (j) and (k), r. and recr. (3) (h) (intro.), 1. and 2. and (4) (g), cr. (4) (h), Register, May, 1990, No. 413, eff. 6-1-90.

HSS 107.25 Diagnostic testing services. (1) COVERED SERVICES. Professional and technical diagnostic services covered by MA are laboratory services provided by a certified physician or under the physician's supervision, or prescribed by a physician and provided by an independent certified laboratory, and x-ray services prescribed by a physican and provided by or under the general supervision of a certified physician.

(2) OTHER LIMITATIONS. (a) All diagnostic services shall be prescribed or ordered by a physician or dentist.

(b) Laboratory tests performed which are outside the laboratory's certified areas are not covered.

(c) Portable x-ray services are covered only for recipients who reside in nursing homes and only when provided in a nursing home.

(d) Reimbursement for diagnostic testing services shall be in accordance with limitations set by P.L. 98-369, Sec. 2303.

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

HSS 107.26 Dialysis services. Dialysis services are covered services when provided by facilities certified pursuant to s. HSS 105.45.

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

HSS 107.27 Blood. The provision of blood is a covered service when provided to a recipient by a physician certified pursuant to s. HSS 105.05, a blood bank certified pursuant to s. HSS 105.46 or a hospital certified pursuant to s. HSS 105.07.

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

HSS 107.28 Health maintenance organization and prepaid health plan services. (1) COVERED SERVICES. (a) *HMOs.* 1. Except as provided in subd. 2, all health maintenance organizations (HMOs) that contract with the department shall provide to enrollees all MA services that are covered services at the time the medicaid HMO contract becomes effective with the exception of the following:

a. EPSDT outreach services;

b. County transportation by common carrier;

c. Dental services; and

d. Chiropractic services.

2. The department may permit an HMO to provide less than comprehensive coverage, but only if there is adequate justification and only if commitment is expressed by the HMO to progress to comprehensive coverage.

(b) *Prepaid health plans.* Prepaid health plans shall provide one or more of the services covered by MA.

(2) CONTRACTS. The department shall establish written contracts with qualified HMOs and prepaid health plan organizations which shall:

(a) Specify the contract period;

(b) Specify the services provided by the contractor;

(c) Identify the MA population covered by the contract;

(d) Specify any procedures for enrollment or reenrollment of the recipients;

(e) Specify the amount, duration and scope of medical services to be covered;

(f) Provide that the department may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed under the contract;

(g) Provide that the department may audit and inspect any of the contractor's records that pertain to services performed and the determination of amounts payable under the contract and stipulate the required record retention procedures;

(h) Provide that the contractor safeguards recipient information;

(i) Specify activities to be performed by the contractor that are related to third-party liability requirements; and

(j) Specify which functions or services may be subcontracted and the requirements for subcontracts.

(3) OTHER LIMITATIONS. Contracted organizations shall:

(a) Allow each enrolled recipient to choose a health professional in the organization to the extent possible and appropriate;

(b) 1. Provide that all medical services that are covered under the contract and that are required on an emergency basis are available on a 24-hour basis, 7 days a week, either in the contractor's own facilities or through arrangements, approved by the department, with another provider; and

2. Provide for prompt payment by the contractor, at levels approved by the department, for all services that are required by the contract, furnished by providers who do not have arrangements with the contractor to provide the services, and are medically necessary to avoid endan-