Chapter HSS 107

COVERED SERVICES

HSS 107.01 General statement of coverage (p. 117)
HSS 107.02 General limitations (p. 118)
HSS 107.03 Services not covered (p. 122)
HSS 107.035 Definition and identification of experimental services (p. 123)
HSS 107.04 Coverage of out-of-state services (p. 124)
HSS 107.05 Coverage of emergency services provided by a person not a certified provider (p. 124)
HSS 107.06 Physician services (p. 124)
HSS 107.065 Anesthesiology services (p. 132)
HSS 107.07 Dental services (p. 133)
HSS 107.08 Hospital services (p. 139)
HSS 107.09 Nursing home services (p. 142)
HSS 107.10 Drugs (p. 153)
HSS 107.11 Home health services (p. 155)
HSS 107.112 Personal care services (p. 158)
HSS 107.12 Independent nursing services (p. 160)
HSS 107.121 Nurse-midwife services (p. 162)
HSS 107.122 Independent nurse practicioner services (p. 162)
HSS 107.13 Mental health services (p. 164)
HSS 107.14 Podiatry services (p. 174-5)
HSS 107.15 Chiropractic services (p. 174-7)
HSS 107.16 Physical therapy (p. 174-8)
HSS 107.17 Occupational therapy (p. 183)
HSS 107.18 Speech and language pathology services (p. 189)
HSS 107.19 Audiology services (p. 194)
HSS 107.20 Vision care services (p. 197)
HSS 107.21 Family planning services (p. 198)
HSS 107.22 Early and periodic screening, diagnosis and treatment (EPSDT) services (p. 201)
HSS 107.23 Transportation (p. 203)
HSS 107.24 Durable medical equipment and medical supplies (p. 206)
HSS 107.25 Diagnostic testing services (p. 211)
HSS 107.26 Dialysis services (p. 211)
HSS 107.27 Blood (p. 211)
HSS 107.28 Health maintenance organization and prepaid health plan services (p. 211)
HSS 107.29 Rural health clinic services (p. 213)
HSS 107.30 Ambulatory surgical center services (p. 214)
HSS 107.31 Hospice care services (p. 216)
HSS 107.32 Case management services (p. 219)
HSS 107.33 Ambulatory prenatal services for recipients with presumptive eligibility (p. 224)

Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.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, the PRO review process or the department fiscal agent's professional consultants determine to be medically unnecessary, inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration;

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

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

(2m) SERVICES REQUIRING A PHYSICIAN'S ORDER OR PRESCRIPTION. (a) The following services require a physician's order or prescription to be covered under MA:

1. Skilled nursing services provided in a nursing home;

2. Intermediate care services provided in a nursing home;

3. Home health care services;

4. Independent nursing services;

5. Respiratory care services for ventilator-dependent recipients;

6. Physical and occupational therapy services;

7. Mental health and alcohol and other drug abuse (AODA) services;

8. Speech pathology and audiology services;

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

10. Drugs, except when prescribed by a nurse practitioner under s. HSS 107.122, or a podiatrist under s. HSS 107.14;

11. Prosthetic devices;

12. Laboratory, diagnostic, radiology and imaging test services;

13. Inpatient hospital services;

14. Outpatient hospital services;

15. Inpatient hospital IMD services;

16. Hearing aids;

17. Specialized transportation services for persons not requiring a wheelchair, except when prescribed by a nurse practitioner under s. HSS 107.122;

18. Hospital private room accommodations;

19. Personal care services; and

20. Hospice services.

(b) Except as otherwise provided in federal or state statutes, regulations or rules, a prescription or order shall be in writing or be given orally and later be reduced to writing by the provider filling the prescription or order, and shall include the date of the prescription or 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, the brand of drug or drug product equivalent medically required and the prescriber's signature. For 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 prescribed or ordered shall be provided within one year of the date of the prescription.

(c) A prescription 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, which may not exceed 90 days.

(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 infor-

mation 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 prescription drugs if the recipient uses one pharmacy or pharmacist as his or her sole provider of prescription drugs.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. (1) and am. (14) (c) 12. and 13., Register, February, 1988, No. 386, eff. 3-1-88; cr. (4) (c) 14., Register, April, 1988, No. 388, eff. 7-1-88; r. and recr. (4) (c), Register, December, 1988, No. 396, eff. 1-1-89; 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; am. (2) (b), r. (2) (c), renum. (2) (d) and (e) to be (2) (c) and (d), cr. (2m), Register, September, 1991, No. 429, eff. 10-1-91.

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 s. 150.21, 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) (e);

(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.

6. Proper storage;

7. Prescription refill information; and

8. Action to be taken in the event of a missed dose.

(c) The pharmacist shall make a reasonable effort to obtain, record and maintain at least the following information regarding each MA recipient for whom the pharmacist dispenses drugs under the MA program:

1. The individual's name, address, telephone number, date of birth or age and gender;

2. The individual's history where significant, including any disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices; and

3. The pharmacist's comments relevant to the individual's drug therapy.

(d) Nothing in this subsection shall be construed as requiring a pharmacist to provide consultation when an MA recipient, the recipient's legal representative or the recipient's caregiver refuses the consultation.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (3) (h), Register, February, 1988, No. 386, eff. 3-1-88; emerg. am. (2) (e) and (f), (4) (k), cr. (2) (g), (3) (j) and (k), (4) (l), eff. 4-27-91; r. and recr. Register, December, 1991, No. 432, eff. 1-1-92.

HSS 107.11 Home health services. (1) DEFINITIONS. In this section:

(a) "Extended visit" means each hour of a visit by a registered nurse or a practical nurse after 8 hours of home health service in a calendar day, or each hour of a visit by a home health aide after 8 hours of home health aide service in a calendar day.

(b) "Home health aide services" means medically oriented tasks necessitated by the recipient's physical requirements and performed by a home health aide in the recipient's home to enable the physician to treat the recipient as an outpatient.

(c) "Home health visit" or "visit" means a period of time during which home health services are provided through personal contact in the recipient's place of residence for the purpose of providing a covered home health service. The services are provided by a home health worker on the staff of the home health agency, by a home health worker under contract to the home health agency or by another arrangement with the home health agency. A visit includes reasonable time spent on recordkeeping, travel time to and from the recipient's residence and actual service time in the home.

(d) "Initial visit" means the first 2 hours of service by a registered nurse or a practical nurse in a calendar day and the first hour of service by a home health aide in a calendar day.

(e) "Subsequent visit" means each hour of service following the initial visit in a calendar day up to a maximum of:

1. Eight hours of registered nurse or practical nurse service, including the initial visit; or

2. Eight hours of home health aide service, including the initial visit.

Emerg. r. & recr. eff. 7/1/92

(f) "Therapy visit" means a visit by a physical therapist, occupational therapist or speech and language pathologist to provide a service for a period of time which lasts from at least 15 minutes to 90 minutes.

(2) COVERED SERVICES. Services provided by an agency certified under s. HSS 105.16 which are covered by MA are: nursing services, home health aide services, medical supplies, equipment and appliances suitable for use in the home, and therapy services which the agency is certified to provide. These services are covered only when provided upon prescription of a physician to a recipient confined to a place of residence other than a hospital, a skilled nursing facility or an intermediate care facility. Home health aide services include, but are not limited to:

(a) Prescribed range of motion exercises;

(b) Taking of temperature, pulse and respiratory rates;

(c) Bowel and bladder care except for routine toileting;

(d) Application of heat and cold treatments as prescribed;

(e) Recording fluid intake and output;

(f) Respiratory assistance, including assistance with oxygen and other equipment;

(g) Catheter care;

(h) Bathing in bed or complete bathing;

(i) Wound care;

(j) Turning and positioning; and

(k) All medically oriented services provided to an ill and bed-bound recipient. In this subdivision, "bed-bound" means that the recipient, due to illness or frailty, is required to remain in bed essentially full time and

Next page is numbered 157

cannot leave his or her bed without assistance. The illness or frailty encompassed by this definition does not include uncomplicated neurological, neuromuscular or musculoskeletal deficit.

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

(a) Initial visits by a registered nurse or practical nurse in excess of 50 visits in a calendar year;

(b) Initial visits by a home health aide in excess of 50 visits in a calendar year;

(c) Therapy visits by a physical therapist, occupational therapist or speech and language pathologist in excess of 50 visits in a calendar year;

(d) All registered nurse, practical nurse or home health aide extended visits; and

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

(f) Home health aide services listed in sub. (2) (a) to (j) if performed by a personal care worker employed by a personal care agency which is not a home health agency and supervised by a registered nurse under s. HSS 107.112. Prior authorization may be granted only for those specific tasks necessary for the care of a recipient able to direct his or her own care and performed by a personal care worker specifically assigned to that recipient, as requested by the personal care worker's supervising registered nurse.

(4) OTHER LIMITATIONS. (a) All durable medical equipment and disposable medical supplies shall meet the requirements of s. HSS 107.24.

(b) Services provided to residents of community-based residential facilities may not exceed the limits of ch. HSS 3.

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

(a) Services provided by a home health agency to a recipient who is able to leave the home without assistance, when the services are available outside the home;

(b) Respite care;

(c) Parenting;

(d) Supervision of a recipient, when supervision is the only service provided at the time;

(e) Services to other members of the recipient's household;

(f) Mental health services and services for alcohol and other drug abuse, for which certification is required under ss. HSS 105.22 and 105.23;

(g) Hospice care as provided under s. HSS 107.31;

(h) More than one initial visit per discipline in a calendar day;

(i) More than 6 hours of subsequent visits by a registered nurse or a practical nurse in a calendar day;

(j) More than 7 hours of subsequent visits by a home health aide in a calendar day;

(k) More than 16 hours of extended visits by a registered nurse or a practical nurse in a calendar day;

(l) Housekeeping tasks exceeding 25% of the home health aide's time in a visit;

(m) Services requiring prior authorization that are provided without prior authorization;

(n) Nursing services contracted by a home health agency; and

(o) Any other service not mentioned in this section.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. Register, April, 1988, No. 388, eff. 7-1-88; am. (3) (d) and (e), cr. (3) (f), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.112 Personal care services. (1) COVERED SERVICES. (a) Personal care services are medically oriented activities related to assisting a recipient with activities of daily living necessary to maintain the recipient in his or her place of residence in the community. These services shall be provided upon written orders of a physician by a provider certified under s. HSS 105.17 and by a personal care worker employed by the provider or under contract to the provider who is supervised by a registered nurse according to a written plan of care. The personal care worker shall be assigned by the supervising registered nurse to specific recipients to do specific tasks for those recipients for which the personal care worker has been trained. The personal care worker's training for these specific tasks shall be assured by the supervising registered nurse. The personal care worker is limited to performing only those tasks and services as assigned for each recipient and for which he or she has been specifically trained.

(b) Covered personal care services are:

1. Assistance with bathing;

2. Assistance with getting in and out of bed;

3. Teeth, mouth, denture and hair care;

4. Assistance with mobility and ambulation including use of walker, cane or crutches;

5. Changing the recipient's bed and laundering the bed linens and the recipient's personal clothing;

6. Skin care excluding wound care;

7. Care of eyeglasses and hearing aids;

8. Assistance with dressing and undressing;

9. Toileting, including use and care of bedpan, urinal, commode or toilet;

10. Light cleaning in essential areas of the home used during personal care service activities;

11. Meal preparation, food purchasing and meal serving;

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

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

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

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

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

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

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

2. Frequency and anticipated duration of service;

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Skilled nursing services, including:

1. Insertion and sterile irrigation of catheters;

2. Giving of injections;

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

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

(h) Therapy services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. All extended care home nursing services.

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

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

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

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

HSS 107.121 Nurse-midwife services. (1) COVERED SERVICES. Covered services provided by a certified nurse-midwife may include the care of mothers and their babies throughout the maternity cycle, including pregnancy, labor, normal childbirth and the immediate postpartum period, provided that the nurse-midwife services are provided within the limitations established in s. 441.15 (2), Stats., and ch. N 4.

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

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

(a) Under assessment and nursing diagnosis:

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

2. Evaluating and analyzing a health history critically;

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

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

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

(b) Under analysis and decision-making:

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

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

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

4. Interpreting screening and selected diagnostic tests;

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

or to inpatients in IMDs are not considered inpatient services. Reimbursement shall be made to the psychiatrist or psychologist billing provider certified under s. HSS 105.22 (1) (a) or (b) or 105.23 who provides AODA treatment services to hospital inpatients in accordance with requirements under this subsection.

4. Medical detoxification services are not considered inpatient services if provided outside an inpatient general hospital or IMD.

(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);

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

3. Detoxification provided in a social setting, as described in s. HSS 61.58, is not a covered service.

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

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

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

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

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

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

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

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

2. Any recommendation by the county human services department under s. 46.23, Stats., or the county community programs department under s. 51.42, Stats., shall be considered in review and approval of the prior authorization request.

3. Department representatives who review and approve prior authorization requests shall meet the same minimum training requirements as

those mandated for AODA day treatment providers under s. HSS 105.25.

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

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

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

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

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

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

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

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

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

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

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

(4) DAY TREATMENT OR DAY HOSPITAL SERVICES. (a) *Covered services.* Day treatment or day hospital services are covered services when prescribed by a physician, when provided by a provider who meets the requirements of s. HSS 105.24, and when the following conditions are met:

1. Before becoming involved in a day treatment program, the recipient is evaluated through the use of the functional assessment scale provided by the department to determine the medical necessity for day treatment and the person's ability to benefit from it;

2. The supervising psychiatrist approves a written treatment plan for each recipient and reviews the plan no less frequently than once every 60 days. The treatment plan shall be based on the initial evaluation and shall include individual goals, and the treatment modalities to be used to achieve these goals and the expected outcome of treatment;

3. Up to 90 hours of day treatment services in a calendar year may be reimbursed without prior authorization. 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 provided by the department; 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. 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. Medical or AODA 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; emerg. r. and recr. (1) (b) 3., am. (1) (f) 6., eff. 1-1-91; am. (1) (a), (b) 1. and 2., (c), (f) 5., 6. and 8., (2) (a)

1., 3. a. and b., 4. f., 6., 7., (b) 1. and 2., (c) 2., (3) (a) (intro.), 4., 5., 7., (b) 1. and 2., (c) 1. (3) (d) 1. and 2., (4) (a) 3. and 6. and (d) 6., r. and recr. (1) (b) 3. and (e), r. (4) (b) 1. d., renum. (4) (b) 1. c. to be d., cr. (2) (c) 6., (3) (c) 3. and 4., (3) (d) 3., Register, September, 1991, No. 429, eff. 10-1-91.

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 residents 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 performed by a physical therapy aide under par. (e) are covered when provided in accordance with supervision requirements under par. (e) 3.

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

1. Stress test;

2. Orthotic check-out;

3. Prosthetic check-out;

4. Functional evaluation;

5. Manual muscle test;

6. Isokinetic evaluation;

7. Range-of-motion measure;

8. Length measurement;

9. Electrical testing:

a. Nerve conduction velocity;

b. Strength duration curve — chronaxie;

c. Reaction of degeneration;

d. Jolly test (twitch tetanus); and

Next page is numbered 175