(j) Services provided by a provider who fails or refuses to meet and maintain any of the certification requirements under ch. HSS 105 applicable to that provider.

(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;

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 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 transferable.* 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.

(i) *Significance of prior authorization approval.* 1. Approval or modification by the department or its fiscal agent of a prior authorization request, including any subsequent amendments, extensions, renewals, or reconsideration requests:

a. Shall not relieve the provider of responsibility to meet all requirements of federal and state statutes and regulations, provider handbooks and provider bulletins;

b. Shall not constitute a guarantee or promise of payment, in whole or in part, with respect to any claim submitted under the prior authorization; and

c. Shall not be construed to constitute, in whole or in part, a discretionary waiver or variance under s. HSS 106.13.

2. Subject to the applicable terms of reimbursement issued by the department, covered services provided consistent with a prior authorization, as approved or modified by the department or its fiscal agent, are reimbursable provided:

a. The provider's approved or modified prior authorization request and supporting information, including all subsequent amendments, renewals and reconsideration requests, is truthful and accurate;

b. The provider's approved or modified prior authorization request and supporting information, including all subsequent amendments, extensions, renewals and reconsideration requests, completely and accurately reveals all facts pertinent to the recipient's case and to the review process and criteria provided under s. HSS 107.02 (3);

c. The provider complies with all requirements of applicable state and federal statutes, the terms and conditions of the applicable provider agreement pursuant to s. 49.45 (2) (a) 9, Stats., all applicable requirements of chs. HSS 101 to 108, including but not limited to the requirements of ss. HSS 106.02, 106.03, 107.02, and 107.03, and all applicable prior authorization procedural instructions issued by the department under s. HSS 108.02 (4);

d. The recipient is MA eligible on the date of service; and

e. The provider is MA certified and qualified to provide the service on the date of the service.

(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; emerg. cr. (3) (i), eff. 7-1-92; am. (2) (c) and (d), cr. (2) (e) to (j) and (3) (i), Register, February, 1993, No. 446, eff. 3-1-93; r. (2m) (a) 17., Register, November, 1994, No. 467, eff. 12-1-94.

**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.

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**HSS 107.23 Transportation.** (1) COVERED SERVICES. (a) *Purpose.* Transportation by ambulance, specialized medical vehicle (SMV) or county-approved or tribe-approved common carrier as defined under par. (d) 1, is a covered service when provided to a recipient in accordance with this section.

(b) *Transport by ambulance.* Ambulance transportation shall be a covered service if the recipient is suffering from an illness or injury which contraindicates transportation by other means, but only when provided:

1. For emergency care, when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient's condition:

a. From the recipient's residence or the site of an illness or accident to a hospital, physician's office, or emergency care center;

b. From a nursing home to a hospital;

c. From a hospital to another hospital; and

2. For non-emergency care when authorized by a physician, physician assistant, nurse midwife or nurse practitioner by written documentation which states the specific medical problem requiring the non-emergency ambulance transport:

a. From a hospital or nursing home to the recipient's residence;

b. From a hospital to a nursing home;

c. From a nursing home to another nursing home, a hospital, a hospice care facility, or a dialysis center; or

d. From a recipient's residence or nursing home to a hospital or a physician's or dentist's office, if the transportation is to obtain a physician's or dentist's services which require special equipment for diagnosis or treatment that cannot be obtained in the nursing home or recipient's residence.

(c) *Transport by specialized medical vehicle (SMV).* 1. In this paragraph, "indefinitely disabled" means a chronic, debilitating physical impairment which includes an inability to ambulate without personal assistance or requires the use of a mechanical aid such as a wheelchair, a walker or crutches, or a mental impairment which includes an inability to reliably and safely use common carrier transportation because of organic conditions affecting cognitive abilities or psychiatric symptoms that interfere with the recipient's safety or that might result in unsafe or unpredictable behavior. These symptoms and behaviors may include the inability to remain oriented to correct embarkation and debarkation points and times and the inability to remain safely seated in a common carrier cab or coach.

2. SMV transportation shall be a covered service if the recipient is legally blind or is indefinitely disabled as documented in writing by a physician, physician assistant, nurse midwife or nurse practitioner. The necessity for SMV transportation shall be documented by a physician, physician assistant, nurse midwife or nurse practitioner. The documentation shall indicate in a format determined by the department why the recipient's condition contraindicates transportation by a common carrier as defined under par. (d) 1, including accessible mass transit services,

or by a private vehicle and shall be signed and dated by a physician, physician assistant, nurse midwife or nurse practitioner. For a legally blind or indefinitely disabled recipient, the documentation shall be rewritten annually. The documentation shall be placed in the file of the recipient maintained by the provider within 14 working days after the date of the physician's, physician assistant's, nurse midwife's or nurse practitioner's signing of the documentation and before any claim for reimbursement for the transportation is submitted.

3. If the recipient has not been declared legally blind or has not been determined by a physician, physician assistant, nurse midwife or nurse practitioner to be indefinitely disabled, the transportation provider shall obtain and maintain a physician's, physician assistant's, nurse midwife's or nurse practitioner's written documentation for SMV transportation. The documentation shall indicate in a format determined by the department why the recipient's condition contraindicates transportation by a common carrier, including accessible mass transit services, or by a private vehicle and shall state the specific medical problem preventing the use of a common carrier, as defined under par. (d) 1, and the specific period of time the service may be provided. The documentation shall be signed and dated by a physician, physician assistant's, nurse midwife or nurse practitioner. The documentation shall be valid for a maximum of 90 days from the date of the physician's, physician assistant's, nurse midwife's or nurse practitioner's signature. The documentation shall be placed in the file of the recipient maintained by the provider within 14 working days after the date of the physician's, physician assistant, nurse midwife's or nurse practitioner's signing of the documentation and before any claim for reimbursement for the transportation is submitted.

4. SMV transportation, including the return trip, is covered only if the transportation is to a location at which the recipient receives an MA-covered service on that day. SMV trips by cot or stretcher are covered if they have been prescribed by a physician, physician assistant, nurse midwife or nurse practitioner. In this subdivision, "cot or stretcher" means a bed-like device used to carry a patient in a horizontal or reclining position.

5. Charges for SMV unloaded mileage are reimbursable only when the SMV travels more than 20 miles by the shortest route available to pick up a recipient and there is no other passenger in the vehicle, regardless of whether or not that passenger is an MA recipient. In this subdivision, "unloaded mileage" means the mileage travelled by the vehicle to pick up the recipient for transport to or from MA-covered services.

6. When a recipient does not meet the criteria under subd. 2, SMV transportation may be provided under par. (d) to an ambulatory recipient who needs transportation services to or from MA-covered services if no other transportation is available. The transportation provider shall obtain and maintain documentation as to the unavailability of other transportation. Records and charges for the transportation of ambulatory recipients shall be kept separate from records and charges for non-ambulatory recipients. Reimbursement shall be made under the common carrier provisions of par. (d).

(d) *Transport by county-approved or tribe-approved common carrier.* 1. In this paragraph, "common carrier" means any mode of transportation approved by a county or tribal agency or designated agency, except an ambulance or an SMV unless the SMV is functioning under subd. 5.

2. Transportation of an MA recipient by a common carrier to a Wisconsin provider to receive MA-covered services shall be a covered service if the transportation is authorized by the county or tribal agency or its designated agency. Reimbursement shall be for the charges of the common carrier, for mileage expenses or a contracted amount the county or tribal agency or its designated agency has agreed to pay a common carrier. A county or tribal agency may develop its own transportation system or may enter into contracts with common carriers, individuals, private businesses, SMV providers and other governmental agencies to provide common carrier services. A county or tribe is limited in making this type of arrangement by sub. (3) (c).

3. Transportation of an MA recipient by a common carrier to an out-of-state provider, excluding a border-status provider, to receive MA-covered services shall be covered if the transportation is authorized by the county or tribal agency or its designated agency. The county or tribal agency or its designated agency may approve a request only if prior authorization has been received for the nonemergency medical services as required under s. HSS 107.04. Reimbursement shall be for the charges of the common carrier, for mileage expenses or a contracted amount the county or tribal agency or its designated agency has agreed to pay the common carrier.

4. Related travel expenses may be covered when the necessary transportation is other than routine, such as transportation to receive a service that is available only in another county, state or country, and the transportation is prior authorized by the county or tribal agency or its designated agency. These expenses may include the cost of meals and commercial lodging enroute to MA-covered care, while receiving the care and when returning from the care, and the cost of an attendant to accompany the recipient. The necessity for an attendant, except for children under 16 years of age, shall be determined by a physician, physician assistant, nurse midwife or nurse practitioner with that determination documented and submitted to the county or tribal agency. Reimbursement for the cost of an attendant may include the attendant's transportation, lodging, meals and salary. If the attendant is a relative of the recipient, reimbursed costs are limited to transportation, commercial lodging and meals. Reimbursement for the costs of meals and commercial lodging shall be no greater than the amounts paid by the state to its employes for those expenses. The costs of more than one attendant shall be reimbursed only if the recipient's condition requires the physical presence of another person. Documentation stating the need for the second attendant shall be from a physician, physician assistant, nurse midwife or nurse practitioner and shall explain the need for the attendant and be maintained by the transportation provider if the provider is not a common carrier. If the provider is a common carrier, the statement of need shall be maintained by the county or tribal agency or its designated agency authorizing the transportation. If the length of attendant care is over 4 weeks in duration, the department shall determine the necessary expenses for the attendant or attendants after the first 4 weeks and at 4-week intervals thereafter. In this subdivision, "attendant" means a person needed by the transportation provider to assist with tasks necessary in transporting the recipient and that cannot be done by the driver or a person traveling with the recipient in order to receive training in the care of the recipient, and "relative" means a parent, grandparent, grandchild, stepparent, spouse, son, daughter, stepson, stepdaughter, brother, sister, half-

brother or half-sister, with this relationship either by consanguinity or direct affinity.

5. If a recipient for emergency reasons beyond that person's control is unable to obtain the county or tribal agency's or designee's authorization for necessary transportation prior to the transportation, such as for a trip to a hospital emergency room on a weekend, the county or tribal agency or its designee may provide retroactive authorization. The county or tribal agency or its designee may require documentation from the medical service provider or the transportation provider, or both, to establish that the transportation was necessary.

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

(a) All non-emergency transportation of a recipient by water ambulance to receive MA-covered services;

(b) All non-emergency transportation of a recipient by fixed-wing air ambulance to receive MA-covered services;

(c) All non-emergency transportation of a recipient by helicopter ambulance to receive MA-covered services;

(d) Trips by ambulance to obtain physical therapy, occupational therapy, speech therapy, audiology services, chiropractic services, psychotherapy, methadone treatment, alcohol abuse treatment, other drug abuse treatment, mental health day treatment or podiatry services;

(e) Trips by ambulance from nursing homes to dialysis centers; and

(f) All SMV transportation to receive MA-covered services, except for services to be received out of state for which prior authorization has already been received, that is over 40 miles for a one-way trip in Brown, Dane, Fond du Lac, Kenosha, La Crosse, Manitowoc, Milwaukee, Outagamie, Sheboygan, Racine, Rock and Winnebago counties from a recipient's residence, and 70 miles for a one-way trip in all other counties from a recipient's residence.

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

(3) LIMITATIONS. (a) *Ambulance transportation.* 1. When a hospital-to-hospital or nursing home-to-nursing home non-emergency transfer is made by ambulance, the ambulance provider shall obtain, before the transfer, written certification from the recipient's physician, physician assistant, nurse midwife or nurse practitioner explaining why the discharging institution was not an appropriate facility for the patient's condition and the admitting institution is appropriate for that condition. The document shall be signed by the recipient's physician, physician assistant, nurse midwife or nurse practitioner and shall include details of the recipient's condition. This document shall be maintained by the ambulance provider.

2. If a recipient residing at home requires treatment at a nursing home, the transportation provider shall obtain a written statement from the provider who prescribed the treatment indicating that transportation by ambulance is necessary. The statement shall be maintained by the ambulance provider.

3. For other non-emergency transportation, the ambulance provider shall obtain documentation for the service signed by a physician, physician assistant, nurse midwife, dentist or nurse practitioner. The documentation shall include the recipient's name, the date of transport, the details about the recipient's condition that preclude transport by any other means, the specific circumstances requiring that the recipient be transported to the office or clinic to obtain a service, the services performed and an explanation of why the service could not be performed in the hospital, nursing home or recipient's residence. Documentation of the physician, dentist, physician assistant, nurse midwife or nurse practitioner performing the service shall be signed and dated and shall be maintained by the ambulance provider. Any order received by the transportation provider by telephone shall be repeated in the form of written documentation within 10 working days of the telephone order or prior to the submission of the claim, whichever comes first.

4. Services of more than the 2 attendants required under s. 146.50 (4), Stats., are covered only if the recipient's condition requires the physical presence of more than 2 attendants for purposes of restraint or lifting. Medical personnel not employed by the ambulance provider who care for the recipient in transit shall bill the program separately.

5. a. If a recipient is pronounced dead by a legally authorized person after an ambulance is requested but before the ambulance arrives at the pick-up site, emergency service only to the point of pick-up is covered.

b. If ambulance service is provided to a recipient who is pronounced dead enroute to a hospital or dead on arrival at the hospital by a legally authorized person, the entire ambulance service is covered.

6. Ambulance reimbursement shall include payment for additional services provided by an ambulance provider such as for drugs used in transit or for starting intravenous solutions, EKG monitoring for infection control, charges for reusable devices and equipment, charges for sterilization of a vehicle including after carrying a recipient with a contagious disease, and additional charges for services provided at night or on weekends, or on holidays. Separate payments for these charges shall not be made.

7. Non-emergency transfers by ambulance that are for the convenience of the recipient or the recipient's family are reimbursed only when the attending physician documents that the participation of the family in the recipient's care is medically necessary and the recipient would suffer hardship if the transfer were not made by ambulance.

(b) *SMV transportation.* 1. Transportation by SMV shall be covered only if the purpose of the trip is to receive an MA-covered service.Documentation of the name and address of the service provider shall be kept by the SMV provider. Any order received by the transportation provider by telephone shall be repeated in the form of written documentation within 10 working days of the telephone order or prior to the submission of the claim, whichever comes first.

2. Charges for waiting time are covered charges. Waiting time is allowable only when a to-and-return trip is being billed. Waiting time may only be charged for one recipient when the transportation provider or driver waits for more than one recipient at one location in close proximity to where the MA-covered services are provided and no other trips are

made by the vehicle or driver while the service is provided to the recipient. In this subdivision, "waiting time" means time when the transportation provider is waiting for the recipient to receive MA covered services and return to the vehicle.

3. Services of a second SMV transportation attendant are covered only if the recipient's condition requires the physical presence of another person for purposes of restraint or lifting. The transportation provider shall obtain a statement of the appropriateness of the second attendant from the physician, physician assistant, nurse midwife or nurse practitioner attesting to the need for the service and shall retain that statement.

4. SMV services may only be provided to recipients identified under sub. (1) (c).

5. A trip to a sheltered workshop or other nonmedical facility is covered only when the recipient is receiving an MA-covered service there on the dates of transportation and the medical services are of the level, intensity or extent consistent with the medical need defined in the recipient's plan of care.

6. Trips to school for MA-covered services shall be covered only if the recipient is receiving services on the day of the trip under the Individuals with Disabilities Education Act, 20 USC 33, and the MA-covered services are identified in the recipient's individual education plan and are delivered at the school.

7. Unloaded mileage as defined in sub. (1) (c) 5 is not reimbursed if there is any other passenger in the vehicle whether or not that passenger is an MA recipient.

8. When 2 or more recipients are being carried at the same time, the department may adjust the rates.

9. Additional charges for services at night or on weekends or holidays are not covered charges.

10. A recipient confined to a cot or stretcher may only be transported in an SMV if the vehicle is equipped with restraints which secure the cot or stretcher to the side and the floor of the vehicle. The recipient shall be medically stable and no monitoring or administration of non-emergency medical services or procedures may be done by SMV personnel.

(c) *County-approved or tribe-approved transportation.* 1. Non-emergency transportation of a recipient by common carrier is subject to approval by the county or tribal agency or its designee before departure.The reimbursement shall be no more than an amount set by the department and shall be less per mile than the rates paid by the department for SMV purposes. Reimbursement for urgent transportation is subject to retroactive approval by the county or tribal agency or its designee.

2. The county or tribal agency or its designee shall reimburse the recipient or the vendor for transportation service only if the service is not provided directly by the county or tribal agency or its designee.

3. Transportation provided by a county or tribal agency or its designee shall involve the least costly means of transportation which the recipient is capable of using and which is reasonably available at the time the service is required. Reimbursement to the recipient shall be limited to mile-

age to the nearest MA provider who can provide the service if the recipient has reasonable access to health care of adequate quality from that provider. Reimbursement shall be made in the most cost-effective manner possible and only after sources for free transportation such as family and friends have been exhausted.

4. The county or tribal agency or its designee may require documentation by the service provider that an MA-covered service was received at the specific location.

5. No provider may be reimbursed more for transportation provided for an MA recipient than the provider's usual and customary charge. In this subdivision, "usual and customary charge" means the amount the provider charges or advertises as a charge for transportation except to county or tribal agencies or non-profit agencies.

(4) NON-COVERED SERVICES. The following transportation services and charges related to transportation services are non-covered services:

(a) Emergency transportation of a recipient who is pronounced dead by a legally authorized person before the ambulance is called;

(b) Transportation of a recipient's personal belongings only;

(c) Transportation of a laboratory specimen only;

(d) Charges for excess mileage resulting from the use of indirect routes to and from destinations;

(e) Transport of a recipient's relatives other than as provided in sub. (1) (d) 4;

(f) SMV transport provided by the recipient or a relative, as defined in sub. (1) (d) 4, of the recipient;

(g) SMV transport of an ambulatory recipient, except an ambulatory recipient under sub. (1) (c) 1, to a methadone clinic or physician's clinic solely to obtain methadone or related services such as drug counseling or urinalysis;

(h) Transportation by SMV to a pharmacy to have a prescription filled or refilled or to pick up medication or disposable medical supplies;

(i) Transportation by SMV provided solely to compel a recipient to attend therapy, counseling or any other MA-covered appointment; and

(j) Transportation to any location where no MA-covered service was provided either at the destination or pick-up point.

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (c) and (4) (5), Register, February, 1988, No. 386, eff. 3-1-88; r. and recr., Register, November, 1994, No. 467, eff. 12-1-94.

**HSS 107.24 Durable medical equipment and medical supplies.** (1) DEFINITION. In this chapter, "medical supplies" means disposable, consumable, expendable or nondurable medically necessary supplies which have a very limited life expectancy. Examples are plastic bed pans, catheters,

electric pads, hypodermic needles, syringes, continence pads and oxygen administration circuits.

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