HSS 101 to 108

C E R T I F I C A T E

STATE OF WISCONSIN)
)SS
DEPARTMENT OF HEALTH AND SOCIAL SERVICES)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Donald E. Percy, Secretary of the Department of Health and Social Services and custodian of the official records of said department do hereby certify that the annexed rules relating to medical assistance were duly approved and adopted by this department on February 28, 1979.

I further certify that said copy has been compared by me with the original on file in this department and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the department at the State Office Building in the City of Madison, this 28th day of February, 1979.

D. E. P.

DONALD E. PERCY, SECRETARY
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Seal:

ORDER OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES REPEALING, RECREATING AND AMENDING RULES

Pursuant to authority vested in the Department of Health and Social Services by section 227.014(2), Wis. Stats., and section 49.45(10),Wis. Stats., the Department of Health and Social Services hereby repeals, recreates and amends rules as follows:

Chapter HSS 2 of the WISCONSIN ADMINISTRATIVE CODE is created to read:

Renumbered chapters HSS 101 to 108
Dary L. Poulson

The rules contained herein shall take effect on the first day of the second month following publication in the WISCONSIN ADMINISTRATIVE REGISTER, or July 1, whichever is later as provided in section 227.026, Wis. Stats.

DONALD E. PERCY, SECRETARY
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

February 23, 1979

Seal:

Gary Peterson
411 West

Administrative Rule

WISCONSIN MEDICAL ASSISTANCE PROGRAM

FEB 12 1979

Final Draft

BUREAU OF HEALTH CARE FINANCING

Division of Health

Department of Health and Social Services

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MEDICAL ASSISTANCE ADMINISTRATIVE RULE
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DHSS 113 Chapter I: Introduction

1.01 Authority and Purpose. Pursuant to section 49.45(10), Wis. Stats., the rules of this chapter are adopted for the purpose of administering the medical assistance program in Wisconsin.

1.02 Applicability. The rules apply to all recipients of, providers of, and all persons engaged in the administration of the medical assistance program. [NOTE: This rule shall become effective on the first day of the second month after publication, or July 1, whichever is later.]

1.03 Definitions. [NOTE: For ease of reference, some definitions have been grouped together under broad category headings (e.g., definitions of terms specific to one coverage area or subject, or definitions of terms which have specific meanings within the context of a section). Definitions of terms which appear with more frequency throughout the rule (e.g., "provider", "recipient") and definitions of terms which appear in only one spot in the rule have been placed together under the category General Definitions.]

General Definitions

(1) Accredited. "Accredited" means approved by a national accrediting agency or association which has been recognized by the U.S. commissioner of education.

(2) Ambulatory. "Ambulatory" means able to walk independently, without assistance.

(3) ANSI. "ANSI" means American National Standards Institute.

(4) Border-Status Provider. "Border-status provider" means a provider located outside of Wisconsin which regularly gives service to Wisconsin recipients and which is certified to participate in the Wisconsin program.

(5) Bureau. "Bureau" means the bureau of health care financing in the department of health and social services.

(6) Bureau of Health Care Financing. "Bureau of Health Care Financing" means the bureau within the division responsible for administration of the Medical Assistance program.

(7) CFR. "CFR" means the Code of Federal Regulations.

(8) Christian Science Nurse. "Christian science nurse" means a nurse who meets the requirements of section 5.18.

(9) Claim. "Claim" means a request from a provider on an approved claim form for payment for services to a recipient.

(10) Clinical Note. "Clinical note" means a dated written notation of contact with a patient by a member of a health team. The clinical note contains a description of sign and symptoms, treatment or drug given, or both, the patient's reaction, and any changes in physical or emotional conditions.

(11) Consultation. "Consultation" means communication between two or more providers concerning the diagnosis or treatment in a given case (e.g., history-taking examination of the patient, rendering an opinion concerning diagnosis or treatment, offering service, assistance, or advice, etc.).

(12) Control Interest or Ownership. A person with an ownership or control interest for purposes of disclosure under subsections 5.01(2) and 5.01(3) means a person who:

(a) Possesses a direct or indirect interest in five (5) percent or more of the issued shares of stock in a corporate entity, or 5% or more of other evidences of ownership in an entity, corporate or otherwise.

(b) Is the owner of an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by an entity or any of the property or assets thereof; or

(c) Is an officer or director of an entity if the entity is organized as a corporation; or

(d) Is a partner in a partnership if the entity is organized as a partnership.

(13) Corrective Shoes. "Corrective shoes" means:

(a) Surgical straight case shoes for metatarsus adductus.

(b) Any shoe attached to a brace or prosthesis. (Arch supports are not considered a brace).

(c) Mismated shoes involving a difference of a full size or more.

(d) Shoe modifications for a discrepancy in limb length or a rigid foot deformation.

(14) Covered Services. "Covered services" means services, supplies, or items provided or performed by a provider or under a provider's supervision to an eligible recipient of Medical Assistance, for which Medical Assistance reimbursement may be made.

(15) County Agency. "County agency" means the county department of social services or public welfare.

(16) Department. "Department" means the department of health and social services.

(17) Dispensary Providers. "Dispensary providers" means providers who dispense drugs or medical supplies and equipment upon a prescription or order from a prescriber authorized under state law to prescribe such items. Examples of dispensary providers are pharmacies, durable medical equipment suppliers, providers of vision care supplies, etc.

(18) Division. "Division" means the division of health within the department.

(19) Drug Dispensing. "Drug dispensing" means an act entailing the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a patient or for a service unit of the facility.

(20) Drugs in Schedules II, III, IV and V. "Drugs in Schedules II, III, IV and V" means those drugs listed in Schedules II, III, IV and V of subchapter II of the Controlled Substances Act, sections 161.17 through 161.24, Wis. Stats.

(21) Durable Medical Equipment. "Durable medical equipment" means equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (e.g., wheelchairs, hospital beds, and side rails).

(22) Emergency Services. "Emergency services" means those services which are necessary to prevent the death or serious impairment of the health of the individual.

(23) Enrolled Recipient. "Enrolled recipient" means a recipient who has entered into an agreement to receive services from a provider reimbursed under the terms of a prepaid capitation contract with the department.

(24) Episode of Illness (for Chiropractic). "Episode of illness" means either the acute onset of a new condition or an exacerbation of a pre-existing condition which limits the functional ability of a person and requires a sequence of chiropractic adjustments to rectify.

(25) EPSDT Screening Clinic. "EPSDT screening clinic" means a provider certified to provide EPSDT screening services and meeting the requirements of subsection 5.37(2).

(26) Eyeglasses. "Eyeglasses" means lenses, including frames where necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye or by a licensed optometrist.

(27) Fiscal Agent. "Fiscal agent" means the organization under contract to the department to process claims for services provided under the medical assistance program.

(28) Health Care Project Grant Center. "Health care project grant center" means an organization, supported in whole or in part by federal project grant financial assistance, which provides or arranges for medical services to an enrolled population and receives payment for services to eligible recipients through contract with the department.

(29) Health Maintenance Organization (HMO). "Health maintenance organization" means a legal entity determined by the department to meet the following conditions:

(a) The entity provides to its enrolled recipients: inpatient and outpatient hospital services, laboratory and x-ray services, family planning services and supplies, physicians' services and home health care services.

(b) The entity provides the services in (a) above in a manner prescribed in section 1301(b) of the Public Health Service Act.

(c) The entity is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act.

(30) Hospital. "Hospital" has the same meaning as that in section 50.33(1), Wis. Stats. but excluding those facilities exempted by section 50.39(3), Wis. Stats.

(31) Institutionalized. "Institutionalized" means being a patient in a medical institution or a resident of an intermediate care facility.

(32) Institutional Provider. "Institutional provider" means a hospital, nursing home, health maintenance organization, home health agency, 51.42 board-operated facility, or other comparable facility meeting the requirements of subsection 5.01(5)(a).

(33) Laboratory. "Laboratory" means a laboratory certified pursuant to section 5.43 or 5.48(1)(c).

(34) Medical Assistance Program. "Medical assistance program" means the programs operated by the department of health and social services under Title XIX of the federal social security act, related federal regulations, and chapter 49, Wis. Stats.

(35) Medicare. "Medicare" means the program operated by the U.S. department of health, education and welfare under Title XVIII of the federal social security act and related federal regulations.

(36) Non-Covered Service. "Non-covered service" means a service, item or supply for which MA reimbursement shall not be made (e.g., services for which prior authorization has been denied, services listed as non-covered in chapter 7, services considered by consultants to the department to be not medically necessary or unreasonable or inappropriate).

(37) Nonprofit Agency. "Nonprofit agency" means an agency exempt from federal income taxation under section 501 of the internal revenue code of 1954.

(38) Person. "Person" means an individual, corporation, partnership, association, trustee, governmental unit or other entity. WSS 703.02(]2)

(39) Portable X-Ray Service. "Portable x-ray service" means a service certified pursuant to section 5.44.

(40) Practical Nurse. "Practical nurse" means a person who is licensed as a practical nurse by the State in which practicing.

(41) Prepaid Health Plan. "Prepaid health plan" means a health care provider that is not a health maintenance organization, and that provides medical services to enrolled recipients under contract with the department on a prepaid capitation basis. This includes the entities that meet the criteria of section 1903(m)(b)(i) or (ii) of the social security act.

(42) Prescription. "Prescription means a written order (or an oral order later reduced to writing) by a practitioner for a service for a particular patient, which specifies the date of its issue, the name and address of the practitioner prescribing the service, the name and address of the patient, the specific service prescribed, including quantity, duration and other characteristics, directions or explanations for carrying out the prescribed service, and, in case of a written order, the signature of the practitioner.

(43) Primary Provider. "Primary provider" means a provider as defined in section 49.43(11), Wis. Stats., providing health care services in the area wherein the recipient resides and designated as the primary provider by the recipient with the concurrence of the provider.

(44) Prior Authorization. "Prior authorization" means the written authorization issued by the Department to a provider for the provision of a specified covered service.

(45) Provider. "Provider" means a person who has been certified by the department to provide services to recipients and receive reimbursement under the Medical Assistance Program.

(46) Provider Agreement. "Provider agreement" means the contract between a provider and the department which sets forth conditions of participation and reimbursement.

(47) Provider Certification. "Provider certification" means the process and approval of a provider for participation in the program, as specified in section 5.01 of this rule.

(48) Provider's Eligibility Date. "Provider's eligiblity date" means the first date on which a provider may begin participation in medical assistance, and shall be no earlier than (and may be later than) the initial date of ~~a signed written~~ application.

(49) Provider's Initial Date of Application. "Provider's initial date of application" means either:

(a) The date on which the department received a telephone call or letter from a person requesting an application to be a provider; or

(b) The date on which the department receives an unsolicited application form from a person wishing to become a provider; or

(c) The date on which the department receives a person's rejected claim which was rejected due to an invalid provider number.

(50) PSRO. "PSRO" or "Professional Standards Review Organization" means the organization under contract with the department of health, education, and welfare, which makes determinations of medical necessity and reviews quality of services received by recipients of Medical Assistance, Medicare and Maternal and Child Health programs when such recipients are hospitalized.

(51) Public Agency. "Public agency" means an agency operated by a state or local government.

(52) Public Health Agency. "Public health agency" means an official agency established by a state or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and in certain cases, therapeutic services.

(53) Public Health Nurse. "Public health nurse" means a registered nurse who has completed a baccalaureate degree program approved by the national league for nursing for public health nursing preparation or post-registered nurse study which includes content approved by the national league for nursing for public health nursing preparation.

(54) Recipient. "Recipient" means a natural person who is entitled to receive benefits under the Medical Assistance program.

(55) Registered Nurse. "Registered nurse" means a nurse who is registered with the appropriate licensing agency in the state in which practicing.

(56) Rural Health Clinic. "Rural health clinic" means a clinic that is located in a rural area designated as a shortage area, either as a shortage of personal health services under section 1302(7) of the Public Health Services Act or a shortage of primary medical care under section 332 of that act; is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other appropriate regulations.

(57) Rural Shortage Area. "Rural shortage area" means a defined geographic area that is not delineated as an urbanized area by the Bureau of the Census, and that is designated by the department as having either:

(a) A shortage of personal health services (under section 1302(7) of the Public Health Service Act), or

(b) A shortage of primary medical care personnel (under section 332 of the Public Health Service Act).

(58) Semi-Private Room. "Semi-private room" means the lowest cost, multiple-bed accomodation in the section of the hospital appropriate for treatment of the recipient's condition, which is available at the time of admission.

(59) Service. "Service" means any health care service, supply or item.

(60) Specialized Medical Transportation Service. "Specialized medical transportation service" means service provided by a specialized transportation vehicle or by an ambulance, to a recipient who is non-ambulatory and requires a wheelchair, or whose condition contraindicates use of ordinary transportation service.

(61) Supervision. Unless indicated otherwise in this rule, supervision means at least intermittent face-to-face contact between supervisor and assistant and a regular review of the assistant's work by the supervisor.

(62) Time Out. "Time out" means the time out from positive reinforcement; a behavior modification procedure in which, contingent upon undesired behavior, the resident is removed from the situation in which positive reinforcement is available.

(63) Treatment Unit. "Treatment unit" is a term used for purposes of reimbursement which means the time spent in both direct treatment services to the individual patient as well as in related activities preparatory and subsequent to such treatment. Such activities as preparation of the patient for treatment, preparation of the treatment area, and preparing the patient for return are considered to be within the unit of treatment. Activities not associated with the treatment of the individual patient, such as end of the day clean-up of the treatment area are not considered part of the treatment unit.

(64) Wisconsin Drug Formulary. "Wisconsin drug formulary" means the formulary compiled by the department with the advice of its drug quality council and contained in Wis. Adm. Code, chapter H27.

(65) Wisconsin Medical Assistance Uniform Code on Dental Procedures and Nomenclature. "Wisconsin medical assistance uniform code on dental procedures and nomenclature" means the procedure code and nomenclature used by the medical assistance program for the purpose of billing, prior authorization and reimbursement for dental services. The uniform code is a modified adaptation of the current uniform code on dental procedures and nomenclature of the American Dental Association. (Published in Journal ADA; Vol 92; Mar. 1976; p.647).

(66) X-Ray Facility. "X-ray facility" means a facility certified pursuant to section 5.44.

Home Health

(67) Administrator, Home Health Agency. "Administrator, home health agency," means a person who:

(a) Is a licensed physician; or

(b) Is a registered nurse; or

(c) Has training and experience in health service administration and at least one year of supervisory or administrative experience in home health care or related health programs.

(68) Branch Office. "Branch office" means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.

(69) Bylaws or Equivalent. "Bylaws or equivalent" means a set of rules adopted by a home health agency for governing the agency's operation.

(70) Home Health Agency. "Home health agency" means a public agency or private organization, or a subdivision of such an agency or organization which is primarily engaged in providing skilled nursing services and other therapeutic services to a recipient at the recipient's place of residence.

(71) Home Health Aide. "Home health aide" means an individual employed by or under contract with a certified home health agency to provide home health aide (including personal care) services under the supervision of a registered nurse.

(72) Parent Home Health Agency. "Parent home health agency" means the agency that develops and maintains administrative controls of subunits or branch offices or both.

(73) Primary Home Health Agency. "Primary home health agency" means the agency that is responsible for the service rendered to patients and for implementation of the plan of treatment.

(74) Proprietary Agency. "Proprietary agency" means a private profit-making agency licensed by the state.

(75) Social Work Assistant. "Social work assistant" means a person who:

(a) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least one year of social work experience in a health care setting; or

(b) Has two years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the U.S. Public Health Service , except that such determinations of proficiency to not apply with respect to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.

(76) Subdivision. "Subdivision" means a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the conditions of participation for home health agencies. A subdivision which has subunits or branches or both is regarded as a parent agency.

(77) Subunit. "Subunit" means a semi-autonomous organization, which serves patients in a geographic area different from that of the distance between it and the parent agency. The subunit by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision, and services on a daily basis with the parent agency and must, therefore, independently meet the conditions of participation for home health agencies.

Laboratories

(78) Clinical Laboratory. "Clinical laboratory" means a clinical laboratory-with a director at the doctoral level-of a hospital, a health department, university, medical research institution or military installation of the United States government; or a clinical laboratory licensed under the Clinical Laboratories Improvement Act of 1967; for the provision of microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(79) Director at the Doctoral Level. "Director at the doctoral level" means a person having the qualifications described in section 5.43(1)(b) except for paragraphs 5.43(1)(b)5.b.,c., and d.

(80) Histocompatibility Testing. "Histocompatibility testing" means laboratory test procedures which determine a potential donor or organ transplant recipient.

(81) Independent Laboratory. "Independent laboratory" means one which is independent both of the attending or consulting physician's office and of a hospital. A laboratory is not an independent laboratory if it (1) is located in a hospital or, if outside the hospital, is operated under the supervision of the hospital or its organized medical staff, and (2) serves the hospital's patients. Out-of-hospital laboratories under the direction of a physician such as a pathologist, are considered to be independent laboratories if the physician holds the physician's services and office facilities out to other physicians as being available for the performance of diagnostic tests. A laboratory maintained by a physician for performing diagnostic tests for that physician's own patients is not an independent laboratory unless such laboratory accepts at least 100 specimens in any category during any calendar year on referral from other physicians. For purposes of this definition a category shall be one of the following: (i) Microbiology and serology; (ii) clinical chemistry; (iii) immunohematology; (iv) hematology; (v) pathology; (vi) radiobioassay.

(82) Personal and Direct Supervision. "Personal and direct supervision" means that a qualified general supervisor or supervisory cytotechnologist, where applicable, is present in the immediate bench area when laboratory procedure are being performed.

(83) Proficiency Testing Program. "Proficiency testing program" means a program which:

(a) is either operated or approved by the department and

(b) meets at a minimum the requirements for a proficiency testing program acceptable to the department.

(84) Radiobioassay. "Radiobioassay" means

(a) an examination to identify radionuclides or determine and quantitate body levels of radionuclides which are taken in by chronic or acute absorption, ingestion, or inhalation; and

(b) following the administration of a radioactive material to a patient, the subsequent analysis of a body fluid, or excreta in order to evaluate body function.

(85) Subsequent to Graduation. "Subsequent to graduation" means laboratory training and experience acquired after receipt of the degree specified. However for purposes of sections 5.43(3) and (4) experience as a technologist in an approved clinical laboratory, which was gained prior to acquiring

such degree, may be substituted on an equivalency basis of 1.5 years of such experience for every one year of post-degree training and experience. Experience as a general supervisor in an approved clinical laboratory which was gained prior to acquiring such degree, may be substituted on a one-for-one basis.

(86) Substitution of Education for Experience. "Substitution of education for experience" means that a minimum of 30 semester hours of credit from an approved school of medical technology, or towards a bachelor's degree from an accredited institution with a chemical, physical, or biological science as the major subject is considered equivalent to 2 years of experience. Additional education is equated at the rate of 15 semester hours of credit for one year of experience.

(87) Technician Trainee. "Technician trainee" means a high school graduate or equivalent who is gaining the required 2 years of clinical laboratory on-the-job experience to qualify as a technician, and is participating in a structured training program approved by the department designed to provide the trainee with a broad range of laboratory procedures of progressive technical difficulty.

Mental Health Services

(88) Active Treatment. "Active treatment" means implementation and administration of a professionally developed and supervised individual plan of care, which plan shall be developed and implemented no later than 14 days after admission to the facility. Active treatment must be reasonably expected to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan of care shall be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

(89) AODA Treatment Services. "AODA treatment services" means those services provided by a provider certified pursuant to sections 5.22 or 5.23 of this rule, to inform, motivate, guide and assist alcoholics and drug abusers, and those persons affected by problems related to the abuse of alcohol or drugs. Examples of AODA services include but are not limitated to client evaluation, orientation and motivation, treatment planning, consultation and referral, client education, individual counseling, group counseling, and crisis intervention.

(90) Board. "Board" means a community mental health board established under s.51.42, Wis. Stats., a developmental disabilities board established under s.51.437, Wis. Stats., or a community human services board established under s.46.23, Wis. Stats.

(91) Day Treatment. "Day treatment" means a non-residential program that provides structural rehabilitative activities including training in basic living skills, interpersonal skills, leisure educational skills and

problem solving skills. Case management, medical care, psychotherapy and follow-up are also provided to alleviate problems related to mental illness or emotional disturbances. Day treatment services are delivered in a medically supervised setting and are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day.

(92) Differential Diagnostic Examination. "Differential diagnostic examination" means an examination and assessment of the person's emotional and social functioning which shall include one or more of the following: neurologic studies, psychological tests and psycho-social assessments of the recipient's functioning.

(93) Inmate. "Inmate of a public institution" means a person who has resided for a full calendar month in an institution that is the responsibility of a governmental unit, or over which a governmental unit exercises administrative control, to participate in the living arrangement and to receive treatment or services provided there which are appropriate to the person's requirements.

(94) Inpatient Psychiatric Facility. "Inpatient psychiatric facility" means an inpatient facility which meets the requirements of section 5.21.

(95) Institution for mental diseases. "Institution for mental diseases" means a mental hospital, a psychiatric facility, and a skilled nursing or intermediate care facility that primarily cares for mental patients.

(96) Outpatient Facility. "Outpatient facility" means a facility licensed or approved by the department under section 632.89, Wis. Stats.

(97) Prescription. "Prescription" means an order by a physician for treatment for a particular person. The order shall be in writing and shall include the date of the order, the name and address of the physician, the physician's medical assistance provider number, the name and address of the recipient, the recipient's medical assistance eligibility number, the nature of the recommended treatment based upon the diagnostic examination, and the physician's signature.

(98) Psychiatric facility. "Psychiatric facility" means a psychiatric program as defined in HSS 107.13(1)(b).

(99) Psychiatric Hospital. "Psychiatric hospital" means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

(100) Psychotherapy. "Psychotherapy" means treatment of an individual with mental illness or medically significant emotional or social dysfunctions by psychological or interpersonal means. The treatment is a planned and structured program which is based on information from a differential diagnostic examination and which is directed at the accomplishment of specified goals. The treatment goals may include removing, modifying, or retarding existing symptoms, mediating disturbed patterns of behavior, and promoting positive personal growth and development by enhancing the ability to adapt and cope with internal and external stresses.

(101) Psychotherapy Provider. "Psychotherapy provider" means a natural person certified by the department to participate in the medical assistance program with the following minimum qualifications:

(a) A licensed physician who has completed a residency in psychiatry, or who is certified by the American Board of Family Practice; or

(b) A licensed psychologist who is listed or eligible to be listed in the National Register of Health Services Providers in Psychology; or

(c) An outpatient facility operated by a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats.; or

(d) An outpatient facility operated by a provider hospital which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and which is accredited by JCAH, Accreditation Program for Psychiatric Facilities; or

(e) At the discretion of the department, an outpatient facility under contract to a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable), Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and which has made substantial effort to comply with the requirements for accreditation by JCAH, Accreditation Program for Psychiatric Facilities.

Nursing Homes

(102) Ancillary Cost. "Ancillary cost" means an extraordinary and unique cost incurred by a nursing home or other qualified provider of services or materials furnished to a resident, which cost is not included in calculating the nursing home's daily rate, and for which the medical assistance program is authorized to reimburse separately.

(103) Charge Nurse. "Charge nurse" means a person who is:

(a) Licensed by the state as a:

1. Registered nurse; or
2. Practical nurse.

(b) A licensed practical nurse, when performing as charge nurse, may practice only within the scope of licensure.

(104) Chief Executive Officer. "Chief executive officer" means the individual appointed by the governing body of a facility to act in its behalf in the overall management of the facility. Job titles may include, but are not limited to, superintendent, director, and administrator.

(105) Daily Nursing Home Rate. "Daily nursing home rate" means the amount reimbursed to a nursing home under the Medical Assistance program for providing routine, day-to-day health care services to a patient recipient, determined in accordance with section 49.45(6m)(a), Wis. Stats.

(106) Department-Approved Occupancy Rate. "Department-approved occupancy rate" means a rate of occupancy established by the department and communicated to providers which is used for purposes of determining whether bed-hold payment may be made to a nursing home.

(107) Dietetic Service Supervisor. "Dietetic service supervisor" means a person who:

(a) Is a qualified dietician; or

(b) Is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or

(c) Is a graduate of a state-approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietician; or

(d) Has training and experience in food service supervision and management in a military service equivalent in content to the program in paragraph (b) or (c) above.

(108) Dietician. "Dietician" means a person who:

(a) Is eligible for registration by the American Dietetic Association under its requirements in effect on January 17, 1974; or

(b) Has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, has one year of supervisory experience in the dietetic service of a health care institution and participates annually in continuing dietetic education.

(109) Director of Nursing Services. "Director of nursing services" means a registered nurse who is licensed by the state in which practicing, and has one year of additional education or experience in nursing service administration, as well as additional education or experience in such areas as rehabilitative or geriatric nursing, and participates annually in continuing nursing education.

(110) Direct Services. "Direct services" mean those services that tend to benefit patient recipients on an individual basis, as opposed to a group basis, and include but are not limited to: physician visits to patients, therapy modalities, drug dispensing, radiology or laboratory services provided by a certified radiology or laboratory unit, oral exams, and physical examinations. Direct services are often referred to as billable services, medical services, or professional services.

(111) District. For purposes of section 5.105, "district" means each Wisconsin county, with the exception of multi-county districts as periodically defined by the department. Juneau and Wood; Menominee and Shawano; and Bayfield and Douglas Counties are current multi-county districts.

(112) Drug Administration. "Drug administration" means an act in which a single dose of prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual doses to the proper patient, and promptly recording the time and dose given.

(113) Elderly Population. For purposes of section 5.105, "elderly population" means the population of those aged 65 and over who reside in a district, as determined annually on July 1, by the department using the latest available published data.

(114) Existing Buildings. "Existing buildings" for the purposes of ANSI standard no. A117.1 and minimum patient room size in skilled nursing facilities or parts thereof means buildings whose construction plans are approved and stamped by the department before the date these regulations become effective.

(115) Facility. "Facility" for purposes of section 5.12, means an intermediate care facility for the mentally retarded or persons with related conditions.

(116) Hospital visit. "Hospital visit" means at least an overnight stay by a patient recipient in a certified hospital.

(117) Governing Body. "Governing body" means the policy-making authority, whether an individual or a group, that exercises general direction over the affairs of a facility and establishes policies concerning its operation and the welfare of the individuals it serves.

(118) Indirect Services. "Indirect services" mean those services that tend to benefit patient recipients on a group basis, as opposed to an individual basis, and include but are not limited to: consulting, in-service training, medical direction, utilization review, and the services of unlicensed or uncertified assistants who are not under direct supervision. Indirect services are often referred to as non-billable services, non-medical services, or non-professional services.

(119) Independent Provider of Service. "Independent provider of service" means an individual or agency which, in its own right, is eligible to provide health care services to patient recipients, to have a provider number, and to submit claims for reimbursement under the medical assistance

program. Independent providers of service include, but are not limited to: physicians, dentists, chiropractors, podiatrists, registered physical therapists, certified occupational therapists, certified speech therapists, certified audiologists, psychiatrists, pharmacists, ambulance service agencies, specialized medical vehicle service agencies, psychologists, x-ray clinics and laboratories. Independent providers of service may provide either direct or indirect services.

(120) Intermediate Care Facility (ICF) Services.

(a) "Intermediate care facility services, other than in an institution for tuberculosis or mental diseases" means services provided in a facility that:

1. Fully meets the requirements for a state license to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services that are above the level of room and board; and can be made available only through institutional facilities;

2. Has been certified to meet the requirements of HSS 105.10(19) as evidenced by a valid agreement between the department and the facility for providing intermediate care facility services and making payments for services under the plan; and

3. Meets the conditions of HSS 105.11.

(b) "Intermediate care facility services" include services

1. Considered appropriate by the department and provided by a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass.; or

2. Provided by a facility located on an Indian reservation that:

a. Furnishes, on a regular basis, health-related services; and

b. Is certified to meet the standards in HSS 105.11.

(c) "Intermediate care facility services" may include services in an institution for the mentally retarded or persons with related conditions if:

1. The primary purpose of the institution is to provide health or rehabilitation services for mentally retarded individuals or persons with related conditions;

2. The institution meets the standards in HSS 105.11; and

3. The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in HSS 101.103.

(d) "Intermediate care facility services" may include services provided in a distinct part of a facility other than an intermediate care facility if the distinct part:

1. Meets all requirements for an intermediate care facility;

2. Is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;

3. Consists of all beds and related facilities in the unit;

4. Houses all recipients for whom payment is being made for intermediate care facility services, except as provided in paragraph (e) of this section;

5. Is clearly identified; and

6. Is approved in writing by the department.

(e) If a state includes as intermediate care facility services those services provided by a distinct part of a facility other than an intermediate care facility, it may not require transfer of a recipient within or between facilities if, in the opinion of the attending physician, it might be harmful to the physical or mental health of the recipient.

(121) Large Skilled Nursing Facility. For purposes of section 5.105, "large skilled nursing facility" means skilled nursing facility with 100 beds or more.

(122) Living Unit. "Living unit" means a resident-living unit that includes sleeping areas and may additionally include dining and activity area.

(123) Medical Record Practitioner. "Medical record practitioner" means a person who:

(a) Is eligible for certification as a registered record administrator (RRA), or an accredited record technician (ART), by the American Medical Record Association under its requirements in effect on the date these regulations become effective; or

(b) Is a graduate of a school of medical record science that is accredited jointly by the council on medical education of the American Medical Association and the American Medical Record Association.

(124) Mobile Non-Ambulatory. "Mobile non-ambulatory" means unable to walk independently or without assistance, but able to move from place to place with the use of devices such as walkers, crutches, wheel chairs, or wheeled platforms.

(125) Non-Ambulatory. "Non-ambulatory" means unable to walk independently, without assistance.

(126) Non-Mobile. "Non-mobile" means unable to move from place to place.

(127) Nursing Home. "Nursing home" means a health care and treatment facility as defined in s.50.01(3), Stats.

(128) Patient Activities Coordinator. "Patient activities coordinator" means a person who:

(a) Is a qualified therapeutic recreation specialist; or

(b) Has 2 years of experience in a social or recreational program within the last 5 years, one year of which was full-time in a patient activities program in a health care setting; or

(c) Is an occupational therapist or occupational therapy assistant.

(129) Personal Care Services (as a component of institutional nursing care services). "Personal care services" when provided as part of nursing care in a hospital, nursing home or other institutional setting, means services which do not require the skills of qualified professional, except for services provided under subsection 7.09(3)(e)3.

(130) Persons With Related Conditions. "Persons with related conditions" means those individuals who have epilepsy, cerebral palsy, or other developmental disabilities a defined pursuant to Part C of the Developmental Disabilities Services and Facilities Construction Act (PL 91-517).

(131) Progress Note. "Progress note" means a dated, written notation by a member of the health team summarizing facts about care and the patient's response during a given period of time.

(132) Qualified Therapist. "Qualified therapist" means:

(a) In the case of a physical therapist, a person who meets the qualifications of section 5.27.

(b) In the case of an occupational therapist, a person who meets the qualifications of section 5.28.

(c) In the case of a speech pathologist, a person who meets the qualifications of section 5.30.

(133) Qualified Mental Retardation Professional. "Qualified mental retardation professional" means a person who has specialized training or one year of experience in treating or working with the mentally retarded and is one of the following:

(a) A psychologist with a master's degree from an accredited program.

(b) A physician licensed under state law to practice medicine or osteopathy.

(c) A social worker with a bachelor's degree in social work from an accredited program, or a bachelor's degree in a field other than social work and at least three years social work experience under the supervision of a qualified social worker.

(d) A physical or occupational therapist who meets the requirements of Sec. 5.27 or 5.28.

(e) A speech pathologist or audiologist who meets the requirements of Sec. 5.30 or 5.31.

(f) A registered nurse.

(g) An educator with a degree in education from an accredited program.

(h) A therapeutic recreation specialist who is a graduate of an accredited program.

(i) A rehabilitation counselor who is certified by the committee on rehabilitation counselor certification.

(134) Resident-Living. "Resident-living" means pertaining to residential services provided by an ICF/MR.

(135) Resident Recipient (also, Patient Recipient). "Resident recipient" (or "patient recipient") means a person who is residing in a nursing home and is eligible to receive or is receiving benefits under the Medical Assistance program.

(136) Skilled Nursing or Skilled Rehabilitation Services. "Skilled nursing or skilled rehabilitation services" means those services furnished pursuant to physician orders which require the skills of technical or professional personnel, e.g., registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech pathologist, or audiologist; and which

Are provided either directly by or under the supervision of such professional personnel. Examples of services which could qualify as either skilled nursing or skilled rehabilitation services include, but are not limited to:

(a) Overall management and evaluation of care plan. The development, management, and evaluation of a patient care plan, based on the physician's orders constitute skilled services when in terms of the patient's physical or mental condition, such development, management, and evaluation necessitate the involvement of technical or professional personnel to meet needs, promote recovery, and actuate medical safety. This would include the management of a plan involving only a variety of personal care services where in light of the patient's condition the aggregate of such service necessitates the involvement of technical or professional personnel. Skilled planning and management activities are not always specifically identified in the patient's clinical record. In light of this, where the patient's overall condition would support a finding that recovery or safety could be assured only if the total care required is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided.

(b) Observation and assessment of the patient's changing condition. When the patient's condition is such that the skills of a nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until the patient's condition is stabilized, such services constitute skilled services. Patients who in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, etc., may also require skilled observation and assessment by technical or professional personnel to assure their safety and the safety of others, i.e., to observe for

indications of suicidal or hostile behavior. In such cases, special services required must be documented by physician's orders or nursing or therapy notes.

(c) Patient education services. In cases where the use of technical or professional personnel is necessary to teach a patient self-maintenance, such teaching services would constitute skilled services.

(d) Examples of services which would qualify as skilled nursing services include, but are not limited to:

1. Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;
2. Levin tube and gastrostomy feedings;
3. Nasopharyngeal and tracheotomy aspiration;
4. Insertion and sterile irrigation and replacement of catheters;
5. Application of dressings involving prescription medications and asceptic techniques;
6. Treatment of extensive decubitus ulcers or other widespread skin disorder;
7. Heat treatments which have been specifically ordered by a physician as part of active treatment and which required observation by nurses to adequately evaluate the patient's progress;
8. Initial phases of a regimen involving administration of medical gases;
9. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

(e) Examples of services which would qualify as skilled rehabilitation services include, but are not limited to:

1. Ongoing assessment of rehabilitation needs and potential. Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders, sensory integrative abilities;
2. Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;
3. Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;
4. Range of motion exercises; Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored).
5. Sensory integrative evaluation and training: Sensory integrative evalution and training which, because of the type of training or the condition of the patient must be performed by or under the supervision of a qualified occupational therapist or physical therapist or other appropriate licensed health care provider to ensure the safety of the patient and the effectiveness of the treatment.

6. Preventive therapy: Preventive therapy utilizes the principles or techniques of minimizing further debilitation in the areas of energy preservation, joint protection, edema control, positioning, etc. and requires the specialized knowledge and judgment of a qualified occupational or physical therapist.

7. Maintenance therapy: Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance.

8. Ultrasound, shortwave, and microwave therapy treatments by a qualified physical therapist;

9. Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool: Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool, in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required;

10. Therapeutic adaptations: Therapeutic adaptations include the following: orthotics, splinting, prosthetics and assistive or adaptive equipment prescribed by a physician and provided by a qualified occupational or physical therapist;

11. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(137) Skilled Nursing Facility (SNF) Services.

(a) "Skilled nursing facility services for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases," means services that are:

1. Needed on a daily basis and required to be provided on an inpatient basis;

2. Provided by a facility or distinct part of a facility that is certified to meet the requirements for participation under HSS 105.10; and

3. Ordered by and under the direction of a physician.

(b) Skilled nursing facility services includes services provided by any facility located on an Indian reservation and certified by the department as meeting the requirements of HSS 105.10.

(138) Social Worker (Qualified Consultant). For purposes of the nursing home sections of this rule, "social worker" means a person who is a graduate of a school of social work accredited or approved by the council on social work education, and who has one year of social work experience in a health care setting.

(139) Summary Report. "Summary report" means a compilation of the pertinent factors from the clinical notes and progress notes regarding a patient, which is submitted as a summary report to the patient's physician.

(140) Therapeutic/Rehabilitative Program. "Therapeutic/rehabilitative program" means a formal or structured activity which is, or whose sponsoring group is, certified or approved by a recognized standard-setting or certifying organization when such an organization exists, and which is designed to contribute to the mental, physical or social development of its participants.

(141) Therapeutic Visit. "Therapeutic visit" means at least an overnight visit by a patient recipient with relatives or friends.

(142) Training and Habilitation Services. For the purposes of section 5.12(12), "Training and habilitation services" means the facilitation of the intellectual, sensorimotor, and emotional development of the individual.

(143) Vocational Specialist. "Vocational specialist" means a person who has a baccalaureate degree and:

(a) Two years experience in vocational counseling in a rehabilitation setting such as a sheltered workshop, state employment service agency, etc., or

(b) At least 18 semester hours in vocational rehabilitation, educational or vocational guidance, psychology, social work, special education or personnel administration, and one year of experience in vocational counseling in a rehabilitation setting; or

(c) A master's degree in vocational counseling.

Occupational Therapy

(144) Direct, Immediate, On-Premises Supervision. "Direct, immediate, on-premises supervision" means supervision with face-to-face contact between the supervisor and the person being supervised, when necessary. The supervisor is physically present in the same building when the service is being performed by the person being supervised.

(145) Group Occupational Therapy Treatment. "Group occupational therapy treatment" means the delivery of occupational therapy treatment procedures as established in a group setting. A group of up to but no more than six patients shall be supervised by one qualified occupational therapist. If the group consists of more than six but no more than twelve patients, at least two qualified occupational therapy staff members, one of whom must be a registered occupational therapist, shall meet with the group to carry out the designated treatment goals. Group treatment using acceptable principles of group dynamics is an appropriate means of delivering the procedures of social-interpersonal and psychological intrapersonal skills. A development gross motor exercise group program using the techniques of Sensory Integration as developed by Lorna Jean King is an appropriate means of service delivery of the procedure Sensorimotor Integration. Any other form of group treatment is not appropriate for any of the reimbursable procedures.

(146) Individual Occupational Therapy Treatment. "Individual occupational therapy treatment" consists of one-to-one delivery of occupational therapy treatment procedures as established in the individual patient's plan of care for the purpose of restoring, improving or maintaining optimal functioning.

(147) Occupational Therapist. "Occupational therapist" means a person who meets the requirements of section 5.28.

(148) Occupational Therapist Assistant. "Occupational therapist assistant" means a person who meets the requirements of section 5.285 of this rule.

(149) Occupational Therapy Procedure. "Occupational therapy procedure" means treatment (with or without equipment or apparatus) which requires the personal continuous attendance of a registered occupational therapist, or a certified occupational therapist assistant or a student occupational therapist. Both COTA and student occupational therapist work under the direct, immediate on-the-premises supervision of a registered occupational therapist.

(150) Occupational Therapy Treatment Unit. "Occupational therapy treatment unit" for the purposes of reimbursement, includes the time spent in both direct treatment services to the patient(s) as well as up to 15 minutes per patient per treatment day spent in the related activities preparatory and subsequent to such treatment. Such activities as preparation of the patient(s) for treatment, preparation of the treatment area, and preparing the patient for return are considered to be within the treatment unit. Such activities not associated with treatment of the patient(s), such as end-of-day clean-up of the treatment area, are not considered part of the time of treatment for reimbursement purposes.

(151) Preventive/Maintenance Occupational Therapy. "Preventive/maintenance occupational therapy" means procedures which are provided to forestall deterioration of the patient's condition or to preserve the patient's current status. Preventive/maintenance occupational therapy utilizes the procedures and techniques of minimizing further deterioration in areas such as, but not limited to the treatment of arthritic conditions, multiple sclerosis, upper extremity contractures, chronic or recurring mental illness and mental retardation.

(152) Qualified OTR and COTA. A medical assistance qualified OTR means the primary performing provider of services who is responsible for and signs all billing. No supervision is required. A medical assistance qualified COTA is defined as a non-billing performing provider of services who must be under the direct immediate, on-premises supervision of a medical assistance qualified OTR. A non-billing performing provider cannot bill directly. The non-billing performing provider's services must be billed under the performing provider number of the supervisor. Reimbursement goes directly to the supervisor or facility or other payee designated by the supervisor.

(153) Restorative Occupational Therapy. "Restorative occupational therapy" means the use of procedures for the purpose of achieving maximum reduction of a physical disability or the establishment of a patient at the best functional level. Restorative occupational therapy includes but is not limited to those techniques which increase motor skills, sensory integrative functioning, cognitive skills, activities of daily living, social interpersonal skills and psychological intrapersonal

skills. Restorative occupational therapy also includes those procedures provided to relieve pain, to improve cardio pulmonary function and adaptations
of orthotic, prosthetic, assistive and adaptive appliances or devices and training in their use.

Personal Care

(154) Disabled. "Disabled" means a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which lasted or can be expected to last for a continuous period of not less than 12 months.

(155) Personal Care Services. "Personal care services" means those services enumerated in section 7.12 when provided by a provider meeting the requirements of sections 5.16 or 5.17.

(156) Personal Care Worker. "Personal care worker" means an individual employed by or under contract with a medicaid-certified social service agency to provide personal care services under the supervision of a registered nurse.

(157) Social Service Agency. "Social Service Agency" means an agency approved by the department as meeting the provisions of section 5.17 to provide personal care services.

Physical Therapy

(158) Evaluation. "Evaluation" means one or more of the tests or measures indicated in subsection 7.16(1)(a).

(159) Modality. "Modality" means a treatment involving physical therapy equipment or apparatus that does not require the physical therapist's personal continuous attendance during the periods of use but that does require setting up, frequent observations, and evaluation of the treated body part prior to and after treatment.

(160) Outpatient Physical Therapy Services. "Outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, a rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient. The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this rule.

(161) Physical Therapist. "Physical therapist" means a person who meets the requirements of section 5.27.

(162) Physical Therapist Assistant. "Physical therapist assistant" means a person who meets the requirements of section 5.275.

(163) Preventive/Maintenance Physical Therapy. "Preventive/maintenance physical therapy" means those physical therapy modalities and procedures which are provided to forestall the patient's condition from deteriorating or to preserve the patient's current physical status. Preventive/maintenance physical therapy utilizes the procedures and techniques of minimizing further deterioration in areas such as but not limited to daily living skills, mobility, positioning, edema control and other physiological processes.

(164) Procedure. "Procedure" means a treatment with or without equipment or apparatus that requires the physical therapist's personal continuous attendance.

(165) Restorative Physical Therapy. "Restorative physical therapy" means the use of physical therapy modalities and procedures which are provided for the purpose of achieving maximum reduction of a physical disability or the establishment of the patient at the best possible functional level. Restorative physical therapy includes but is not limited to exercises to increase range-of-motion, strength, tolerance, coordination, and activities of daily living. Restorative physical therapy also includes those physical therapy modalities and procedures provided to relieve pain, to promote wound healing, to improve cardio pulmonary function and adaption of orthotic, prosthetic, assistive and adaptive appliances or devices and training in their use.

(166) Treatment Unit. "Treatment unit" is a term used for purposes of reimbursement which means the time spent in both direct treatment services to the individual patient as well as in related activities preparatory and subsequent to such treatment. Such activities as preparation of the patient for treatment, preparation of the treatment area, and preparing the patient for return are considered to be within the unit of treatment. Activities not associated with the treatment of the individual patient, such as end of day clean-up of the treatment area are not considered part of the treatment unit.

Physician Services--Sterilization

(167) Hysterectomy. "Hysterectomy" means a medical procedure or operation for the purpose of removing the uterus.

(168) Institutionalized individual. "Institutionalized individual" means an individual who is:

(a) Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

(b) Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

(169) Mentally incompetent individual. "Mentally incompetent individual" means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(170) Sterilization. "Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

(171) Physician. "Physician" means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which such function or action is performed.

Recipients (Eligibility, Fair Hearing etc.)

(172) Applicant. "Applicant" means a person who has directly, or through an authorized representative (or where incompetent or incapacitated, through someone acting responsibly for the applicant), made application for medical assistance with the social security administration or the local county department of social services.

(173) Application. "Application" means the process of completing and signing a department-approved application form, by which action a person indicates in writing to the agency authorized to accept the application a desire to receive medical assistance.

(174) Categorical Assistance. "Categorical assistance" means Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) both of which are cash payment programs.

(175) Concurrent Review. As it pertains to fair hearings, "concurrent review" means the department's informal review (including an investigation into the facts) of a recipient's request for a fair hearing whereby the department attempts to achieve an informal resolution acceptable to the recipient before the fair hearing takes place. Such review shall not in any way preclude the recipient's right to a fair hearing.

(176) Earned Income. "Earned income" means income received in the form of wages, salary, commissions or profits from activities in which the applicant or recipient is engaged as an employee or as a self-employed person.

(177) Explanation of Benefits Notice. "Explanation of benefits notice" means the monthly report sent by the department to a recipient containing a summary of the department's record of medical assistance claims paid on the recipient's behalf during that month.

(178) Fair Hearing. "Fair hearing" has the same meaning as that in Wis. Adm. Code PW-PA 20.18(2)(b).

(179) Fiscal Test Group. "Fiscal test group" means the following persons listed on an application for medical assistance, whose income and assets are compared to program eligibility limits:

(a) Persons in the medical assistance group.

(b) Non-financially eligible parents or spouses who are legally responsible for someone in the MA group, who live in the same household as the person or persons for whom they are legally responsible, and who are not SSI recipients.

(180) Homestead (Home). "Homestead (home)" means a place of abode and lands used or operated in connnection therewith. In urban situations the home usually consists of a house and lot. There will be situations where the home will consist of a house and more than one lot. As long as the lots adjoint one another, they are considered part of the home. In farm situations, the home consists of the house and building together with the total acreage property upon which they are located and which is considered a part of the farm. There will be farms where the land is on both sides of a road and considered a part of the homestead.

(181) Income. "Income" means any benefit received by or available to a medical assistance applicant or recipient as earnings or otherwise. Income may be earned or unearned. In family groups living together, the income of a spouse is considered available to the other spouse and the income of a parent is considered available to the parent's children under 18 years of age.

(182) Inconsequential Income. "Inconsequential income" means income that is usually unpredictable and irregular, and is of no appreciable effect on continuing need.

(183) Medical Assistance Group. "Medical assistance group" means all persons listed on an application for MA who meet non-financial eligibility requirements except that AFDC recipients comprise a separate MA group, and each child with no legally responsible relative comprises a separate MA group.

(184) Migrant. "Migrant" means person as defined in s.101.20, Stats.

(185) Net Income. "Net income" means the amount left after deducting allowable expenses and income disregards.

(186) Participation in the Work Incentive Program. "Participation in the Work Incentive Program" means being or having been registered under the work incentive program.

(187) Property. "Property" means a recipient's homestead and all other personal and real property in which the recipient has a legal interest.

(188) Residence (or Abode). "Residence" or "abode" means the place where a person lives and intends to remain.

(189) Retroactive Eligibility. "Retroactive eligibility" means eligibility for medical assistance which decision has been made retroactive for up to 3 months prior to the month of application to allow MA reimbursement for services covered by the program which were provided to the recipient before the recipient made application for medical assistance.

(190) Spend-Down. "Spend-down" means the process by which income which exceeds the amount protected by state law for maintenance needs is reduced, according to the procedures of section 3.02(]6) and section 49.47(4)(c)(2.) Wis. Stats.

(191) Stepparent Family. "Stepparent family" means a family in which a legal parent, a stepparent and a child under age 18 are residing in the home.

(192) Unearned Income. "Unearned income" means income which is not the direct result of labor or services performed by the individual as an employee or as a self-employed person.

Rehabilitation Agencies

(193) Administrator. "Administrator" means a person who has a bachelor's degree and either: experience or specialized training in the administration of health institutions or agencies; or, qualifications and experience in one of the professional health disciplines.

(194) Clinic. "Clinic" means a facility established primarily for the provision of outpatient physicians' services. To meet this definition, an organization must meet the following test of physician participation:

(a) The medical services of the clinic are provided by a group of physicians (i.e., more than two) practicing medicine together; and

(b) A physician is present in the clinic at all times during hours of operation to perform medical services (rather than only administrative services).

(195) Organization. "Organization" means a clinic, rehabilitation agency or public health agency.

(196) Rehabilitation Agency. "Rehabilitation agency" means an agency which provides a integrated multi-disciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program which, in addition to physical therapy or speech pathology services, includes social or vocational adjustment services.

(197) Vocational Specialist. "Vocational specialist" means a person who has a bachelor's degree and;

(a) Two years experience in vocational counseling in a rehabilitation setting such as a sheltered workshop, state employment service agency, etc.; or

(b) At least 18 semester hours in vocational rehabilitation, educatonal or vocational guidance, psychology, social work, special education or personnel administration, and one year of experience in vocational counseling in a rehabilitation setting; or

(c) A master's degree in vocational counseling.

Speech Pathology

(198) Individual Speech/Language Pathology Treatment. "Individual speech/language pathology treatment" means one-to-one or the individual delivery of speech/language pathology treatment procedures as established in the individual patient's plan of care for the purpose of restoring, improving, and/or maintaining optimal speech and language functioning.

(199) Group Speech/Language Pathology Treatment. "Group speech/language pathology treatment" means the delivery of speech/language pathology treatment procedures in a group setting. Groups may include up to four M.A. recipients. Billing for groups of more than four recipients will be suspended and sent to the medicaid speech therapy consultant to determine the validity of the billing. Claims for a recipient who is involved in a group pathology setting for more than 16 hours per 60 days per diagnosis will also be suspended for review. Group speech/language pathology treatment is limited to the following areas: expressive language, receptive language, hearing/auditory training (auditory training, lip reading, and hearing-aid orientation).

(200) Non-Billing Performing Provider Number. "Non-billing performing provider number" means the provider number assigned to persons with a bachelors degree in speech/language pathology. In order to bill the MA program for their services, these persons must be under the supervision of an ASHA recognized and MA-certified supervisor, who is responsible and liable for the performance of delivering services. In addition, these persons can not bill the MA program for services which they render. Their services can be billed only by the ASHA recognized and MA certified supervisor or through the performing provider number of the certified state approved speech and hearing centers. The claim form for services performed by a person with a bachelors degree must contain the performing provider number of either the state approved center or the MA certified supervisor. In the latter case, the form must also contain the provider number, name, and signature in the appropriate cells. The claim form must indicate the name of the person with the bachelors degree who performed the service.

(201) Speech Pathology Performing Provider Number. "Performing provider number" means the provider number assigned only to ASHA recognized speech/language pathologists (granted the certificate of clinical competence or completed the equivalent educational requirements and work experience necessary for such a certificate). This number may be used to independently bill the MA program; no additional numbers or supervision is required.

(202) Treatment Unit. "Treatment unit" for the purpose of reimbursement, includes the time spent in direct pathology treatment services to the patient(s) and, if incurred, a maximum 15 minutes per patient (or per group) per treatment day spent in activities preparatory and subsequent to such treatment. In this latter case, incurred activities such as preparation of the patient(s) treatment and preparation of the treatment area are considered appropriate for the 15 minute reimbursement maximum. Activities not associated with treatment of the patient(s), such as end-of-day clean-up of the treatment area, are not considered appropriate for reimbursement.

Chapter 2: Application for Medical Assistance.

2.01 Application for medical assistance shall be made pursuant to sections 49.47(3) (relating to application criteria for medically indigent persons) and 49.19(1)(b) (relating to application for aid to families with dependent children), Wis. Stats., and these rules.

(1) Any person has the right to apply for medical assistance to the county agency in the county in which the person resides, regardless of whether or not it appears the person will be found eligible for participation in the MA program. The county agency shall promptly advise the applicant of the MA program's eligibility requirements.

(2) Each application form shall be signed under oath by the applicant or the applicant's responsible relative, legal guardian or authorized representative, or, where the applicant is incompetent or incapacitated, someone acting responsibly for the applicant, and such signing shall be in the presence of a county agency representative.

(3) As soon as possible, but no later than thirty days from the date the county agency receives a signed application completed to the best of the applicant's ability, the county agency shall conduct a personal interview with the applicant and shall determine the applicant's eligibility for medical assistance. If a delay in processing the application occurs because necessary information cannot be obtained within the time limits, the county agency shall notify the applicant in writing that there is a delay in processing the application, specify the reason for the delay, and inform the applicant of the right to appeal such delay.

(4) Adequate notice shall be sent to applicants and recipients to indicate that assistance has been authorized or that it has been denied or terminated. Such notice shall be communicated in language the individual can comprehend and understand. Under this requirement, adequate notice means a written notice that contains a statement of the action taken, and the reasons for and specific regulations supporting such action, and an explanation of the individual's right to request a hearing.

(5) Any person has the right to reapply for medical assistance. New applications shall be taken whenever a previous application has been denied or withdrawn, or when the county of residency has been changed.

(6) Eligibility Re-determinations.

(a) Where an individual has been determined to be eligible, eligibility shall be reconsidered or redetermined:

1. When information previously obtained by the county agency concerning anticipated changes in the individual's situation indicates the need for redetermination; or

2. Promptly, after a report is obtained which indicates changes in the individual's circumstances that may affect the individual's eligibility; or

3. At least once every 6 months in AFDC-related cases (under this requirement, the first required review of eligibility for an AFDC-related case is due during the sixth month from the county agency's initial decision date. For example, if the decision date for AFDC-related

case falls between June 1 and June 30, the first review shall be done during the month of November); or

4. At least once every 12 months from the date of certification, in SSI related cases.

(b) Once a person is determined to be permanently disabled, no further determination needs to be made of that disability, unless the agency becomes aware of information that would affect the determination of permanent disability.

(7) The county agency shall verify information contained in the application only with the applicant's written permission. If the applicant refuses to permit the county agency to verify any needed information, the application shall be automatically denied. The following information shall be verified:

(a) Social security numbers, as required under section 3.06(3) of this rule.

(b) Any information contained on the application for eligibility, which the county agency deems necessary under the circumstances of each particular case. The standards and methods for determining eligibility shall be consistent with the objectives of the medical assistance program, and shall respect the rights of individuals under the United States Constitution, the Social Security Act, the Civil Rights Act of 1964 and all other relevant provisions of federal and state laws.

(8) Persons inquiring about or applying for medical assistance shall be given the following information by the county agency in written form, and orally as appropriate: coverage; conditions of eligibility; scope of the program and related services available; and applicant and recipient rights and responsibilities. Bulletins or pamphlets specifically developed for this purpose shall be written in simple, understandable terms, publicized, and available in quantity at the county agency. In those instances where there is a substantial non-English-speaking or limited-English-speaking population, the county agency shall take steps as are necessary to communicate fully and effectively with such population in its primary language. The office of civil rights in the department shall provide technical assistance necessary to facilitate compliance with this requirement.

(9) Applications From Outside of Wisconsin. Generally, applications for Wisconsin medical assistance cannot be made by or for a person residing outside the state of Wisconsin, except that a Wisconsin resident who becomes ill or injured when absent from the state, or who is taken outside the state for medical treatment, may apply from the other state. In such instances, application may be made on a Wisconsin application form and witnessed by the public welfare agency in the other state, as a service to the Wisconsin county agency. Eligibility can then be determined by the Wisconsin county agency when the form is returned.

Chapter 3: Eligibility for Medical Assistance. Eligibility for medical assistance shall be determined pursuant to sections 49.46(1) (relating to eligibility standards for recipients of social security aids) and s.49.47(4) (relating to eligibility standards for medically indigent persons) Wis. Stats., Wis. Adm. Code Chapter PW-PA 20 and these rules.

3.01 Residence. Wisconsin residence is an eligibility requirement. No specific length of residence is required.

(1) Who is a Wisconsin resident. Except as provided in an interstate agreement, a resident of Wisconsin is any individual who:

(a) Is living in Wisconsin with the intention to remain here permanently or for an indefinite period;

(b) Is living in Wisconsin for purposes of employment;

(c) Meets the conditions in subsections 3.01 (2), (3), or (4).

(2) Rules applicable to individuals under age 21. (a) The state of residence of any individual under ager 21, except those whose medicaid eligibility is based on blindness or disability, shall be determined in accordance with the rules governing residence under the aid to families with dependent children program.

(b) The state of residence for any individual under age 21 whose medicaid eligibility is based on blindness or disability shall be the parent's state of residence, except:

1. If the parents reside in separate states, the state of residence of the parent who is applying for medicaid eligibility on behalf of the individual shall be the individual's state of residence; or

2. If the parents reside outside the United States, or cannot be located or are deceased, or if a legal guardian is appointed for the individual, the state in which the individual is physically present, not for a temporary purpose, shall be the individual's state of residence.

(3) Rules applicable to individuals over age 21 who are incapable of indicating intent. (a) An individual shall be considered incapable of indicating intent if:

1. The individual's I.Q. is 49 or less or the individual has a mental age of 7 or less;

2. The individual is judged legally incompetent; or

3. Medical documentation, or other documentation acceptable to the department, supports a finding that the individual is incapable of stating intent.

(b) For an individual who became incapable of indicating intent before age 21, the state of residence shall be determined in accordance with subsection 3.01(2)(b).

(c) For an individual who became incapable of indicating intent at or after age 21, the state of residence shall be the state in which the individual most recently established residence before becoming incapable of indicating intent.

(4) Placement by states in a Wisconsin institution. If another state arranges for an individual to be placed in a Wisconsin institution, the state making the placement shall be the individual's state of residence, irrespective of the individual's indicated intent or ability to indicate intent.

3.02 Income. The following standards shall be used to determine income levels for the purpose of eligibility determination:

(1) Determining Income from Gross Self-Employment Income. Adjusted gross income as determined for income tax purposes shall be used for determining self-employment income. For this purpose, the applicant shall submit to the county agency the applicant's most recent federal income tax return.

(a) To be considered a self-employed business, at least 50% of a family's income shall be derived from the self-employed business, and a form 1040 C shall be filed for income tax purposes. If no return has been filed, the applicant shall complete a form 1040 C to determine net earnings or loss, or to anticipate net earnings, (in the case of relatively new businesses) as required by the federal internal revenue service.

(b) Federal income tax returns for the previous three years shall be used to determine whether or not the self-employed business operation is profitable or becoming profitable. If it is not profitable or not becoming profitable, all assets related to it shall be treated as available assets when determining eligibility.

(2) Determining Income from Gross Farm Income. Adjusted gross income as determined for income tax purposes shall be used for determining farm income. The applicant shall submit to the county agency for this purpose the applicant's most recent federal income tax return.

(a) To be considered a "farm" operation, at least 50% of a family's income shall be derived from the farm operation, and a form 1040 F shall be filed for income tax purposes. If no return has been filed, the applicant shall complete a form 1040 F to determine net earnings or loss, or to anticipate net earnings, (in case of relatively new businesses) as required by the federal internal revenue service.

(b) Federal income tax returns for the previous three years shall be used to determine whether or not the farm operation is profitable or becoming profitable. If the farm operation is not profitable or not becoming profitable, all assets related to the farm operation shall be treated as available assets when determining eligibility. The homestead, which consists of the house and buildings together with the total acreage property upon which they are located, shall be an exempt asset if the applicant or recipient resides there or if the conditions specified under section 3.03(2) are met.

(3) Income used for Supporting Others.

(a) If there is a court order requiring a person in the medical assistance group (or fiscal test group) to pay support to a person who is not in the medical assistance group (or fiscal test group), this income is deemed unavailable to the medical assistance group.

(b) If a person in the medical assistance group has legal responsibility for a person residing in an institution where the cost of care cannot be covered by medical assistance, any income actually made available by the medical assistance group toward the institutional cost of care is deducted from the medical assistance group's income.

(4) Loans, grants, scholarships, stipends for education or training, and county training program allowances.

(a) Loans, grants, scholarships, and stipends for education or training which are not specifically exempted by federal regulation or statute shall be treated as follows: Tuition, fees, books, transportation necessary for education or training, and essential day care shall be subtracted from the amount of the loan, grant, scholarship or stipend, and the amount remaining shall be treated as unearned income available to the MA applicant or recipient. In situations where the loan, grant, scholarship or stipend is designated for a semester or longer the county agency shall compute a monthly amount.

(b) When the county agency itself pays a training or educational allowance, such allowance shall be disregarded in determining medical assistance eligibility.

(5) Tax deductions from Income. The amount deducted as tax deductions from earned income shall be based on the department's IM Income Table and on the size of the medical assistance group or fiscal test group. [NOTE: The Income Maintenance Income Table is the table used by county departments to calculate amounts to be deducted from earned income when determining eligibility for income maintenance and other programs (AFDC, Food Stamps, Medical Assistance).]

(6) Lump-Sum or "Windfall" Payments. All lump-sum or "windfall" payments, unless specifically exempted by federal law or regulation, shall be treated as assets instead of income. Some examples of lump-sum or windfall payments are: retroactive social security payments, income tax refunds, and retroactive unemployment benefits.

(7) In-Kind Benefits. Predictable in-kind benefits received regularly and in return for a service or product delivered shall be treated as income. The value of such in-kind income is determined by using the prevailing wage rate in the local community for the type of work performed for in-kind income.

(8) Inconsequential income. In determining need, inconsequential income shall be disregarded. Examples of inconsequential income include but are not limited to: interest from liquid assets (investments, savings, bonds, and funeral trusts); income tax refunds; dividends from life insurance policy; earnings as census enumerator; occasional cash gifts; Menominee Indian Bond interest; Homestead Relief payments; CAP emergency fuel granted under the auspices of the department of local affairs and development.

(9) Room and board income. The department shall consider the profit from room and board as income.

(10) Income From Rentals. If the owner does not report rental income to the Internal Revenue Service as self-employment income, net rental income shall be determined as follows:

(a) When the owner is not an occupant, net rental income is the rental income minus the mortgage payment(s) and verifiable operational costs.

(b) When the owner receives rental income from a duplex or multiple rental unit building, and the owner resides in one of the units, net rental income shall be computed according to the following method:

1. Compute total mortgage payment and total operation costs common to the entire operation;

2. Compute total owner expenses as follows: Multiply number of rental units by total of 1. above. Then divide that result by the total number of units to get the "proportionate share". Add the "proportionate share" to any operation costs paid by the owner that are unique to any rental unit. The result equals the total owner expense.

3. Subtract total owner expense from rent payments to get rental income.

(11) Travel expenses. In addition to employment expenses allowed by state statute through adoption of federal regulation(s), work-related travel expenses shall be deducted in determining net income. Such expenses shall be based on the number of miles to and from employment. Additional miles necessary for work-related child care may also be deducted up to a maximum of 10 miles per day. The total mileage allowed shall not exceed 50 miles per day unless there are extenuating circumstances, as determined by the county agency.

(12) Striker Benefits as Income. If a striker receives benefits from the striker's union while on strike, the benefits shall be considered earned income when determining medical assistance eligibility if the striker has to engage in some strike-related activity such as walking in a picket line. If the striker is not required to engage in some strike-related activity, then the benefits shall be considered as unearned income.

(13) Incarcerated Persons: Income from Work-Release Employment. Prisoners employed under the section 56.065 Wis. Stats. work release plan shall be considered gainfully employed, and wages earned and quarters worked under section 56.065 shall be used when determining eligibility for MA due to the unemployment of a parent.

(14) Subsidized adoption payments. When determining eligibility for medical assistance, payments for subsidized adoptions shall be disregarded.

(15) Adjustment of The SSI-Related Categorically Needy Income Limit Due to Living Arrangement. The SSI-related categorically needy monthly income limit for an applicant who is living with another person (or for an applicant couple) shall be adjusted according to the following procedure:

(a) Subtract the federal allowable shelter maximum (one-third of the Federal Standard Payment Amount) from the sum of the Social Security Administration's Federal Standard Payment Amount and the State Supplemental Payment Amount.

(b) To the result in number (a) above, add the amount of actual shelter costs up to a maximum of one-third the Federal Standard Payment Amount.

(16) Spend-down Requirements For All Persons Who Are Not Residing in Institutions.

(a) Medical expenses to be considered for spend-down purposes include all costs for medical services and goods that could be covered by medical assistance, plus health insurance premiums. Only those medical expenses which are incurred during the spend-down period can be used to meet the spend-down requirement.

(b) No medical costs that are incurred and are to be paid or have been paid by a person other than the applicant(s) or members of the fiscal test group shall be counted for the spend-down. No expenses for which a third party is liable (such as medicare, private health insurance, or court-ordered medical support obligation) shall be used to meet the spend-down requirement.

(c) The spend-down period shall begin on the first day of the month in which all eligibility factors (except income) were met, but no earlier than the first of the month three months before the month of application. However, at the recipient's option, it can begin on the first of any of the months three months prior to the month of application if all eligibility factors (except income) were met in that month. A recipient's decision to choose an optional beginning date shall be recorded in the county agency's case record. For persons who were receiving medical assistance and are now reapplying, the spend-down period cannot cover the time during which they were receiving medical assistance.

(d) The spend-down shall run for six months from the beginning of the spend-down period.

(e) Changes. If the amount of the monthly excess income changes before the spend-down is achieved, an adjustment shall be made. When the size of the medical assistance group changes, the monthly income limit shall be adjusted appropriately to the size of the new group, and the spend-down amount shall be adjusted accordingly. If any change is reported that may affect eligibility, the eligibility of the entire medical assistance group may be redetermined and, if it turns out to be a spend-down situation, a new spend-down period shall be established.

1. The medical assistance group is eligible as of the date on which the incurred medical expenses reach the spend-down amount. In some situations the applicant will still be responsible for some bill(s) or parts of bills incurred on that day.

2. Once the spend-down has been met, the MA group shall remain eligible for the balance of the six-month spend-down period, unless it is determined that assets have increased enough to make the MA group ineligible, or that a change in circumstances has caused someone in the MA group to become ineligible for non-financial reasons.

a. If the entire group is determined ineligible, then the MA certification shall be discontinued, with the proper notice.

b. If only part of the MA group is determined ineligible for non-financial reasons, only the ineligible person's MA certification shall be discontinued, with the proper notice. The other person or persons in the MA group continue eligible until the end of the six-month period.

c. If the size of the MA group increases (for example, a child is born into the family or child under 18 comes home from a specialized school) that child is eligible for benefits during the spend-down period.

3.03 Assets.

(1) Money from the Sale of Property. Money from the sale of property shall be treated as an asset. An exception to this principle exists when property used as a home is sold and the proceeds are placed in escrow in contemplation of purchase of another home. Proceeds in escrow shall be disregarded as assets for a maximum of one year.

(2) The Homestead Property of an Institutionalized Medical Assistance Applicant or Recipient. The homestead property of an institutionalized person is not counted as an asset when any one of the following conditions is satisfied:

(a) The institutionalized person's homestead property is currently occupied by the institutionalized person's child who is under age 18, or who is 18 years or older and who is developmentally disabled, or who is a spouse.

(b) The institutionalized person intends to return to the home and the anticipated absence from the home, as verified by a physician, is less than 12 months.

(c) The anticipated absence is for more than 12 months but there is a realistic expectation, as verified by a physician, that the person will be likely to return to the homestead. That expectation must include a determination of the availability of home health care services which would enable the recipient to return home.

(d) If neither (a), (b), nor (c) above is met, the property is no longer the principal residence and becomes non-home property.

(3) Non-Home Property of Applicant or Recipient.

(a) If the value of the non-home property, together with all assets, does not exceed the asset limit, an otherwise eligible person may receive MA and retain the property.

(b) If the value of non-home real property together with the value of the other assets exceeds the asset limit, it need not be counted as an asset if the non-home property produces a reasonable amount of net income. What is "reasonable" shall depend on the county agency's interpretation of whether the net income is a fair return considering the value and marketability of the non-home property.

(c) If the total value of non-home real property and non-exempt assets exceeds the asset limit, the person who owns the non-home real property shall list the property for sale with a realtor at a price at which realtors estimate it can be sold. Failure to so list the property shall cause the property to be considered a non-exempt asset. The property, while listed, is deemed inaccessible to the recipient and is not counted as an asset. When the property is sold, the proceeds shall be counted as an asset.

(4) Joint Accounts. When determining medical assistance eligibility, a proportionate monetary share shall be deemed available to each person whose name is on a banking, savings or checking account.

(5) Types of property ownership.

(a) Where there is joint ownership of property, an equal share of the value of the property is considered available to each owner for the purpose of determining the assets of the applicant or recipient.

(b) If the applicant or recipient is a joint owner with a person who refuses to sell the property and who is not a legally responsible relative of the applicant or recipient, the property is not considered available to the applicant or recipient and cannot be counted as an asset.

(6) Life Estate. A recipient or the spouse of a recipient may own a life estate in a home without affecting eligibility for medical assistance. If the recipient leaves the property and it is sold, any proceeds received shall be considered liquid assets and the limitations of this rule shall apply.

(7) Limitation on Ownership of Motor Vehicles. For purposes of eligibility, motor vehicles are vehicles, including snowmobiles, which meet all of the following conditions: they are driven or drawn on the road; state registered; and owned by a member of the MA group. The following limitations apply to vehicles:

(a) One vehicle does not affect the eligibility of the MA group.

(b) If the MA group has two vehicles and both vehicles are needed to maintain employment or to obtain medical care, or both, the vehicles do not affect the eligibility of the MA group.

(c) If the MA group has two vehicles, and if both are not needed to maintain employment or to obtain medical care, or both, the MA group is not eligible.

(d) Any MA group with three or more vehicles is not eligible.

(e) For a vehicle which does not meet the definition above, the equity value of that vehicle is counted as an asset.

(8) Assets and the institutionalized applicant or recipient of medical assistance. In some cases income which has been protected for personal needs of institutionalized persons may accumulate to the point where these persons may lose eligibility.

(a) In order to maintain uninterrupted eligibility, a recipient who is close to exceeding the asset limitation may voluntarily apply accumulated assets as a refund. If the recipient elects this option, the county agency shall project the amount of asset accumulation expected over an annual time period to arrive at an amount for the recipient to refund. When refunds equal MA benefits already received, no additional refunds shall be made until additional MA benefits have been received.

(b) If the recipient does not elect the refund option, eligibility shall cease at the time the asset limitation is exceeded, and the person shall remain ineligible until the assets are again below the limit. At that point the person may reapply for MA.

3.04 Relative Responsibility

(1) Children Under Age 18 in Institutions. The eligibility of children residing in institutions approved for medical assistance payments shall be determined by the same method used to determine the eligibility of adults residing in nursing homes except that only the child's income and assets shall be considered in this determination. The income and assets of the child's parent(s) shall be evaluated by the department to determine whether, pursuant to section 46.10(14) Wis. Stats., such parent(s) is subject to collections. If the child is residing in an institution not specified in section 46.10(14), but the institution is approved to receive medical assistance payments, the parental liability shall be the same as that provided in section 46.10(14) Wis. Stats. and collected in the same manner.

(2) Eligibility Determinations Where One Spouse is at Least 65 or Blind or Disabled and the Other Spouse Does Not Meet Any of These Characteristics. When spouses reside together and one of them is at least age 65 or blind or disabled (i.e., is "SSI-related") and the other spouse does not meet any of those characteristics, the income and assets of both spouses shall be measured against the eligibility levels for a family of two, to determine the eligibility of the SSI-related individual. In such cases, the husband and wife shall be referred to as a fiscal test group.

(3) Eligibility Determinations When Legal Parents are not Eligible, but Their Children Residing with Them May be Eligible. If a child's legal parents do not satisfy nonfinancial eligibility requirements but the child does, the income and assets of the legally-responsible parents together with the income and assets of the child shall be measured against the eligibility levels for an equivalent number of people to determine the child's eligibility. In such cases, the legal parents and the children will be referred to as a fiscal test group. Exception: When the family income or assets exceed AFDC-related levels and the child is SSI-related due to blindness or disability, the child is evaluated for eligibility against the eligibility levels for one person after parental income and assets are deemed to the child. NOTE: For deeming rule see subsection 3.04(5) below.

(4) When Caretaker Relatives are Categorically or Medically Needy and the Children They are Caring for Are Not Financially Eligible. When a caretaker relative, (i.e., any relative other than a legally responsible parent) cares for a child under age 18 and the child does not satisfy the financial eligibility requirements of the medical assistance program, the eligibility of the caretaker relative shall be determined by measuring that relative's income and assets against the eligibility levels for a family of one or, in the case of spouses, against the levels for a family of two.

(5) Deeming of Parental Income to Blind or Disabled Child not Receiving SSI When Parents and Child are Residing Together.

(a) In determining the eligibility of only the blind or disabled child, the basic SSI-related procedures (procedures relating to three classifications of income, unearned, earned and a mixture of unearned and earned), shall be used. Before applying those procedures, up to $88.90 of parental income shall be deemed available to each ineligible child in the home as the child's income.

(b) In cases where there are two parents in the home, parental assets in excess of $2,250 are deemed to the blind or disabled child. Where there is one parent, parental assets in excess of $1,500 are deemed to the child. The blind or disabled child is then treated as a family of one for the purpose of determining eligibility.

(6) When a Child Resides with a Qualifying Non-Legally Responsible Caretaker Relative. When a child resides with qualifying caretaker relatives (i.e. not legally responsible relatives) and there are no legally responsible parents in the same residence, the child is treated as a family of one for eligibility determination.

(7) What Constitutes "Caring For" a Child Under Age 18. For the child to be under the care of a person, the person must exercise the primary responsibility for the care and control of the child including making plans for the child, and must maintain a home in which the person and the child live. Furthermore, for MA purposes, a home is considered to exist even though circumstances may require temporary absence from the home of either the child or the caretaker. Absences may include attendance at public educational institutions, specialized schools, hospitalization, employment, visits and similar situations of a temporary nature.

(a) The caretaker's legal spouse, if residing in the home, is included in the medical assistance group (or, if appropriate, the fiscal test group). Temporary absence from the home of the spouse due to employment, short-term hospitalization, or visits does not interrupt the residence of the spouse.

(b) The first generation of 3-generation family configurations is considered to be "caring for" both the 2nd and 3rd generation children.

(c) For purposes of this rule a three-generation case is defined as one having all of the following characteristics: All three generations are residing in the home and the second generation has in it at least one never-married parent under age 18.

(8) A "Qualifying" Relative for the Purpose of Determining Relatedness to the AFDC Program. Qualifying relative determinations shall be made pursuant to Wis. Adm. Code PW-PA 20.06.

(9) Eligibility of Second-Generation Minor Parent In a Three-Generation Home. In homes where all three generations are residing and there is a second-generation minor parent who has at one time been married, the eligibility of such minor parent and child of the minor parent shall be determined separately from the rest of the family.

(10) Determinations for persons 18 years of age or older. Persons 18 years of age or older who are listed as children on an application for medical assistance shall have their eligibility (and the eligibility of their spouse or child, if any) determined separately from the rest of the persons listed on the application.

(11) Excluding A Child From The Medical Assistance Eligibility Determination. A child's income and assets may be excluded from the MA determination if one of the following conditions is met:

1. There is a court order designating funds to be used exclusively for the maintenance needs of the child; or
2. Social security benefits are designated for the needs of the child and not any other members of the family, regardless of who receives and cashes the check; or
3. Court-ordered child support is designated for the needs of the child alone; or
4. There is other income or assets restricted by law for only the child's needs.

(12) Excluding An Adult. An adult may be excluded from medical assistance benefits if the adult so wishes, but if the adult is legally responsible for anyone else applying, the adult's income and assets will be considered in the eligibility determination.

(13) Applications Involving No Minor Children When One Spouse is Under Age 21 or 3 Months Pregnant and One is SSI-related (Blind, Disabled or At least Age 65).

(a) A husband and wife with no minor children, where one spouse is under age 21 or pregnant and one is blind or disabled or at least age 65, shall have their financial eligibility determined according to SSI-related medical assistance procedures.

(b) Pursuant to s.49.19(4)(g), Stats., aid shall be granted to a pregnant woman who is otherwise eligible for aid during the period extending from the time that pregnancy is confirmed. The pregnant woman shall count as one person in determining family size for grant determination.

(14) Families in Which Some are Receiving AFDC and Some Are Applying for Medical Assistance Only.

1. If a person in the medical assistance-only group is legally responsible for, or the legal responsibility of, someone in the home who has been determined eligible for AFDC, the income of the MA-Only group (or, if appropriate, of the fiscal test group) will be measured against its share of the total family income limit. However, the assets of the entire family will be measured against the medical assistance asset limits.

2. For purposes of this paragraph, the family consists of parents and all children, including AFDC recipients in the household for whom either spouse is legally responsible, except that the family does not include SSI recipients, children who do not have a legally responsible parent in the home, or children excluded from medical assistance according to section 3.04(11).

(15) Allocation of Institutionalized Person's Income to Dependent Outside the Institution.

(a) No allocation shall be made from an institutionalized applicant or recipient to a spouse who is eligible for SSI but who refuses to obtain SSI. Likewise, no allocation shall be made to a spouse or minor children under the spouse's care, if the spouse or any of the children are receiving AFDC or SSI.

(b) If the spouse is caring for a minor child for whom either the institutionalized person or the spouse is legally responsible, the AFDC assistance standard, plus medical expenses that would be allowed under the spend-down provision, shall be used to determine the need of the spouse and children. If their total net income is less than their need, income of the institutionalized person may be allocated in an amount sufficient to bring the spouse's and children's income up to their monthly need. The total net income is equal to unearned income plus net earned income. The spouse's and children's net earned income shall equal their gross earned income minus 18% for work-related expenses plus a deduction for work-related child care.

(c) If the spouse is not caring for a minor child, the SSI payment level for one person plus the Wisconsin supplement shall be used to determine the spouse's monthly need. The spouse's earned income shall be netted by subtracting 18% for work-related expenses, and $20 from earned or unearned income or both. If the spouse's income is less than the spouse's monthly need, income of the institutionalized person may be allocated in an amount sufficient to bring the spouse's income up to monthly need.

(d) The following amounts shall be excluded when computing the income of the spouse or children under the provisions of this rule:

1. All earnings of a child less than 14 years old.

2. All earnings of a child less than 18 years old who is a full time student.

3. All earnings of a child less than 18 years old, who attends school part time and is not employed full time (greater than 30 hours a week).

4. Any portion of any grant, scholarship, or fellowship used to pay the costs of tuition, fees, books, transportation to and from classes (e.g., not used for basic maintenance).

5. Amounts received for foster care or subsidized adoption.

6. Bonus value of food stamps and the value of foods donated by the federal department of agriculture.

7. Home produce grown for personal consumption.

8. Income actually set aside as an educational plan for a child who is a junior or senior in high school.

(e) If the spouse of an institutionalized applicant or recipient has income greater than the spouse's monthly need (or spouse's and children's monthly need), and if the county agency questions whether the spouse ought to make a contribution (or a greater contribution) to the cost of institutional care, the criteria in section (16) below should be used to determine whether court action under section 52.01 Wis. Stats. should be pursued. Section (16) also applies if the county agency questions whether or not the assets of the spouse are sufficient to warrant referral for a support action.

(16) Criteria to determine whether the spouse of an institutionalized applicant or recipient should be referred for support action under Section 52.01 Wis. Stats.

(a) In no case shall support from the spouse of an institutionalized applicant or recipient be pursued when the spouse's assets, not counting homestead property, and an automobile, are less than $1,500, and when the spouse's income is less than monthly need as specified in subsection 3.04(15).

(b) In any other situation, the county agency shall decide if a spouse is to be referred for support action. When deciding whether to refer for support action, the county agency shall consider the spouse's basic and essential needs and present and future expenses which invariably cannot be anticipated by rule.

(17) When both spouses are institutionalized and there is an application for medical assistance. When both spouses are institutionalized, the following shall apply:

(a) If one spouse applies for medical assistance, the total income of both spouses may be combined to see if their combined total income is less than total need, providing that the spouse not applying:

1. has income obviously exceeding that spouse's needs; and

2. is willing to make that income available.

(b) If the combined income of both spouses is less than total need, separate determinations shall be made to see which spouse has the excess income. The excess may be allocated to the other spouse. Either one or both of the spouses could be eligible depending on income allocation.

(c) If the combined income of both spouses exceeds total need, separate determinations shall be made. Only the actual amount of income made available from one spouse to the other shall be used in determining the eligibility of the other spouse.

(d) If a spouse refuses to make a reasonable amount available, the county agency shall review the case to determine whether legal action for support should be taken pursuant to Section 52.01 Wis. Stats. and subsection 3.04(16) above.

(18) Method of Determining Eligibility for Institutionalized Person When Spouse Resides Outside of Institution. Eligibility of all institutionalized applicants or recipients shall be determined individually. Only income and assets actually contributed by a relative or spouse or ordered by a court shall be considered as available. Nothing in this subsection shall limit or prevent a county agency from seeking a support action under section 52.01 Wis. Stats.

(19) Determining Eligibility for a Stepchild Only or Third-Generation Child Only.

(a) In stepparent families or three-generation families, the children of each legal parent form an MA group for purposes of determining eligibility. Each group of children shall be tested against a medical assistance income test limit. That limit is a proportionate share of the MA standard for the appropriate family size.

(b) For purposes of this rule, the family shall include parents and all children in the household for whom either spouse is legally responsible, including the 3rd generation. Family shall not include SSI recipients or NLRR children.

(c) The legal parent's net income and assets (except an automobile and the homestead) are considered available to the parent's children. If the stepchild or third-generation child is ineligible for medical assistance because of excess income, the applicant may elect either a family spend-down or a children-only spend-down.

(20) The county agency may seek proof of actual contribution by relatives or other persons by review of the income tax returns of the applicant or other person suspected of contributing to the child's support. Such proof of support or contribution may also be obtained by direct inquiry of the adult family members residing in the home.

3.05 Institutional Status--Monthly Need Computation for Institutionalized Persons. The monthly need of institutionalized applicants or recipients shall be determined by including the following:

(1) The cost of institutional care.
(2) The standard personal allowance.
(3) The cost of health insurance (if the person is already carrying such insurance at the time of application).
(4) Other medical expenses allowed under the spend-down provisions.
(5) Any court-ordered support obligation, and any other support obligation recognized in sections 3.04(5), (6) and (7).
(6) If employed, 18% of gross income to cover the expenses of producing the income.

3.06 Other factors.

(1) Children Under Age 18 in Licensed Foster or Group Homes. A foster child under age 18 residing in a licensed foster home or group home satisfies the non-financial eligibility requirements of the medical assistance program. Only the child's own income and assets shall be used when determining the child's financial eligibility. The child's income and assets shall be measured against a standard for one.

(2) Application On Behalf of Deceased Persons. An application on behalf of a deceased person may be made by an interested person who attests to the correctness of the eligibility information submitted on behalf of the deceased.

(3) Social Security Number. If a social security number (SSN) is required as a condition of eligibility for public assistance or other categorical aid programs leading to the medical assistance entitlement, the county agency shall obtain a SSN from each individual (including children) for whom medical assistance is requested. An applicant's failure to provide immediately the SSN shall not be reason to withhold processing of the original application or to deny an application for original eligibility, if such eligibility otherwise exists. If the applicant does not have a SSN, the county agency shall assist the person in filling out such forms as may be required by the social security administration. The county agency shall terminate eligibility in the program if, by the time of the first review of eligibility determination, the applicant has not provided the SSN, or has not applied for and has not given the county agency permission to apply for the SSN.

(4) When a Striker rejects a Wisconsin Job Service Referral. A striking applicant or recipient shall not be forced to surrender the rights and benefits the striker has accumulated in the striker's present job. A rejection of a job referral by Wisconsin Job Service, when acceptance would have required the striker to quit or resign the job from which the striker is on strike, shall not cause ineligibility for medical assistance.

(5) Special Eligibility Procedures for Seasonally Employed Migrants. Nonfinancial and financial criteria are the same for migrant and non-migrant cases except as noted in this subsection.

(a) In determining eligibility for MA-only medically needy, annual income shall be taken into account.

(b) Because of the unusual circumstances of the average migrant a special transportation allowance of $400.00 shall be deducted from the annual income of the family group in determining eligibility for MA-only medically needy.

(c) The method of computing annual income by multiplying current monthly income by twelve is not appropriate because of the highly variable nature of a migrant's employment and the frequent periods of unemployment. If no basis for estimating income can be established, the current monthly Wisconsin income shall be multiplied by the number of months in the annual period it is believed the family will be employed in Wisconsin.

(d) If the applicant is unable to produce adequate information on income, the employer may be contacted for such information. If the information obtained from the employer differs from that given by the applicant, the applicant shall be provided an opportunity to concur with or refute that information.

(e) Children of migrant laborers are considered Wisconsin residents by virtue of their parent's employment in this state or by virtue of their parents being in this state to secure such employment.

(f) The eligibility certification period shall be the period of time it is anticipated the family will remain in Wisconsin, not to exceed the maximum periods of eligibility determination allowed under state statute. If the family remains longer than expected, eligibility shall be reviewed and a new certification period will be initiated, if indicated.

(g) MA cards issued to migrants shall be marked "Not valid outside state of Wisconsin".

3.07 Singular enrollment. A person may not be certified eligible in more than one medical assistance case.

3.08 Termination of Medical Assistance.

(1) Except in the case of death of the recipient, when eligibility is terminated before the end of a month, the medical assistance certification and medical assistance card shall be valid for that entire month.

(2) The county agency shall give the applicant or recipient timely advance notice of its intention to terminate medical assistance. This notice shall be in writing and mailed to the recipient at least 10 calendar days before the effective date of such proposed action and shall clearly state what action the county agency intends to take, the specific regulation supporting such an action, an explanation of the right to appeal such proposed action and the circumstances under which medical assistance is continued if a hearing is requested.

3.09 Expiration of Eligibility.

(1) The county agency shall give the recipient timely advance notice of the eligibility redetermination date. This notice shall be in writing and mailed to the recipient at least 15 calendar days (and no more than 30 calendar days) before the redetermination date. Exception: The requirement for timely advance notice of eligibility redetermination does not apply to spend-down cases in which the period of certification is less than 60 days.

(2) If the recipient does not contact the county agency, the county agency shall make a follow-up contact. A home visit shall be made whenever the situation warrants it.

3.10 Providing correct and truthful information. Applicants and recipients are responsible for providing to the county agency, the department or its delegated agent, full, correct and truthful information necessary for eligibility determination or redetermination. Necessary information includes but is not limited to:

(1) Information concerning eligibility for or coverage under medicare, health or accident insurance plans, governmental or private benefit plans including workmen's compensation, or any other real or potential third party coverage.

(2) Changes in income, resources or other circumstances which may affect eligibility status. Such changes must be reported to the county agency within 10 days of the change.

3.11 Refusal to Provide Information. An application shall be denied if the applicant refuses to provide information necessary to determine eligibility. In stepparent families where the stepparent refuses to give information necessary to determine the stepparent's eligibility, the stepparent's spouse and any child for whom the stepparrent has legal responsibility are not eligible for medical assistance. Likewise, in a 3-generation family, if a member of the first generation refuses to divulge eligibility information, the member's spouse and any child for whom the member has legal responsibility are not eligible.

Chapter 4: Recipients' Rights and Duties

4.01 Recipient Rights.

(1) Civil Rights. No applicant for or recipient of medical assistance shall be excluded from participation in medical assistance, or denied medical assistance benefits, or otherwise subjected to discrimination under the medical assistance program for reasons which violate Title VI of the Civil Rights Act.

(2) Rights under Section 504 of the Rehabilitation Act of 1973. No otherwise qualified handicapped individual shall, solely by reason of handicap, be excluded from the participation in, be denied benefits or be subjected to discrimination under any program or activity receiving federal financial assistance.

(3) Confidentiality of Medical Information. Pursuant to sec. 905.04(4)(f), Wis. Stats., no privilege shall exist under the medical assistance program regarding communications or disclosures of information requested by appropriate federal or state agencies, or their authorized agents, concerning the extent or kind of services provided recipients under the program. The disclosure by a provider of such communications or medical records, made in good faith under the requirements of this program, shall not create any civil liability or provide any basis for criminal actions of unprofessional conduct.

(4) Free choice of Provider.

(a) The department shall maintain a current list of certified providers and shall assist eligible persons in securing appropriate care.

(b) A recipient may request service from any certified provider, subject to sec. 4.02(1) and 4.03.

(c) A recipient who believes the recipient's freedom of choice of provider has been denied or impaired may request a fair hearing pursuant to PW-PA 20.18 Wis. Adm. Code.

(d) Free choice of a skilled nursing home shall be limited so as to provide only care which is necessary to meet the medical and nursing needs of the recipient.

(e) A recipient's participation in medical assistance does not preclude the recipient's right to seek and pay for services not covered by the program.

(5) Appeals.

(a) Fair Hearing. Applicants and recipients have the right to a fair hearing in accordance with established procedures and consistent with applicable state law and federal regulations when aggrieved by action or inaction of the county agency or the department. (NOTE: This subsection does not apply to actions taken by the PSRO.)

1. Every applicant or recipient shall be informed in writing at the time of application and at the time of any action affecting the recipient's claim, of the right to a fair hearing, of the manner by which a fair hearing may be obtained, and of the right to be represented or to represent self at such a fair hearing.

2. The applicant or recipient shall be provided reasonable time, not to exceed 90 days, in which to appeal an agency action. The department shall take prompt, definitive, and final administrative action within 90 days of the date of the request for a hearing.

3. The procedure for the fair hearing shall be found in PW-PA 20.18, Wis. Adm. Code.

(b) The purpose of the fair hearing is to allow a recipient to appeal department actions which result in the denial, discontinuation, termination, suspension, or reduction of the recipient's medical assistance. The fair hearing process is not intended for recipients who wish to lodge complaints against providers concerning quality of services received, nor is it intended for recipients who wish to institute legal proceedings against providers. Recipients' complaints about quality of care should be lodged with the appropriate channels established for such purposes, such as provider peer review organizations, consumer advocacy organizations, regulatory agencies or the courts.

(c) Concurrent review. After the department has received a recipient's request for a fair hearing and has set the date for the hearing, the department shall review and investigate the facts surrounding the recipient's request for fair hearing in an attempt to resolve the problem informally.

1. If, before the hearing date, an informal resolution is proposed and is acceptable to the recipient, the recipient may withdraw the request for fair hearing.

2. If, before the fair hearing date, the concurrent review results in an informal resolution not acceptable to the recipient, the fair hearing shall proceed as scheduled.

3. If the concurrent review has not resolved the recipient's complaint satisfactorily by the fair hearing date but an informal resolution acceptable to the recipient appears imminent to all parties, the hearing may be dropped without prejudice and resumed at a later date. However, if the informal resolution proposed by the department is not acceptable to the recipient, the recipient may proceed with a fair hearing, and a new hearing date shall be set promptly.

4. If before the fair hearing date, the concurrent review has not been initiated, the fair hearing shall proceed as scheduled.

(6) Out-of-State Coverage. Medical assistance shall be furnished under the following circumstances to recipients who are Wisconsin residents but who are absent from the state:

(a) When an emergency arises from accident or illness; or

(b) When the health of the recipient would be endangered if the care and services were postponed until the recipient returned to Wisconsin; or

(c) When the recipient's health would be endangered if the recipient undertook travel to return to Wisconsin; or

(d) When prior authorization has been granted for provision of a non-emergency service, except that prior authorization is not required for non-emergency services provided to Wisconsin recipients by border status providers.

(7) Free Choice of Family Planning Method. Recipients eligible for family planning services and supplies shall have freedom of choice of method so that a recipient may choose in accordance with the dictates of conscience and shall neither be coerced nor pressured into choosing any particular method of family planning.

(8) Continuation of Benefits to Community Care Organization Clients. Recipients eligible for or receiving services from any of the local Community Care Organization project sites (La Crosse County, Barron County, Milwaukee County), as of April 1976, shall be allowed to continue to receive any of the CCO services, and such services shall be reimbursed under the program.

(9) Right To Information Concerning Program Policy.

(a) Program Manuals. Recipients may examine program manuals and policy issuances which affect the public, including rules and regulations governing eligibility, need and amount of assistance, recipients' rights and responsibilities and services offered under medical assistance, at the department's state, county or regional offices on regular work days during regular office hours.

(b) Notice of the department's intention to discontinue, terminate, suspend, or reduce assistance.

1. Except when changes in the law require automatic grant adjustments for classes of recipients, in every instance in which the department intends to discontinue, terminate, suspend or reduce a recipient's medical assistance, or coverage of services to a general class of recipients, the department shall send a written notice to the recipient's last known address no later than 10 days before the date upon which the action would become effective, informing the recipient of the following:

a. the nature of the intended action;

b. the reasons for the intended action;

c. the specific regulations supporting such action;

d. an explanation of the recipient's right to request a fair hearing; and,

e. the circumstances under which assistance is continued if a hearing is requested.

2. The department shall mail such individual written notice to be received no later than the date of intended action under any of the following circumstances:

a. The department receives a clear written statement signed by a recipient that states the recipient no longer wishes assistance, or that gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands that this must be the consequence of supplying such information;

b. The department has factual information confirming the death of a recipient;

c. The recipient has been admitted or committed to an institution and further payments to the recipient do not qualify for federal financial participation under the state plan;

d. The recipient has been placed in skilled nursing care, intermediate care or long-term hospitalization;

e. The recipient's whereabouts are unknown and departmental mail directed to the recipient has been returned by the post office indicating no known forwarding address;

f. A recipient has been accepted for assistance in a new jurisdiction and that fact has been established by the jurisdiction previously providing assistance;

g. An AFDC child is removed from the home as a result of judicial determination, or voluntarily placed in foster care by a legal guardian;

h. A change in level of medical care is prescribed by the recipient's physician.

(10) Prompt Access to Assistance. Applicants have the right to prompt decisions on their applications. Eligibility decisions shall be made within thirty (30) days of the date the application was signed. For individuals applying as disabled, where medical examination reports, determination of disability, and other additional medical and administrative information is necessary for the decision, eligibility decisions shall be made not more than sixty (60) days after the date the application was signed. Care shall be furnished promptly to eligible recipients without any delay attributable to the department's administrative process and shall be continued regularly until the individuals are found ineligible.

(11) Right to Request Return of Payments for Covered Services made by a Recipient during Period of Retroactive Eligibility. If a person has paid all or part of the cost of health care services received and then the person becomes a recipient of MA benefits and the recipient's eligibility is made retroactive to allow the MA program to pay for those covered services for which the recipient has previously made payment, then such recipient has the right to notify the provider of the retroactive eligibility period. At such time the provider shall submit claims to medical assistance for covered services provided to the recipient during the retroactive period. Upon the provider's receipt of MA payment, the provider shall be required to reimburse the lesser of amount received from MA or the amount paid by recipient or other person.

(12) Freedom from Liability for Covered Services.

(a) Recipients can not be held liable by providers for covered services and items furnished by providers under the medical assistance program so long as the recipients are eligible for medical assistance benefits and meet all other program requirements.

(b) Recipients can not be charged by providers for the amount of the difference between charge for service and the program's payment amount, except in the case of recipients wishing to be in a private room in a nursing home or hospital, in which case the provisions of Sec. 7.09(3)(i) shall be met.

4.02 Recipient Duties.

(1) A recipient shall not seek the same or similar services from more than one provider, except as provided in sec. 4.04.

(2) Except in bona fide emergencies that preclude prior identification, the recipient shall, before receiving services, inform the provider that the recipient is receiving benefits under the medical assistance program, and present a valid MA identification card.

(3) Recipients shall review the monthly explanation of benefits notice sent to them by the department and shall report to the department any payments made for services not actually provided. The explanation of benefits notice shall not specify confidential services and shall not be sent if the only service furnished was confidential.

(4) Recipients are responsible for giving providers full, correct and truthful information requested by providers and necessary for the submission of correct and complete claims for medical assistance reimbursement. Such information includes but is not limited to:

(a) Information concerning the recipient's eligibility status, accurate name, address, and MA identification number;

(b) Information concerning the recipient's use of the medical assistance card;

(c) Information concerning the recipient's use of medical assistance benefits;

(d) Information concerning recipient's coverage under other insurance programs.

(5) Recipients who abuse or misuse the MA card or benefits in any manner may be subject to limitation of benefits or decertification from the program.

(6) Recipients shall inform the county agency within 10 days of any change in address, eligibility, income, need, or living arrangements.

(7) Duties of Responsible Relatives. Within the limitations provided by chapter 52, Wis. Stats. and this rule, the spouse of an applicant of any age or the parent of an applicant under 18 years of age shall be charged with the cost of medical services before medical assistance payments shall be made. However, eligibility shall not be withheld, delayed or denied because a responsible relative fails or refuses to accept financial responsibility. When the county agency determines that a responsible relative is able to contribute without undue hardship to self or immediate family but refuses to contribute, the county agency shall exhaust all available administrative procedures to obtain that relative's contribution. If the responsible relative fails to contribute support after the county agency notifies the relative of the obligation to do so, the county agency shall notify the district attorney in an effort to commence legal action against that relative.

4.03 Primary Provider.

(1) If the department discovers program abuse, including abuse under sec. 4.02(1), the department may require the recipient to designate, in any or all categories of health care provider, a primary health care provider of the recipient's choice.

(2) The department shall allow a recipient to choose a primary provider from the department's current list of certified providers. The recipient's choice shall become effective only with the concurrence of the designated primary provider. The name of the primary provider shall be endorsed on the recipient's medical assistance identification card.

(3) A primary provider may, within the scope of the provider's practice, make referrals to other providers of medical services for which reimbursement will be made if the referral can be documented as medically necessary and the services are covered by the medical assistance program. Such documentation shall be made by the primary provider in the recipient's medical record.

(4) The department may allow the designation of an alternate primary provider. When approval is given by the department to select an alternate primary provider, the recipient may designate an alternate primary provider in the same manner a primary provider is designated.

(5) The limitations imposed in this section do not apply in the case of an emergency.

4.04 Second Opinion Program. Pursuant to Ch. 29, Laws of 1977, the department may establish a second opinion program for elective surgical procedures, to promote the quality of care for recipients. The purpose of the program is to provide a recipient additional medical information about the medical appropriateness of the proposed procedure, before the recipient makes a decision to undergo a surgical procedure, and to allow reimbursement of the costs related to providing the second opinion. Second opinions apply only to non-emergency procedures.

Chapter 5: Provider Certification

5.00 Statement of Intent and General Conditions.

This chapter sets forth the terms and conditions under which persons may be certified and participate as providers in the medical assistance program. (The former Wis. Adm. Code chapter PW-MA 24 is repealed and recreated in this chapter and in chapter 6 for purposes of certification, decertification, suspension and general conduct of providers).

5.01 Certification. A person may be certified as a provider of specified services for a reasonable period of time as specified by the department if:

(1) The person affirms in writing that, with respect to each service for which certification is sought, the person and each person employed by the person for the purpose of providing the service holds all licenses or similar entitlements, as specified in this rule and required by federal or state law, rule, or regulation for the provision of the service.

(2) The person affirms in writing that neither it, nor any person in whom it has a control interest, nor any person having a controlling interest in it has, during the preceding five (5) years, been convicted of a crime related to, or been terminated from, federal or state assisted medical programs.

(3) The person furnishes to the department in writing the names and addresses of all vendors of drugs, medical supplies or transportation, or providers in which it has a control interest or ownership and all persons who have a controlling interest in it.

(4) The person has executed a provider agreement with the department.

(5) The following providers are required to be certified:

(a) Institutional/Group Providers. Institutional providers are provider groups or organizations which meet the conditions listed in this subsection. Institutional providers shall be:

1. Entities composed of more than one individual performing services; and

2. Licensed or approved by the appropriate state agency or certified for Medicare participation, or both; and

3. Reimbursed according to a Medicare profile or other cost-based reimbursement mechanism. Examples of institutional providers are hospitals, nursing homes, home health agencies, 51.42 board-operated clinics.

(b) Non-Institutional Providers. Non-institutional providers are providers eligible for direct reimbursement, who are in single practice or providers who, although employed by a provider group, also have private patients for whom they submit claims to Medicaid.

(c) Provider Assistants. Provider assistants are those providers (e.g. physical therapist assistant, physician's assistant, etc.) whose services must be provided under the supervision of a certified or licensed professional provider. Such assistant providers, while required to be certified, are not eligible for direct reimbursement from Medicaid.

(6) Persons who do not need to be individually certified are: (1) Technicians or support staff for a provider, such as:

(a) Dental hygienists
(b) Medical record librarians or technicians
(c) Hospital and nursing home administrators, Clinic managers, and administrative and billing staff
(d) Nursing aides, assistants and orderlies
(e) Home health aides
(f) Personal care workers
(g) Dietitians
(h) Laboratory technologists
(i) X-ray technicians
(j) Patient activities coordinators
(k) Volunteers
(l) All other persons whose cost of service is built into the charge submitted by the provider (housekeeping, maintenance staff, etc.);

or (2) providers employed by or under contract to certified institutional providers, e.g., physicians, therapists, nurses and provider assistants when they are employes of a hospital, nursing home, home health agency or other certified institutional provider.

5.02 Requirements for Maintaining Certification. Providers shall comply with the following requirements in order to maintain certification in the medical assistance program:

(1) Providers shall report to the department in writing any change in licensure, certification, corporate name or ownership by the time of the effective date of such changes. Such changes may require that the provider complete a new provider application and a new provider agreement. Changes in a provider's address require immediate notification of the department but do not require completion of a new provider application or a new provider agreement.

(2) In the event of a change of ownership, the provider agreement shall automatically terminate, except that provider shall continue to maintain records required by sections 5.02(3), (4) and (5) unless an alternative method of providing for maintenance of such records has been established in writing and approved by the department.

(3) Providers shall prepare and maintain such records as are necessary fully to disclose the nature and extent of services provided by the provider under the program. Records to be maintained are those enumerated in subsection 5.02(4) and (5). All records shall be retained by providers for a period of not less than five years from date of payment by the department for the services rendered, unless otherwise stated in this rule. In the event a provider's participation in the program is terminated for any reason, all Medicaid-related records shall remain subject to the conditions enumerated in subsection 5.02(2) and (3).

(4) All providers shall maintain the following records:

(a) Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by the Medicaid program.

(b) Medicaid billings and records of services or supplies which are the subject of such billings, as are necessary fully to disclose the nature and extent of services or supplies.

(c) Any and all prescriptions necessary to disclose the nature and extent of services provided and billed under the program.

(5) These other records shall be maintained:

(a) Hospitals, skilled nursing facilities (SNFs), intermediate care facilities (ICFs) and home health agencies (except that home health agencies are not required to maintain records listed at 11 and 14 below):

1. Annual budgets.
2. Patient census information.
   a. All patients
   b. Medical assistance recipients
3. Annual cost settlement reports for Medicare.
4. Reimbursement rate proposals (hospitals only).
5. Annual Medicaid cost reports (SNF and ICFs only).
6. Independent accountants' audit reports.
7. Records supporting historical costs of buildings and equipment.
8. Building and equipment depreciation records.
9. Cash receipt and receivable ledgers, and supporting receipts and billings.
10. Accounts payable, operating expense ledgers, and cash disbursement ledgers, with supporting purchase orders, invoices, or checks.
11. Records by department, of the use of support service departments such as dietary, laundry, plant and equipment, housekeeping.
12. Payroll records.
13. Inventory records.
14. Ledger identifying dates and amounts of all deposits to and withdrawals from medical assistance resident trust fund accounts, including documentation of the amount, date, and purpose of the withdrawal when withdrawal is made by anyone other than the resident. (When the resident chooses to retain control of the funds, such decision shall be documented in writing and retained in the resident's records. When such decision is made and documented, the facility is relieved of responsibility to document expenditures under this subsection.)
15. All policies and regulations as adopted by the provider's governing body.

(b) Pharmacy and other dispensary providers:

1. Prescriptions which support Medicaid billings.
2. Medicaid patient profiles.
3. Purchase invoices and receipts for such medical supplies and equipment billed to the medical assistance program.

(6) The provider agreement shall, unless terminated, remain in full force and effect for a maximum of one year from the date of execution. The date on which it was signed on behalf of the department by its authorized representative shall be considered the effective date. In the absence of a notice of termination by either party, the agreement shall automatically renew and be extended for periods of one (1) year.

5.03 and 5.04. Sections 5.03 and 5.04 are reserved.

5.05 Participation By Non-Certified Persons Under Emergency Conditions. If a Wisconsin or an out-of-state person who is not certified in the medical assistance program in this state provides emergency services to a Wisconsin recipient, that person shall not be reimbursed for those services from the Wisconsin MA program unless the person meets the conditions outlined in subsection 5.05(2).

(1) No other services provided by the person shall be reimbursed by the Wisconsin MA program unless:

(a) The person becomes certified in the Wisconsin MA program and meets all the requirements for coverage of services in the Wisconsin program; or

(b) The person participates again under emergency conditions and meets the conditions enumerated below.

(2) A non-certified person shall meet the following emergency conditions:

(a) Submit a provider data form and claim for reimbursement of emergency services to the department on forms prescribed by the department.

(b) Submit to the department a statement in writing on a form prescribed by the department explaining the nature of the emergency (including description of recipient's condition, cause of emergency, if known, diagnosis and extent of injuries); the services which were provided and when; and the reason that the recipient could not receive services from a participating certified provider.

(c) Shall be qualified to provide all services for which a claim is submitted.

(3) Based upon the signed statement and the claim for reimbursement, the department's professional consultants shall determine whether the services are reimbursable.

5.06 Supervision of Provider Assistants. Unless otherwise specified under the appropriate section for each provider type, supervision means at least intermittent face-to-face contact between supervisor and assistant, and a regular review of the assistant's work by the supervisor.

5.07 Requirements for Certification of Physicians. Physicians are required to be licensed to practice medicine and surgery pursuant to sections 448.05 and 448.07 Wis. Stats. and Wis. Adm. Code chapters Med 1, 2, 3, 4, 5, and 14.

5.075 Requirements for Certification of Physician's Assistants. Physician's assistants are required to be certified and registered pursuant to sections 448.05 and 448.07 Wis. Stats. and Wis. Adm. Code chapter Med 8.

5.077 Requirements for Certification of Inhalation Therapists. Inhalation therapists are required to be registered with the American Registry of Inhalation Therapy and shall provide service only under the immediate personal supervision of a physician.

5.08 Requirements for Certification of Dentists. Dentists are required to be licensed pursuant to section 447.05 Wis. Stats.

5.09 Requirements for Certification of General Hospitals. Hospitals are required to be approved pursuant to section 50.35, Wis. Stats. and to meet requirements of the rules and standards promulgated under Wis. Adm. Code chapter H 24 and to have a certificate of participation in Medicare or to be qualified to receive such certification, or to be accredited by the Joint Commission on the Accreditation of Hospitals (JCAH). Hospitals are required to have a utilization review plan that meets the requirements of section 5.09(2) through (12). (For purposes of program administration, the following rules, which are a codification of 42 CFR 405.1035 are adopted. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the original federal regulations shall hold).

(1) Professional Standards Review Organization. Hospitals participating in the Professional Standards Review Organization (PSRO) review program shall meet the requirements in the federal regulations for that program. Such hospitals need not meet the requirements of 5.09(2) through (12).

(2) Utilization Review Requirement. The hospital shall have in effect a plan for utilization review which applies to the services furnished by the hospital to inpatients who are entitled to benefits under medical assistance. A hospital's utilization review plan shall provide at least for the timely review of the medical necessity of admissions, extended duration stays, and professional services rendered, and shall have as its objectives both high quality patient care and effective and efficient utilization of available health facilities and services.

(3) Hospitals wishing to establish their eligibility to participate shall submit a written description of their utilization review plan and a certification that it is currently in effect or that it will be in effect no later than the first day on which the hospital expects to become a participating provider of services.

(4) The review plan of a hospital shall have as its overall objective the maintenance of high quality patient care, and an increase in effective use of hospital services to be achieved through an educational approach involving study of patterns of care, and the encouragement of appropriate utilization. A review of the medical necessity of admissions and durations of stay shall take into account alternative use and availability of out-of-hospital facilities and services. The review of professional services furnished may include study of such conditions as overuse or underuse of services, logical substantiation of diagnoses, proper use of consultation, and whether required diagnostic workup and treatment are initiated and carried out promptly. Review of length of stay may consider not only medical necessity, but the effect that hospital staffing may have on duration of stay, whether assistance is available to the physician in arranging for discharge planning, and the availability of out-of-hospital facilities and services which will assure continuity of care.

(5) Costs incurred in connection with the implementation of the utilization review plan are includable in reasonable costs and are reimbursable to the hospital to the extent that such costs relate to medical assistance recipients.

(6) The operation of the utilization review plan is a responsibility of the medical staff. The plan in the hospital shall have the approval of the medical staff and of the governing body.

(7) The hospital shall have a currently applicable, written description of its utilization review plan. Such description shall include:

(a) The organization and composition of the committee or committees which will be responsible for the utilization review function;

(b) Frequency of meetings;

(c) The type of records to be kept;

(d) The method to be used in selecting categories of admissions to be subjected to closer professional scrutiny, and methods for selecting and conducting medical care evaluation studies;

(e) The methods and criteria (including norms where available) used to assign initial extended stay review dates and used to assign or select subsequent dates for continued stay review;

(f) The relationship of the utilization review plan to claims administration by a third party;

(g) Arrangements for committee reports and their dissemination;

(h) Responsibilities of the hospital's administrative staff.

(8) Extended stay review. Before or on the date assigned for extended stay review, the committee or group responsible for conducting utilization review shall make a finding about whether further stay in the hospital by the individual is medically necessary. Such review shall be based on the attending physician's reasons for and plan for continued stay, and other documentation the committee or group considers necessary. For purposes of such review, cases may be screened by a qualified nonphysician representative of the committee or group who uses appropriate criteria, provided that those cases in which further stay does not appear medically necessary according to such criteria are referred to a physician member of the committee or group for further review. If the individual's further stay is determined to be medically necessary, the duration of the further stay shall be certified for an appropriate period of time based on criteria established by the committee or group. Before the expiration of the new period, the case shall be reviewed again in like manner, with such reviews being repeated as long as the stay continues beyond the scheduled review dates and notice has not been given pursuant to section 5.09(9).

(9) If the committee or group, or its nonphysician representative, where a physician member concurs, has reason to believe that further stay is not medically necessary, the committee or group shall so notify the individual's attending physician and afford an opportunity to present views before it makes a final determination. If the final determination of the committee or group is that further stay in the hospital is not medically necessary, written notice of such finding shall be given to the hospital, the attending physician, and the individual (or the next of kin, where appropriate) not later than two days after such determination is made. In no event shall such notification be given later than two working days after the end of the certified period.

(10) Records shall be kept of the activities of the committee, reports shall be regularly made by the committee to the executive committee of the medical staff, and relevant information and recommendations shall be reported through usual channels to the entire medical staff and the governing body of the hospital.

(a) The hospital administration shall study and act upon administrative recommendations made by the committee.

(b) A summary of the number and types of cases reviewed, and the findings, shall be made part of the records.

(c) Minutes of each committee meeting shall be maintained.

(d) Committee action in extended stay cases shall be recorded, with cases identified only by hospital case number.

(11) The committee(s) having responsibility for utilization review functions shall have the support and assistance of the hospital's administrative staff in assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, and promoting the most efficient use of available health services and facilities.

(a) With respect to each of these activities, an individual or department shall be designated as responsible for the particular service.

(b) In order to encourage the most efficient use of available health services and facilities, assistance to the physician in timely planning for post-hospital care shall be initiated as promptly as possible, either by hospital staff, or by arrangement with other agencies. For this purpose, the hospital shall make available to the attending physician current information on resources available for continued out-of-hospital care of patients and shall arrange for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge of a patient.

(12) Medical care evaluation studies. Medical care evaluation studies shall be performed to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionaly recognized standards of health care. Studies shall emphasize identification and analysis of patterns of patient care, and shall suggest possible changes for maintaining consistently high quality patient care and effective and efficient use of services. Each medical care evaluation study (whether medical or administrative in emphasis) shall identify and analyze factors related to the patient care rendered in the facility, and where indicated, results in recommendations for change beneficial to patients, staff, the facility, and the community. Studies on a sample or other basis shall include, but need not be limited to: admissions, durations of stay, ancillary services furnished (including drugs and biologicals), and professional services performed on the hospital premises. At least one study must be in progress at any given time, and at least one study shall be completed each year. The study shall be accomplished by considering and analyzing data obtained from any one or a combination of the following sources:

(a) Medical records or other appropriate hospital data;

(b) External organizations which compile statistics, design profiles, and produce other comparative data; and

(c) By cooperative endeavor with the Professional Standards Review Organization, fiscal intermediary, providers of services, or other appropriate agencies.

(d) The group or committee shall document the results of each medical care evaluation study and how such results have, where appropriate, been used to institute changes to improve the quality of care and promote more effective and efficient use of facilities and services.

5.10 Requirements for Certification of Skilled Nursing Facilities.

Skilled nursing facilities are required to be licensed pursuant to s.50.03, Stats. and to meet the requirements of Wis. Adm. Code chapter H-32 and to meet the requirements for participation in Medicare. For purposes of program administration the following rules, which are a codification of 42 CFR 405.1101 through 42 CFR 405.1137, are adopted. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the federal regulations shall hold.

(NOTE: The following skilled nursing facility rules will be placed into the next complete revision of Wis. Adm. Code chapter H-32, at which time these rules will be repealed.)

(1) Compliance with federal, state, and local laws.

(a) Licensure. The facility shall be licensed pursuant to section 50.02(3) Wis. Stats., except that a facility which formerly met fully such licensure requirements, but is currently determined not to meet fully all such requirements, may be recognized for a period specified by the department.

(b) Licensure or registration of personnel. Staff of the facility shall be licensed or registered in accordance with applicable laws.

(c) Conformity with other federal, state, and local laws. The facility shall be in conformity with all federal, state, and local laws relating to fire and safety, sanitation, communicable and reportable diseases, postmortem procedures, and other relevant health and safety requirements.

(2) Governing body and management. The skilled nursing facility shall have an effective governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility. The governing body shall adopt and enforce rules and regulations concerning the health care and safety of patients, the protection of patients' personal and property rights, and the general operation of the facility.

(a) Disclosure of ownership. The facility shall supply full and complete information to the department on the identity of:

1. Each person who has any direct or indirect ownership interest of 10 percent or more in the facility or, each person who owns (in whole or in part) any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the facility, or any of the property or assets of the facility;

2. If the facility is organized as a corporation, each officer and director of the corporation; and

3. If the facility is organized as a partnership, each partner.

The facility shall promptly report any changes affecting the current accuracy of the information required to be supplied.

(b) Staffing patterns. The facility shall furnish to the department information from payroll records setting forth the average numbers and types of personnel (in full-time equivalents) on each tour of duty during at least one week of each quarter. Such week shall be selected by the department.

(c) Bylaws. The governing body shall adopt effective patient care policies and administrative policies and bylaws governing the operation of the facility, in accordance with legal requirements. Policies and bylaws shall be in writing, dated, and made available to all members of the governing body which shall ensure the policies and bylaws are operational. The governing body shall review and revise policies and bylaws as necessary.

(d) Independent medical evaluation (medical review). The governing body shall adopt policies to ensure that the facility cooperates in an effective and regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including at least an annual medical evaluation of each patient's need for skilled nursing facility care).

(e) Administrator. The governing body shall appoint a qualified administrator who shall be responsible for the overall management of the facility, for enforcing rules and regulations concerning the level of health care and safety of patients and the protection of their personal and property rights, and for planning, organizing, and directing those responsibilities delegated to the administrator by the governing body. Through meetings and periodic reports, the administrator shall maintain ongoing liaison among the governing body, medical and nursing staffs, and other professional and supervisory staff of the facility, and shall study and act upon recommendations made by the utilization review and other committees. In the absence of the administrator, an appropriate employee shall be authorized, in writing, to act on behalf of the administrator.

(f) Institutional planning. The skilled nursing facility, under the direction of the governing body shall prepare an overall plan and budget which provides for an annual operating budget and a capital expenditure plan.

1. Annual operating budget. The annual operating budget shall include all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that an item by item identification of the components of each type of anticipated income or expense is not required to be prepared).

2. Capital expenditure plan.

a. The capital expenditure plan shall be in conformity with the requirements of chapter 150, Wis. Stats.

3. Preparation of plan and budget. The overall plan and budget shall be prepared under the direction of the governing body by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (or chief medical officer, or patient care policies advisory group as specified in section 5.10(3)(a) below).

4. Annual review of plan and budget. The overall plan and budget shall be reviewed and updated at least annually by the committee referred to in paragraph 5.10(2)(f)3 under the direction of the governing body.

(g) Personnel policies and procedures. The governing body, through the administrator, shall implement and maintain written personnel policies and procedures that support sound patient care and personnel practices. Personnel records shall be current and available for each employee and shall contain sufficient information to support placement in the position to which assigned. Written policies for control of communicable disease shall be in effect to ensure that employees with symptoms or signs of

communicable disease or infected skin lesions are not permitted to work, and that a safe and sanitary environment for patients and personnel exists, and that incidents and accidents to patients and personnel are reviewed to identify health and safety hazards. Employees shall be provided or shall otherwise obtain a periodic health examination to ensure freedom from communicable disease.

(h) Staff development. An ongoing educational program shall be planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the aged, ill, and disabled. Each employee shall receive appropriate orientation to the facility and its policies, and to the employee's position and duties. Inservice training shall include at least prevention and control of infections, fire prevention and safety, accident prevention, confidentiality of patient information, and preservation of patient dignity, including protection of privacy and personal and property rights. Records shall be maintained which indicate the content of, and attendance at, such staff development programs.

(i) Use of outside resources. If the facility does not employ a qualified professional person to furnish a specific service, it shall make arrangements to have such a service provided by an outside resource person or agency that will provide direct service to patients or act as a consultant to the facility. The responsibilities, functions, objectives, and the terms of agreement, including financial arrangements and charges, of each such outside resource shall be delineated in writing and signed by an authorized representative of the facility and the person or agency providing the service. Agreements pertaining to services shall specify that the facility assumes professional and adminsitrative responsibility for the services rendered. The outside resource, when acting as a consultant, shall apprise the administrator of recommendations, plans for implementation, and continuing assessment through dated, signed reports, which are retained by the administrator for follow-up action and evaluation of performance.

(j) Notification of changes in patient status. The facility shall have appropriate written policies and procedures relating to notification of the patient's attending physician and other responsible persons in the event of an accident involving the patient, or other significant change in the patient's mental, physical, or emotional status, or patient charges, billings, and related administrative matters. Except in a medical emergency, a patient shall not be transferred or discharged, nor shall treatment be altered radically, without consultation with the patient, or, if the patient is incompetent, without prior notification of next of kin or sponsor.

(k) Patient's rights. The governing body shall establish written policies regarding the rights and responsibilities of patients and, through the administrator, be responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures shall be generally available. The staff of the facility shall be trained and involved in the implementation of these policies and procedures. The patient's rights policies and procedures shall comply with the requirements of s. 50.09, stats. and Wis. Adm. Code H-32.055.

(l) Patient care policies. The skilled nursing facility shall have written patient care policies to govern the continuing skilled nursing care and related medical or other services provided.

1. The facility shall have policies, developed by the medical director or the organized medical staff, with the advice of (and with provision for review of such policies from time to time, but at least annually), by a group of professional personnel including one or more

physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides. These policies shall be generally available and shall provide for the total medical and psychosocial needs of patients, including admission, transfer, and discharge planning; and the range of services available to patients, including frequency of physician visits by each category of patients admitted. These policies shall also include provisions to protect patients' personal and property rights. Medical records and minutes of staff and committee meetings shall reflect whether patient care is being rendered in accordance with the written patient care policies, and whether utilization review committee recommendations regarding the policies are reviewed and necessary steps taken to ensure compliance.

2. The medical director or a registered nurse shall be designated, in writing, to be responsible for the execution of patient care policies. If the responsibility for day-to-day execution of patient care policies has been delegated to a registered nurse, the medical director shall serve as the advisory physician from whom the nurse receives medical guidance.

(3) Medical direction. The facility shall retain pursuant to a written agreement, a physician, licensed under state law to practice medicine or osteopathy, to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the patients and the facility. If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the governing body. A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, a hospital medical staff, or through another similar arrangement. The medical director shall be responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to patients and to maintain surveillance of the health status of employees.

(a) Coordination of medical care. Medical direction and coordination of medical care in the facility shall be provided by a medical director. The medical director shall be responsible for the development of written bylaws, rules, and regulations which shall be approved by the governing body and include delineation of the responsibilities of attending physicians. Coordination of medical care shall include liaison with attending physicians to ensure physicians' orders are written promptly upon admission of a patient, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.

(b) Responsibilities to the facility. The medical director shall be responsible for surveillance of the health status of the facility's employees. Incidents and accidents that occur on the premises shall be reviewed by the medical director to identify hazards to health and safety. The administrator shall be given appropriate information to help ensure a safe and sanitary environment for patients and personnel. The medical director shall be responsible for the execution of patient care policies in accordance with section 5.10(2)(1).

(4) Physician services. Patients in need of skilled nursing or rehabilitative care shall be admitted to the facility only upon the recommendation of, and shall remain under the care of, a physician. Each patient or patient sponsor should designate a personal physician if possible.

(a) Medical findings and physicians' orders at time of admission. There shall be made available to the facility, before or at the time of admission, information concerning the patient, including current medical

findings, diagnoses, and orders from a physician for immediate care of the patient. Information about the rehabilitation potential of the patient and a summary of prior treatment shall be made available to the facility at the time of admission or within 48 hours thereafter.

(b) Supervision of each patient by a physician. Each patient shall be under the supervision of a physician who, based on a medical evaluation of the patient's immediate and long-term needs, shall prescribe a planned regimen of total patient care. Each attending physician shall make arrangements for the medical care of the physician's patients in the physician's absence. The medical evaluation of the patient shall be based on a physical examination done within 48 hours of admission unless such examination was performed within 5 days before admission. The patient shall be seen by the attending physician at least once every 30 days for the first 90 days following admission. The patient's total program of care (including medications and treatments) shall be reviewed during a visit by the attending physician at least once every 30 days for the first 90 days, and revised as necessary. A progress note shall be written and signed by the physician at the time of each visit. The physician shall sign all physician orders. After the 90th day following admission, an alternate schedule for physician visits may be adopted if the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at 30 day intervals. This alternate schedule does not apply for patients who require specialized rehabilitative services. In that case, the review shall be in accordance with subsection 5.10(7)(b). At no time shall the alternate schedule exceed 60 days between visits. If the physician decides upon an alternate schedule of visits of more than 30 days for a patient:

1. The facility shall notify the department of the change in schedule, including justification; and

2. The utilization review committee or the medical review team shall promptly reevaluate the patient's need for monthly physician visits as well as the patient's continued need for skilled nursing facility services. If the utilization review committee or the medical review team does not concur in the schedule of visits at intervals of more than 30 days, the alternate schedule shall not be acceptable.

(c) Availability of physicians for emergency patient care. The facility shall have written procedures, available at each nurse's station, for procuring a physician to furnish necessary medical care in emergencies.

(5) Nursing services. The skilled nursing facility shall provide 24-hour service by licensed nurses, including the services of a registered nurse at least during the day tour of duty 7 days a week. There shall be an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of all patients in the facility.

(a) Director of nursing services. The director of nursing services shall be a qualified registered nurse employed full-time who has administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing staff, and who shall serve only one facility in this capacity. The director of nursing services' duties shall be clearly stated in writing. If the director of nursing services has other institutional responsibilities, a qualified registered nurse shall serve as an assistant so that there is the equivalent of a full-time director of nursing services on duty. The director of nursing services shall be responsible for the development and maintenance of nursing service objectives, standards of nursing practice, nursing policy and

procedure manuals, written job descriptions for each level of nursing personnel, scheduling of daily rounds to see all patients, methods for coordinating nursing services with other patient services, for recommending the number and levels of nursing personnel to be employed, and nursing staff development.

(b) Charge nurse. A registered nurse, or a qualified licensed practical (vocational) nurse shall be designated as charge nurse by the director of nursing services for each tour of duty, and shall be responsible for supervision of the total nursing activities in the facility during each tour of duty. The director of nursing services shall not serve as charge nurse in a facility with an average daily total occupancy of 60 or more patients. The charge nurse shall delegate responsibility to nursing personnel for the direct nursing care of specific patients during each tour of duty on the basis of staff qualifications, size and physical layout of the facility, characteristics of the patient load, and the emotional, social, and nursing care needs of patients.

(c) Twenty four hour nursing service. The facility shall provide 24-hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient care policies. The policies shall be designed to ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing care as needed. Policies shall also ensure that patients receive proper care to prevent decubitus ulcers and deformities and are kept comfortable, clean, well-groomed, and protected from accident, injury, and infection. Patients shall be encouraged, assisted and trained in self-care and group activities. Nursing personnel, including at least one registered nurse on the day tour of duty 7 days a week, licensed practical nurses, nurse aides, orderlies, and ward clerks, shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load. Weekly time schedules shall be maintained and shall indicate the number and classifications of nursing personnel, including relief personnel who worked on each unit for each tour of duty.

(d) Patient care plan. A written patient care plan for each patient shall be developed in coordination with other patient care services to be provided and maintained by the nursing service. This plan shall be consonant with the attending physician's plan of medical care, and shall be implemented upon admission. The plan shall indicate care to be given and goals to be accomplished and which professional service is responsible for each element of care. The patient care plan shall be reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the patient. The original copy of the care plan shall be maintained on the premises of the nursing home.

(e) Rehabilitative nursing care. Nursing personnel shall be trained in rehabilitative nursing, and the facility shall have an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence. Rehabilitative nursing care services shall be performed daily for those patients who require such service, and shall be recorded.

(f) Supervision of patient nutrition. Nursing personnel shall be aware of the nutritional needs and food and fluid intake of patients and assist promptly where necessary in the feeding of patients. A procedure shall be established to inform the dietary service of physicians's diet orders and of patients' dietetic problems. Food and fluid intake of patients shall be observed, and deviations from normal shall be recorded and reported to the charge nurse and the physician.

(g) Administration of drugs. Drugs and biologicals shall be administered only by physicians, licensed nursing personnel, or by other personnel who have completed a state-approved training program in medication administration. Procedures shall be established by the pharmaceutical services committee to ensure that drugs to be administered are checked against physicians' orders, that the patient is identified before administration of a drug, and that each patient has an individual medication record and that the dose of drug administered to that patient is properly recorded therein by the person who administered the drug. Drugs and biologicals shall be administered as soon as possible after doses are prepared, and shall be administered by the same person who prepared the doses for administration, except under single unit dose package distribution systems.

(h) Conformance with physicians' drug orders.

1. Drugs shall be administered in accordance with written orders of the attending physician. Drugs not specifically limited by physician's order as to time or number of doses shall be controlled by automatic stop orders or other methods in accordance with written policies. Physicians' verbal orders for drugs shall be given only to a licensed nurse, pharmacist, or physician and shall be immediately recorded and signed by the person receiving the order. (Verbal orders for drugs listed in Chapter 161, Wis. Stats. and in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be permitted only in the case of a bona fide emergency situation.) All orders shall be countersigned by the attending physician within 48 hours. The attending physician shall be notified of an automatic stop order prior to the last dose so that the physician may decide if the administration of the drug or biological is to be continued or altered.

(i) Storage of drugs and biologicals. Procedures for storing and disposing of drugs and biologicals shall be established by the pharmaceutical services committee. All drugs and biologicals shall be stored in locked compartments under proper temperature controls, and only authorized personnel shall have access to the keys. Separately locked, permanently affixed compartments shall be provided for storage of controlled drugs listed in chapter 161, Wis. Stats. and in Schedule II of the Comprehensive Drug Abuse Prevention & Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. An emergency medication kit approved by the pharmaceutical services committee shall be kept readily available.

(6) Dietetic services. The facility shall provide a hygienic dietetic service that meets the daily nutritional needs of patients, ensures that special dietary needs are met, and provides palatable and attractive meals. A facility that has a contract with an outside food management company may be found to be in compliance with this condition provided the facility or company meets the standards listed herein.

(a) Staffings. Overall supervisory responsibility for the dietetic service shall be assigned to a full-time qualified dietetic service supervisor. If the dietetic service supervisor is not a qualified dietitian, the supervisor shall function with frequent, regularly scheduled consultation from a person so qualified. In addition, the facility shall employ sufficient supportive personnel competent to carry out the functions of the dietetic service. Food service personnel shall be on duty daily over a period of 12 or more hours. If consultant dietetic services are used, the consultant's visits shall be at appropriate times, and of sufficient duration and

frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus, and participation in development or revision of dietetic policies and procedures and in planning and conducting inservice education programs.

(b) Menus and nutritional adequacy. Menus shall be planned and followed to meet nutritional needs of patients in accordance with physician orders and, to the extent medically possible, in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(c) Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician. Therapeutic menus shall be planned in writing, and prepared and served as ordered, with supervision or consultation from the dietitian and advice from the physician whenever necessary. A current therapeutic diet manual approved by the dietitian shall be readily available to attending physicians and nursing and dietetic service personnel.

(d) Frequency of meals. At least three meals or their equivalent shall be served daily, at regular hours, with not more than a 14-hour span between substantial evening meal and breakfast. If not prohibited by patient's diet or condition, bedtime nourishments shall be offered routinely to all patients.

(e) Preparation and service of food. Foods shall be prepared by methods that conserve nutritive value, flavor, and appearance, and shall be attractively servedat the proper temperatures and in a form to meet individual needs. If a patient refuses food served, appropriate substitutes of similar nutritive value shall be offered.

(f) Hygiene of staff. Dietetic service personnel shall be free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with the sanitation, safety, or time required for dietetic work assignments.

(g) Sanitary conditions. Food shall be procured from sources approved or considered satisfactory by federal, state, or local authorities, and stored, prepared, distributed, and served under sanitary conditions. Waste shall be disposed of properly. Written reports of inspections by state and local health authorities shall be on file at the facility, with notation made of action taken by the facility to comply with any recommendations.

(7) Specialized rehabilitative services. In addition to rehabilitative nursing, the skilled nursing facility shall provide or arrange for under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, speech pathology, audiology, and occupational therapy) as needed by patients to improve and maintain functioning. These services shall be provided upon the written order of the patient's attending physician. Safe and adequate space and equipment shall be available, commensurate with the services offered. If the facility does not offer such services directly, it shall not admit or retain patients in need of this care unless provision is made for such services under arrangement with qualified outside resources.

(a) Organization and staffing. Specialized rehabilitative services shall be provided, in accordance with accepted professional practices, by qualified therapists or by qualified assistants or other supportive personnel under the supervision of qualified therapists. Other rehabilitative services also may be provided, but shall be in a facility where all rehabilitative services are provided through an organized rehabilitative

service under the supervision of a physician who determines the goals and limitations of these services and assigns duties appropriate to the training and experience of those providing such services. Written administrative and patient care policies and procedures shall be developed for rehabilitative services by appropriate therapists and representatives of the medical, administrative, and nursing staffs.

(b) Plan of care. Rehabilitative services shall be provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service. Therapy shall be provided only upon written orders of the attending physician. A report of the patient's progress shall be communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services. The patient's progress shall thereafter be reviewed regularly, and the plan of rehabilitative care shall be re-evaluated as necessary, but at least every 30 days, by the physician and the therapist(s). The original copy of the plan of care shall be maintained on the premises of the nursing home.

(c) Documentation of services. The physician's orders, the plan of rehabilitative care, services rendered, evaluations or progress, and other pertinent information shall be recorded in the patient's medical record, and dated and signed by the physician ordering the service and the person who provided the service.

(d) Qualifying to provide outpatient physical therapy services. If the skilled nursing facility provides outpatient physical therapy services, it shall meet the applicable health and safety regulations pertaining to such services as are included in section 5.34 of this rule.

(8) Pharmaceutical services. The skilled nursing facility shall provide appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility shall be responsible for providing such drugs and biologicals for its patients, insofar as they are covered under the programs, and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate federal, state and local laws.

(a) Supervision of services. The pharmaceutical services shall be under the general supervision of a qualified pharmacist who is responsible to the administrative staff for developing, coordinating and supervising all pharmaceutical services. The pharmacist (if not a full-time employee) shall devote a sufficient number of hours, based upon the needs of the facility, during regularly scheduled visits to carry out these responsibilities. The pharmacist shall review the drug regimen of each patient at least monthly, and report any irregularities to the medical director and administrator. The pharmacist shall submit a written report at least quarterly to the pharmaceutical services committee on the status of the facility's pharmaceutical service and staff performance.

(b) Control and accountability. The pharmaceutical service shall have procedures for control and accountability of all drugs and biologicals throughout the facility. Only approved drugs and biologicals shall be used in the facility, and shall be dispensed in compliance with federal and state laws. Records of receipt and disposition of all controlled drugs shall be maintained in sufficient detail to enable an accurate reconciliation. The pharmacist shall determine that drug records are in order and that an account of all controlled drugs is maintained and reconciled.

(c) Labeling of drugs and biologicals. The labeling of drugs and biologicals shall be based on currently accepted professional principles, and shall include the appropriate accessory and cautionary instructions as well as the expiration date when applicable.

(d) Pharmaceutical services committee. A pharmaceutical services committee (or its equivalent) shall develop written policies and procedures for safe and effective drug therapy, distribution, control, and use of drugs. The committee shall include at least the pharmacist, the director of nursing services, the administrator, and one physician. The committee shall oversee pharmaceutical service in the facility, make recommendations for improvement, and monitor service to ensure its accuracy and adequacy. The committee shall meet at least quarterly and document its activities, findings, and recommendations.

(9) Laboratory and radiologic services. The skilled nursing facility shall provide for promptly obtaining required laboratory, x-ray, and other diagnostic services.

(a) Provision for services. If the facility provides its own laboratory and x-ray services, these shall meet the applicable conditions established for certification of hospitals contained in Wis. Adm. Code section H 24.09 and H 24.10 respectively. If the facility itself does not provide such services, arrangements shall be made for obtaining these services from a physician's office, a participating hospital or skilled nursing facility, or a portable x-ray supplier or independent laboratory approved to provide these services under the program. All such services shall be provided only on the orders of the attending physician, who shall be notified promptly of the findings. The facility shall assist the patient, if necessary, in arranging for transportation to and from the source of service. Signed and dated reports of a clinical laboratory, x-ray, and other diagnostic services shall be filed with the patient's medical record.

(b) Blood and blood products. Blood handling and storage facilities shall be safe, adequate, and properly supervised. If the facility provides for maintaining and transfusing blood and blood products, it shall meet the conditions established for certification of hospitals that are contained in Wis. Adm. Code, section H 24.09. If the facility does not provide its own facilities but does provide transfusion services alone, it shall meet at least the requirements of Wis. Adm. Code sections H 24.09(j), 1., 3., 4., 6., and 9.

(10) Dental services. The skilled nursing facility shall have satisfactory arrangements to assist patients to obtain routine and emergency dental care.

(a) Advisory dentist. An advisory dentist shall participate in the staff development program for nursing and other appropriate personnel and recommend oral hygiene policies and practices for the care of patients.

(b) Arrangements for outside services. The facility shall make arrangements for patients who do not have a private dentist. The facility shall assist the patient, if necessary, in arranging for transportation to and from the dentist's office.

(11) Social services. The facility shall have satisfactory arrangements for identifying the medically related social and emotional needs of the patient. The facility itself need not provide social services in order to participate in the program. If the facility does not provide social services, it shall have written procedures for referring patients in need

of social services to appropriate social agencies. Social services offered by the facility shall be provided under a clearly defined plan, by qualified persons, to assist each patient to adjust to the social and emotional aspects of the patient's illness, treatment, and stay in the facility.

(a) Social service functions. The medically related social and emotional needs of the patient shall be identified and services shall be provided to meet them, either by qualified staff of the facility, or by referral to appropriate social service agencies. If financial assistance is indicated, arrangements shall be made promptly for referral to an appropriate agency. The patient and the patient's family or responsible person shall be fully informed of the patient's personal and property rights.

(b) Staffing. If the facility offers social services, a member of the staff of the facility shall be designated responsible for social services. If the designated person is not a qualified social worker, the facility shall have a written agreement with a qualified social worker or recognized social service agency for consultation and assistance on a regularly scheduled basis. The social service shall also have sufficient supportive personnel, easily accessible to patients and staff, and ensure privacy for interviews.

(c) Records and confidentiality of social data. Records of pertinent social data about personal and family problems medically related to the patient's illness and care, and of action taken to meet the patient's needs, shall be maintained in the patient's medical record. If social services are provided by an outside resource, a record shall be maintained of each referral to such resource. Policies and procedures shall be established for ensuring the confidentiality of all patient's social information.

(12) Patient activities. The skilled nursing facility shall provide for an activities program appropriate to the needs and interests of each patient, to encourage self care, resumption of normal activities, and maintenance of an optimal level of psycho-social functioning.

(a) Responsibility for patient activities. A member of the facility's staff shall be designated responsible for the patient activities program. If the staff member is not a qualified patient activities coordinator, the staff member shall function with frequent, regularly scheduled consultation from a person so qualified.

(b) Patient activities program. Provision shall be made for an ongoing program of meaningful activities appropriate to the needs and interests of patients, designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any. Each patient's activities program shall be approved by the patient's attending physician as not in conflict with the treatment plan. The activities shall be designed to promote the physical, social, and mental well-being of the patients. The facility shall make available adequate space and a variety of supplies and equipment to satisfy the individual interests of patients.

(13) Medical records. The facility shall maintain clinical (medical) records on all patients in accordance with accepted professionsl standards and practices. The medical record service shall have sufficient staff, facilities, and equipment to provide medical records that are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. The original copy of the medical record shall be maintained on premises at the nursing home.

(a) Staffing. Overall supervisory responsibility for the medical record service shall be assigned to a full-time employee of the facility. The facility shall also employ sufficient supportive personnel competent to carry out the functions of the medical record service. If the medical record supervisor is not a qualified medical record practitioner, this person shall function with consultation from a person so qualified.

(b) Protection of medical record information. The facility shall safeguard medical record information against loss, destruction, or unauthorized use.

(c) Content. The medical record shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. All medical records shall contain documented evidence of: assessment of the needs of the patient; establishment of an appropriate plan of treatment; care and services provided; authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form); identification data and consent forms; medical and nursing history of the patient; report of physical examination(s); diagnostic and therapeutic orders; observations and progress notes; reports of treatments and clinical findings; and discharge summary including final diagnosis and prognosis.

(d) Physician documentation. Only physicians shall enter or authenticate in medical records opinions that require medical judgment (in accordance with medical staff bylaws, rules, and regulations, if applicable). All entries into the medical record shall be signed by the physician who makes the entry.

(e) Completion of records and centralization of reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record.

(f) Retention and preservation. Medical records shall be retained for 5 years from the date of discharge, or, in the case of a minor, 3 years after the patient becomes of age under state law.

(g) Indexes. Patients' medical records shall be indexed according to name of patient and final diagnoses to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

(h) Location and facilities. The facility shall maintain adequate facilities and equipment, conveniently located, to provide efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).

(14) Transfer agreement. The skilled nursing facility shall have in effect a transfer agreement with one or more hospitals approved for Medicaid participation, under which inpatient hospital care or other hospital services are available promptly to the facility's patients when needed.

(a) Transfer of Patients. A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that:

1. Transfer of patients will be effected between the hospital and the skilled nursing facility ensuring timely admission, whenever such transfer is medically appropriate as determined by the attending physician; and

2. There shall be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for in other than either of the two institutions; and

3. Security and accountability for patients' personal effects are provided during transfer.

(b) A facility which does not have a patient transfer agreement in effect, but which is found by the department to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph 5.10(14)(a)2. shall be considered to have such an agreement in effect if and for so long as the department finds that to do so is in the public interest and essential to ensuring skilled nursing facility services for eligible recipients in the community.

(c) In the case of transfer of a recipient from one facility to another, a copy of the plans of care and medical records shall be maintained in the facility from which the patient is transferred. The records of transferred patients shall be retained for 5 years from date of transfer.

(15) Physical environment. The facility shall be constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public.

(a) Life safety from fire. The skilled nursing facility shall meet such provisions of the Life Safety Code of the National Fire Protection Assocation (21st Edition, 1967) as are applicable to nursing homes; except that, in consideration of a recommendation by the department, the department may waive, for such periods as deemed appropriate, specific provisions of such Code which, if rigidly applied, would result in unreasonable hardship upon a skilled nursing facility, but only if such waiver will not adversely affect the health and safety of the patients. Where waiver permits the participation of an existing facility of two or more stories which is not of at least 2-hour fire resistive construction, blind, nonambulatory, or physically handicapped patients shall not be housed above the street level floor unless the facility is of 1-hour protected noncombustible construction (as defined in National Fire Protection Association Standard No. 220), fully sprinklered 1-hour protected ordinary construction, or fully sprinklered 1-hour protected woodframe construction. Nonflammable medical gas systems, such as oxygen and nitrous oxide, installed in the facility shall comply with applicable provisions of National Fire Protection Association Standard No. 56B (Standard for the Use of Inhalation Therapy) 1968 and National Fire Protection Association Standard No. 56F (Nonflammable Medical Gas Systems) 1970.

(b) Emergency power. The facility shall provide an emergency source of electrical power necessary to protect the health and safety of patients in the event the normal electrical supply is interrupted. The emergency electrical power system shall supply power adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life support systems. Where life support systems are used, emergency electrical service shall be provided by an emergency generator located on the premises.

(c) Facilities for physically handicapped. The facility shall be accessible to, and functional for patients, personnel, and the public. All necessary accomodations shall be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities,

disabilities of coordination, as well as other disabilities, in accordance with the America National Standards Institute (ANSI) Standard No. A117.1, American Standard Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped. The department may waive in existing buildings, for such periods as deemed appropriate, specific provisions of ANSI Standard No. A117.1 which, if rigidly enforced, would result in unreasonable hardship upon the facility, but only if such waiver will not adversely affect the health and safety of patients.

(d) Nursing unit. Each nursing unit shall have at least the following basic service areas: nurses stations, storage and preparation area for drugs and biologicals, and utility and storage rooms adequate in size, conveniently located, and well lighted to facilitate staff functioning. The nurses station shall be equipped to register patients' calls through a communication system from patient areas, including patient rooms and toilet and bathing facilities.

(e) Patient rooms and toilet facilities. Patient rooms shall be designed and equipped for adequate nursing care and the comfort and privacy of patients, and shall have no more than four beds, except in facilities primarily for the care of the mentally ill or retarded or both, where there shall be no more than 12 beds per room. Single patient rooms shall measure at least 100 square feet, and multipatient rooms shall provide a minimum of 80 square feet per bed. The department may permit variations in individual cases where the facility demonstrates in writing that such variations are in accordance with the particular needs of the patients and will not adversely affect their health and safety. Each room shall be equipped with, or be conveniently located near adequate toilet and bathing facilities. Each room shall have direct access to a corridor and outside exposure, with the floor at or above grade level.

(f) Facilities for special care. Provision shall be made for isolating patients as necessary in single rooms ventilated to the outside, with private toilet and handwashing facilities. Procedures in aseptic and isolation techniques shall be established in writing and followed by all personnel. Such areas shall be identified by appropriate precautionary signs.

(g) Dining and patient activities rooms. The facility shall provide one or more clean, orderly, and appropriately furnished rooms of adequate size designated for patient dining and other patient activities. These areas shall be well-lighted and well-ventilated. If a multipurpose room is used for dining and patient activities, there shall be sufficient space to accomodate all activities and prevent their interference with each other.

(h) Kitchen and dietetic service areas. The facility shall have kitchen and dietetic service areas adequate to meet food service needs. These areas shall be properly ventilated, and arranged and equipped for sanitary refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal.

(i) Maintenance of equipment, building, and grounds. The facility shall establish a written preventive maintenance program to ensure that equipment is operative and that the interior and exterior of the building are clean and orderly. All essential mechanical, electrical, and patient care equipment shall be maintained in safe operating condition.

(j) Other environmental considerations. The facility shall provide a functional, sanitary, and comfortable environment for patients, personnel, and the public. Provision shall be made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature, procedures to ensure water to

all essential areas in the event of loss of normal water supply, and adequate ventilitation through windows or mechanical means or a combination of both. Corridors shall be equipped with firmly secured handrails on each side.

(16) Infection control. The facility shall establish an infection control committee of representative professional staff with responsibility for overall infection control in the facility. All necessary housekeeping and maintenance services shall be provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.

(a) Infection control committee. The infection control committee shall be composed of members of the medical and nursing staffs, administration, and the dietetic, pharmacy, housekeeping, maintenance, and other services. The committee shall establish policies and procedures for investigating, controlling, and preventing infections in the facility, and shall monitor staff performance to ensure that the policies and procedures are executed.

(b) Aseptic and isolation techniques. Written effective procedures in aseptic and isolation techniques shall be followed by all personnel. Procedures shall be reviewed and revised annually for effectiveness and improvement.

(c) Housekeeping. The facility shall employ sufficient housekeeping personnel and provide all necessary equipment to maintain a safe, clean, and orderly interior. A full-time employee shall be designated responsible for the services and for supervision and training of personnel. Nursing personnel shall not be assigned housekeeping duties. A facility that has a contract with an outside resource for housekeeping services may be found to be in compliance with this standard provided the facility or outside resources meets the requirements of this standard.

(d) Linen. The facility shall have available at all times a quantity of linen essential for proper care and comfort of patients. Linens shall be handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(e) Pest control. The facility shall be maintained free from insects and rodents through operation of a pest control program.

(17) Disaster preparedness. The facility shall have a written plan, periodically rehearsed, with procedures to be following in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.

(a) Disaster plan. The facility shall have an acceptable written plan in operation, with procedures to be followed in the event of fire, explosion, or other disaster. The plan shall be developed and maintained with the assistance of qualified fire, safety, and other appropriate experts, and shall include procedures for prompt transfer of casualties and records, instructions regarding the location and use of alarm systems and signals and of firefighting equipment, information regarding methods of containing fire, procedures for notification of appropriate persons, and specifications of evacuation routes and procedures.

(b) Staff training and drills. All employees shall be trained, as part of their employment orientation, in all aspects of preparedness for any disaster. The disaster program shall include orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out a specific role in case of a disaster. Drills shall be held at least four times a year on each shift.

(18) Utilization Review.

(a) UR plan required for skilled nursing facility services.

1. The state plan must provide that each SNF furnishing inpatient services under the plan has in effect a written UR plan that provides for review of each recipient's need for the services that the SNF furnishes.

2. Each written SNF UR plan must meet the requirements under HSS 105.10(18)(a) through (s).

(b) UR committee required. The UR plan must:

1. Provide for a committee to perform UR required under this subpart;

2. Describe the organization, composition, and functions of this committee; and

3. Specify the frequency of meetings of the committee.

(c) Organization and composition of UR committee; disqualification from UR committee membership.

1. For the purpose of this subpart, "UR Committee" includes any group organized under paragraphs (2) and (3) of this section.

2. The UR committee must be composed of two or more physicians and assisted by other professional personnel and, in a SNF that cares primarily for mental patients, include at least one physician member who is knowledgeable in the diagnosis and treatment of mental diseases.

3. The UR committee must be constituted as:

a. A committee of individuals with SNF staff privileges;

b. A group outside the SNF established by the local medical or osteopathic society and at least some of the hospitals and SNFs in the locality; or

c. A group capable of performing utilization review and established and organized in a manner approved by the department.

4. The UR committee may not include any individual who:

a. Is directly responsible for the care of patients whose care is being reviewed;

b. Is employed by the SNF; or

c. Has a financial interest in any SNF.

(d) Recipient information required for UR. The UR plan must provide that each recipient's record includes information needed to perform UR required under this subpart. This information must include, at least, the following:

1. Identification of the recipient.

2. The name of the recipient's physician.

3. Date of admission and dates of application for and authorization of medicaid benefits if application is made after admission.

4. The plan of care required under

5. Initial and subsequent continued stay review dates described under HSS 105.10(18)(i) and (j).

6. Reasons and plan for continued stay if the attending physician believes continued stay is necessary.

7. Other supporting material that the committee believes appropriate to be included in the record.

(e) Records and reports. The UR plan must describe:

1. The types of records that are kept by the committee; and

2. The type and frequency of committee reports, and arrangements for their distribution to appropriate individuals.

(f) Confidentiality. The UR plan must provide that the identities of individual recipients in all UR records and reports are kept confidential.

(g) Continued stay review required. The UR plan must provide for a review of each recipient's continued stay in the SNF to decide whether it is needed, in accordance with the requirements of HSS 105.10(18) (h)-(n).

(h) Evaluation criteria for continued stay. The UR plan must provide that:

1. The committee develops written medical care criteria to assess the need for continued stay; and

2. The committee develops more extensive written criteria for cases that its experience shows are:

a. Associated with high costs;

b. Associated with the frequent furnishing of excessive services; or

c. Attended by physicians whose patterns of care are frequently found to be questionable.

(i) Initial continued stay review date. The UR plan must provide that:

1. When a recipient is admitted to the SNF under admission review requirements of this subpart, the committee assigns a specified date by which the need for continued stay will be reviewed;

2. If an individual applies for medicaid while in the SNF, the committee assigns the initial continued stay review date within one working day after the SNF is notified of the application for medicaid;

3. The committee bases its assignment of the initial continued stay review date on the methods and criteria required to be described under HSS 105.10(18)(k)1.

4. The initial continued stay review date is either:

a. Not later than 90 days after the date of the individual's admission or notice to the SNF of application for medicaid, if the date is established using specific periods for diagnostic categories or categories based on functional capabilities; or

b. Not later than 30 days after the date of the individual's admission or notice of application, if the date is established by another method; and

5. The committee ensures that the initial continued stay review date is recorded in the individual's record.

(j) Subsequent continued stay review dates. The UR plan must provide that:

1. The committee assigns subsequent continued stay review dates in accordance with HSS 105.10(18)(i) and (k)1.

2. The committee assigns subsequent continued stay review dates each time it decides under HSS 105.10(18)(l) that the continued stay is needed,

a. At least every 90 days if the dates are established using specific periods for diagnostic categories based on functional capabilities; or

b. At least every 30 days for the first 90 days and at least every 90 days thereafter if the dates are established by another method; and

3. The committee ensures that each continued stay review date that it assigns is recorded in the recipient's record.

(k) Description of methods and criteria: Continued stay review dates: length of stay modification. The UR plan must describe:

1. The methods and criteria that the committee uses to assign initial and subsequent continued stay review dates under HSS 105.10(18)(i) and (j); and

2. The methods used by the committee to modify an approved length of stay when the recipient's condition or treatment schedule changes.

(l) Continued stay review process. The UR plan must provide that:

1. Review of continued stay cases is conducted by:

a. The UR committee;

b. A subgroup of the UR committee; or

c. A designee of the UR committee;

2. The committee, subgroup or designee reviews a recipient's continued stay on or before the expiration of each assigned continued stay review date;

3. For each continued stay of a recipient in the SNF, the committee, subgroup or designee reviews and evaluates the documentation described under HSS 105.10(18)(d) against the criteria developed under HSS 105.10(18)(h) and applies close professional scrutiny to cases described under HSS 105.10(18)(h)2.

4. If the committee, subgroup or designee finds that the recipient's continued stay in the SNF is needed, the committee assigns a new continued stay review date in accordance with HSS 105.10(18)(j).

5. If the committee, subgroup or designee finds that a continued stay does not meet the criteria, the committee or a subgroup that includes at least one physician reviews the case to decide the need for continued stay;

6. If the committee or subgroup making the review under paragraph (e) of this section finds that a continued stay is not needed, it notifies the recipient's attending physician and gives him an opportunity to present his views before it makes a final decision on the need for the continued stay;

7. If the attending physician does not present additional information or clarification of the need for the continued stay, the decision of the committee of subgroup is final; and

8. If the attending physician presents additional information or clarification, at least two physician members of the committee review the need for the continued stay. In an SNF that cares primarily for mental patients, one of these two physicians must be knowledgeable in the treatment of mental diseases. If they find that the recipient no longer needs SNF services their decision is final.

(m) Notification of adverse decision. The UR plan must provide that written notice of any adverse final decision on the need for continued stay under HSS 105.10(18)(l)6. through 8. is sent to:

1. The SNF administrator;
2. The attending physician;
3. The medicaid agency;
4. The recipient; and
5. If possible, the next of kin or sponsor.

(n) Time limits for final decision and notification of adverse decision. The UR plan must provide that:

1. The committee makes a final decision on a recipient's need for continued stay and gives notice under HSS 105.10(18)(m) of an adverse decision within three working days after the assigned review date, except as required under paragraph (b) of the section.

2. If the committee makes an adverse final decision on a recipient's need for continued stay before the assigned review date, the committee gives notice under HSS 105.10(18)(m) within 2 working days after the date of the final decision.

(o) Purpose and general description--Medical Care Evaluation Studies.

1. The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

2. Medical care evaluation studies:

a. Emphasize identification and analyses of patterns of patient care; and

b. Suggest appropriate changes needed to maintain consistently high quality patient care and effective and efficient use of services.

(p) UR plan requirement for medical care evaluation studies.

1. The UR plan must describe the methods that the committee uses to select and conduct medical care evaluation studies under subsection 2.a. of this section.

2. The UR plan must provide that the UR committee

a. Determines the methods to be used in selecting and conducting medical care evaluation studies in the SNF;

b. Documents for each study its results; and how the results have been used to make changes to improve the quality of care and promote more effective and efficient use of facilities and services;

c. Analyzes its findings for each study; and

d. Takes action as needed to:

(i) Correct or investigate further any deficiencies or problems in the review process; or

(ii) Recommend more effective and efficient skilled nursing care procedures.

(q) Content of medical care evaluation studies.
Each medical care evaluation study must:

1. Identify and analyze medical or administrative factors related to the SNF's patient care;

2. Include analysis of at least the following:

a. Admissions,

b. Durations of stay.

c. Ancillary services furnished, including drugs and biologicals.

d. Professional services performed in the SNF; and

3. If indicated, contain recommendations for change beneficial to patients, staff, the SNF and the community.

(r) Data sources for studies. Data that the committee uses to perform studies must be obtained from one or more of the following sources:

1. Medical records or other appropriate data.

2. External organizations that compile statistics, design profiles, and produce other comparative data.

3. Cooperative endeavors with PSRO's; fiscal agents; other providers of services; or other appropriate agencies.

(s) Number of studies required to be performed. The SNF must, at least, have one study in progress at any time and complete one study each calendar year.

(t) Discharge plan.

1. The UR committee must review each recipient's discharge plan.

2. Each discharge plan must insure that the recipient has a planned program of post-discharge continuing care that takes the patient's needs into account.

(u) Discharge planning procedures. Each SNF must maintain discharge planning procedures that describe the following:

1. The staff member of the SNF or the health, social, or welfare agency responsible for discharge planning.

2. The authority of the member or agency, and the methods used in discharge planning, including the relationship with the SNF's staff.

3. The time allowed for determining each recipient's need for discharge planning. The period must not be longer than 7 days after the day of admission.

4. The period after which each recipient's discharge plan will be reevaluated.

5. The local resources available to the SNF, the recipient, and the attending physician to assist in developing and implementing discharge plans.

6. The provision for periodic review and reevaluation of the SNF's discharge planning program.

(v) Information about discharged recipients.

1. When a recipient is discharged, the SNF must provide information that will insure the optimal continuity of care, such as:

a. Current information relative to diagnoses;
b. Prior treatment;
c. Rehabilitation potential;
d. Physician advice concerning immediate care; and
e. Pertinent social information.

2. This information must be provided to those persons who are responsible for the recipient's post-discharge care.

(19) Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases.

(a) Purpose.

This subpart prescribes requirements for periodic inspections of care and services in skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and institutions for mental diseases (IMD's).

(b) Inspection team.

1. A team, as described in this section and HSS 105.10(19)(c) must periodically inspect the care and services provided to recipients in each facility.

2. Each team conducting periodic inspections must have at least one member who is a physician or registered nurse and other appropriate health and social service personnel.

3. For an IMD other than an ICF, each team must have a psychiatrist or physician knowledgeable about mental institutions and other appropriate mental health and social service personnel.

4. For an ICF that primarily cares for mental patients, each team must have at least one member who knows the problems and needs of mentally retarded individuals.

5. For an institution for the mentally retarded or persons with related conditions, each team must have at least one member who knows the problems and needs of mentally retarded individuals.

6. For ICFs primarily serving individuals 65 years of age or older, each team must have at least one member who knows the problems and needs of those individuals.

7. If there is no physician on the team, the medicaid agency must insure that a physician is available to provide consultation to the team.

8. If a team has one or more physicians, it must be supervised by a physician.

(c) Financial interests and employment of team members.

1. Except as provided in paragraph 2 of this section:

a. No member of a team that reviews care in a SNF may have a financial interest in or be employed by any SNF; and

b. No member of a team that reviews care in an INF may have a financial interest in or be employed by an ICF.

2. A member of a team that reviews care in an IMD or an institution for the mentally retarded or persons with related conditions:

a. May not have a financial interest in any institution of that same type but may have a financial interest in other facilities or institutions; and

b. May not review care in an institution where the person is employed but may review care in any other facility or institution.

(d) Physician team member inspecting care of recipients.

No physician member of a team may inspect the care of a recipient for whom he is the attending physician.

(e) Number and location of teams.

There must be a sufficient number of teams so located within the state that onsite inspections can be made at appropriate intervals in each facility caring for recipients.

(f) Frequency of inspections.

The team and the agency must determine, based on the quality of care and services being provided in a facility and the condition of recipients in the facility, at what intervals inspections will be made. However, the team must inspect the care and servicesprovided to each recipient in the facility at least annually.

(g) Notification before inspection.

No facility may be notified of the time of inspection more than 48 hours before the scheduled arrival of the team.

(h) Personal contact with and observation of recipients and review of records.

1. For recipients under age 21 in psychiatric facilities and recipients in SNFs and ICFs, other than those described in paragraph 2 of this section, the team's inspection must include:

a. Person contact with and observation of each recipient; and

b. Review of each recipient's medical record.

2. For recipients age 65 or older in IMDs, the team's inspection must include:

a. Review of each recipient's medical record; and

b. If the record does not contain complete reports of periodic assessment or if such reports are inadequate, personal contact with and observation of each recipient.

(i) Determinations by team.

The team must determine in its inspection whether:

1. The services available in the facility are adequate to:

a. Meet the health needs of each recipient, and the rehabilitative and social needs of each recipient in an ICF; and

b. Promote the person's maximum physical, mental, and psychosocial functioning.

2. It is necessary and desirable for the recipient to remain in the facility;

3. It is feasible to meet the recipient's health needs and, in an ICF, the recipient's rehabilitative needs, through alternative institutional or noninstitutional services; and

4. Each recipient under age 21 in a psychiatric facility and each recipient in an institution for the mentally retarded or persons with related conditions is receiving active treatment as defined in HSS 107.13(1)(b).

(j) Basis for determinations.

In making the determinations on adequacy of services and related matters under HSS 105.10(19)(i) for each recipient, the team may consider such items as whether:

1. The medical evaluation, any required social and psychological evaluations, and the plan of care are complete and current; the plan of care and, where required, the plan of rehabilitation are followed; and all ordered services, including dietary orders, are provided and properly recorded;

2. The attending physician reviews prescribed medications:

a. At least every 30 days in SNFs, psychiatric facilities, and mental hospitals; and

b. At least quarterly in ICFs;

3. Tests or observations of each recipient indicated by the medication regimen are made at appropriate times and properly recorded;

4. Physician, nurse and other professional progress notes are made as required and appear to be consistent with the observed condition of the recipient;

5. The recipient receives adequate services, based on such observations as:

a. Cleanliness;

b. Absence of bedsores;

c. Absence of signs of malnutrition or dehydration; and

d. Apparent maintenance of maximum physical, mental, and psychosocial function;

6. In an ICF, the recipient receives adequate rehabilitative services, as evidenced by:

a. A planned program of activities to prevent regression; and

b. Progress toward meeting objectives of the plan of care;

7. The recipient needs any service that is not furnished by the facility or through arrangements with others; and

8. The recipient needs continued placement in the facility or there is an appropriate plan to transfer the recipient to an alternate method of care.

(k) Reports on inspections.

1. The team must submit a report promptly to the agency on each inspection.

2. The report must contain the observations, conclusions, and recommendations of the team concerning:

a. The adequacy, appropriateness, and quality of all services provided in the facility or through other arrangements, including physician services to recipients; and

b. Specific findings about individual recipients in the facility.

(l) Copies of reports.

The agency must send a copy of each inspection report to:

1. The facility inspected;
2. The facility's utilization review committee;
3. The agency responsible for licensing, certification, or approval of the facility for purposes of medicare and medicaid; and
4. Other state agencies that use the information in the reports to perform their official function, including, if inspection reports concern IMD's, the appropriate state mental health authorities.

(m) Action on reports.

The agency must take corrective action as needed based on the report and recommendations of the team submitted under this subpart.

(n) Inspections by utilization review committee.

A utilization review committee may conduct the periodic inspections required by this subpart if:

1. The committee is not based in the facility being reviewed; and
2. The composition of the committee meets the requirements of this subpart.

5.105 (1) Purpose. These rules, promulgated pursuant to sections 49.45(10) and 50.02(2), Wis. Stats., define the obligation of skilled nursing facilities which are certified under the Medicaid program to make available beds which are certified under the Medicare program.

(2) Requirement for skilled nursing facilities. Skilled nursing facilities in each district which have been certified to provide services and receive reimbursement under Medicaid, or which seek such certification, shall make beds available whcih have been certified under Medicare as follows:

(a) In each district, each large skilled nursing facility seeking recertification or initial certification under Medicaid shall be required to have the lesser of 30% of its beds, or such lower percentage as would be required to establish a ratio of 6 Medicare certified beds per 1,000 elderly population, but in no case fewer than 10 of its beds certified under Medicare.

(b) If the department determines annually that fewer than 6 Medicare certified beds per 1,000 elderly population in a district have been established as a result of subsection 5.105(2)(a), each skilled nursing facility in the district with at least 40 but fewer than 100 beds which seeks recertification or initial certification under Medicaid shall be required to have the lesser of 30% of its beds, or such lower percentage as would be required to establish a ratio of 6 Medicare certified beds/1,000 elderly population, but in no case fewer than 10 of its beds certified under Medicare.

(c) The date on which skilled nursing facilities must meet the requirements for certification of Medicare beds imposed by subsection 5.105(2)(a) or (b) and the requirements of section 49.45(6m)(g), Wis. Stats. shall, subject to Federal Title XVIII approval, be within 90 days of the date of issuance of an initial Medicaid provider agreement or the date of renewal of an existing Medicaid provider agreement.

(3) Consequence of Failure to Make Sufficient Beds Available under Medicare. Any skilled nursing facility seeking recertification or initial certification under Medicaid shall be denied such certification until it meets the requirements imposed by this section.

(4) The department has the right to exempt skilled nursing facilities in an area provided the requirements of this rule are met by other skilled nursing facilities in the same area. Homes wishing to be exempted from the provisions of this rule may apply for such exemptions to the department. Exemption status will be based on assurance of an adequate supply and accessibility of Medicare certified beds.

(5) Homes with 50% or more of their residents classified as mentally retarded shall be exempt from this rule.

105.106 Certification of SNF's and ICF's.

(1) Certification with deficiencies: General provisions. If the department finds a facility deficient in meeting the standards specified in HSS 105.10, 11 or 12, the agency may certify the facility for medicaid purposes under the following conditions:

(a) The agency finds that the facility's deficiencies, individually or in combination, do not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care. The agency must maintain a written justification of these findings.

(b) The department finds acceptable the facility's written plan for correcting the deficiencies.

(c) If a facility was previously certified with a deficiency and has a different deficiency at the time of the next survey, the department documents that the facility:

1. Was unable to stay in compliance with the standard for reasons beyond its control, or despite intensive efforts to comply; and

2. Is making the best use of its resources to furnish adequate care.

(d) If a facility has the same deficiency it had under the prior certification, the department documents that the facility:

1. Did achieve compliance with the standard at some time during the prior certification period;

2. Made a good faith effort, as judged by the department to stay in compliance; and

3. Again became out of compliance for reasons beyond its control.

(e) If an ICF or ICF/MR has a deficiency of the types specified in HSS 105.106 (3) or (4) that requires a plan of correction extending beyond 12 months, the department documents that the conditions of those sections are met.

(2) Certification period: Facilities with deficiencies.

(a) Facilities with deficiencies may be certified under HSS 105.106(1) for the period specified in either paragraph (b) or (c) of this section. However, ICF's with deficiencies that may require more than 12 months to correct may be certified under HSS 105.106(3) and (4).

(b) The department may certify a facility for a period that ends no later than 60 days after the last day specified in the plan for correcting the deficiencies. The certification period must not exceed 12 months, including the period allowed for corrections.

(c) The survey agency may certify a facility for up to 12 months with a condition that the certification will be automatically cancelled on a specified date within the certification period unless:

1. The department finds that all deficiencies have been satisfactorily corrected; or

2. The department finds that the facility has made substantial progress in correcting the deficiencies and has a new plan for correction that is acceptable.

(d) The automatic cancellation date must be no later than 60 days after the last day specified in the plan for correction of deficiencies under HSS 105.106(1).

(3) Extended period for correcting deficiencies: ICF's other than ICF's/MR; environment, sanitation, and Life Safety Code deficiencies.

(a) Scope. This section applies to ICF's other than ICF's/MR that are deficient in meeting requirements for:

1. Environment and sanitation !HSS 105.11(24) through (30)1; or

2. Life Safety Code !HSS 105.11(21) through (23)1.

(b) Certification period. The survey agency may certify an ICF other than an ICF/MR under HSS 105.106(1) for up to 12 months even though the facility has deficiencies that may take up to 2 years after the first certification of the facility to correct, if the conditions in this section are met.

(c) Written plan for correction. The ICF must submit a written plan for correcting the deficiencies that:

1. Specifies the steps the facility will take to correct each deficiency;

2. Specifies a timetable for taking each of those steps and a date for completion of correction of each deficiency that is not later than 2 years after the date the facility is first certified; and

3. Is acceptable to the department.

(d) Feasibility of plan. The department must find that the facility can:

1. Potentially meet the requirements in which it is deficient by taking the steps specified in the plan for correction; and

2. Correct each deficiency by the date specified in the plan for correction; and

(e) Progress in meeting correction plan. Within each 6-month period after acceptance of the plan for correction, the department must find, and record in the survey record, that the facility has made substantial progress in meeting its plan for correction. These findings must be based on onsite surveys by qualified surveyors. The department must support these findings by placing signed contracts, work orders, or other documents in the survey record.

(f) State fire safety and sanitation requirements. The department must find that, during the period allowed for corrections, the facility meets state fire safety and sanitation codes and regulations.

(4) Extended period for correcting deficiencies: ICF's/MR; Life Safety Code and living/dining/therapy area deficiencies.

(a) Scope. This section applies to ICF's/MR that are deficient in meeting requirements for:

1. Life Safety Code [HSS 105.12 (106) through (108)];

2. Living units [HSS 105.12(46)(a)1.,2.,4.,5.,(b),(c); (47)(d); (48)(a),(b); (49)(a)2.; (50)(a); (51) and (52)];

3. Dining rooms [HSS 105.12(70)(a), (c)]; or

4. Therapy areas [HSS 105.12(87)(e)].

(b) Certification period. The survey agency may certify an ICF/MR under HSS 105.106(1) for up to 12 months even though the deficiencies listed in paragraph (a) of this section may take more than 12 months to correct, if the conditions in this section and HSS 105.106(5) are met.

(c) Written plan for correction. Before certifying an ICF/MR under this section, the department must approve, in writing, the ICF/MR's written plan for correcting those deficiencies. The plan must:

1. State the extent to which the ICF/MR complies with the requirements it does not fully meet;

2. Specify the steps the ICF/MR will take to correct the deficiencies;

3. Specify a timetable for taking each of those steps and a date for completion of corrections;

4. For a public ICF/MR, be approved by the state or political subdivision that has jurisdiction over its operation (A public facility is defined as one that is the "responsibility of a governmental unit or over which a governmental unit exercises administrative control."); and

5. Meet the conditions of HSS 105.106(5).

(d) Progress in meeting correction plan. Within each 6-month period after initial approval of the plan, the department must find, and record in the survey record, that the ICF/MR has made substantial progress in meeting the plan for correction. These findings must be based on onsite surveys by qualified surveyors. The survey agency must support these findings by placing signed contracts, work orders, or other documentation in the survey record.

(e) State fire safety and sanitation requirements. The department must find that, during the period allowed for corrections, the ICF/MR meets the state fire safety and sanitation codes and regulations.

(5) Correction plans.

(a) The ICF/MR's plan required by HSS 105.106(4) must provide for completion of corrections by July 18, 1980, or, if authorized by the HEW Secretary under paragraph (b) of this section, by July 18, 1982.

(b) If, at the time of the first survey of the ICF/MR after July 17, 1977, it is unable to develop a plan to complete corrections by July 18, 1980, the department may request the HEW Secretary to authorize approval of a plan to complete them by July 18, 1982. The HEW Secretary will authorize this approval for each deficiency if he determines that time beyond July 18, 1977, is needed:

1. As a practical matter to complete the corrections;

2. To prevent unreasonable hardship to the ICF/MR; and

3. To insure continued care for recipients served by the ICF/MR.

(c) If the plan provides for correction through structural change or renovation, it must:

1. Contain a timetable showing the corrective steps and their completion dates;

2. Specify the structural change or renovation; and

3. Document that sufficient financial resources are available to complete the change or renovation on schedule.

(d) If the plan provides for correction by phasing out part or all of the ICF/MR, it must:

1. Contain a timetable showing the buildings or units to be closed and describing the steps for phasing them out;

2. Describe the methods that insure the recipient's health and safety until the building or unit is closed; and

3. Provide that no new recipients will be admitted to the building or unit after the plan has been approved.

HSS 105.11 Requirements for Certification of Intermediate Care Facilities. Intermediate care facilities are required to be licensed pursuant to s 50.03 Stats., and to meet the following standards which are hereby adopted for purposes of program administration.
[NOTE: The following rules are a codification of 42 CFR Subparts E and F. For the sake of readibility, some editing has been done. In the event of any conflict of meaning, the meaning of the federal regulations shall hold. These rules will be incorporated into the next complete revision of Wis. Adm. Code Chapter H 32, at which time these rules will be repealed.]

(1) State licensing standards.

(a) Except as provided in paragraph (b), an ICF must meet standards for a state license to provide, on a regular basis, health-related care and services to individuals who do not require hospital or SNF care, but whose mental or physical condition requires services above the level of room and board; and that can be provided only by an institution.

(b) An ICF that formerly met state licensing standards but does not currently meet them may continue to receive medicaid payments as a qualified provider during a period specified by the department if, during that period, the ICF takes the steps needed to again meet the standards.

(c) An ICF operated by a government agency must meet the licensing standards that apply to the same type of facility operated under any other ownership.

(d) An Indian Health Service ICF must meet state licensing standards although it need not obtain a license. In making this determination, the licensing authority may not take into account an absence of licensure of any staff member of the facility.

(2) State safety and sanitation standards. An ICF must meet State safety and sanitation standards for nursing homes.

(3) Federal definition and standards.

(a) An ICF other than an ICF/MR must meet the definition in HSS 101 and the standards specified in this subsection and in HSS 105.115, except for provisions waived or accepted under plans of correction as specified in HSS 105.

(b) An ICF/MR must meet the definition in HSS 101 and the standards specified in this subsection and in HSS 105.12 except for provisions waived or accepted under plans of correction as specified in HSS 105.

(4) Standards for hospitals and SNF's providing ICF services.

(a) If a hospital or SNF participating in medicare or medicaid is also a provider of ICF services other than ICF/MR services, it must meet the following ICF standards:

1. HSS 105.115(4), resident services director.
2. HSS 105.115(17), (a), (b), agreements with outside resources for institutional services.
3. HSS 105.115(19), plan of care.
4. HSS 105.115(20), resident financial records.
5. HSS 105.115(24), (b), handrails.

6. HSS 105.155(38) through (42), health services.
7. HSS 105.115(43), rehabilitative services.
8. HSS 105.115(44), social services.
9. HSS 105.115(45), activities program.
10. HSS 105.115(46), physician services.

(b) If a hospital or SNF participating in medicare or medicaid is also a provider of ICF/MR services, it must meet the standards in HSS 105.12.

(5) Utilization Review Requirements -- ICF Services.

(a) State plan UR requirements and options; UR plan required for intermediate care facility services. The State plan must provide that:

1. UR is performed for each ICF that furnishes inpatient services under the plan;

2. Each ICF has on file a written UR plan that provides for review of each recipient's need for the services that the ICF furnishes the patient; and

3. Each written ICF UR plan meets requirements under HSS 105.11(5)(a) through (o).

4. The State plan must specify the method used to perform UR, which may be:

a. Review conducted by the facility;

b. Direct review in the facility by individuals:

i. Employed by the medical assistance unit of the medicaid agency; or

ii. Under contract to the medicaid agency; or

c. Any other method.

(b) Description of UR review function: How and when. The UR plan must include a written description of:

1. How UR is performed in the ICF; and

2. When UR is performed.

(c) Description of UR review function: Who performs UR; disqualification from performing UR.

1. The UR plan must include a written description of who performs UR in the ICF.

2. UR must be performed using a method specified under HSS 105.11(5)(a)4 by a group of professional personnel that includes:

a. At least one physician;

b. In an ICF that cares primarily for mental patients, at least one individual knowledgeable in the treatment of mental diseases; and

c. In an institution for the mentally retarded, at least one individual knowledgeable in the treatment of mental retardation.

3. The group performing UR may not include any individual who:

a. Is directly responsible for the care of the recipient whose care is being reviewed;

b. Is employed by the ICF; or

c. Has a financial interest in any ICF.

(d) UR responsibilities of administrative staff. The UR plan must describe:

1. The UR support responsibilities of the ICF's administrative staff; and

2. Procedures used by the staff for taking needed corrective action.

(e) Recipient information required for UR. The UR plan must provide that each recipient's record include information needed to perform UR required under this subpart. This information must include, at least, the following:

1. Identification of the recipient.

2. The name of the recipient's physician.

3. The name of the qualified mental retardation professional (as defined under HSS 101.103) if applicable.

4. Date of admission, and dates of application for and authorization of medicaid benefits if application is made after admission.

5. The plan of care required under HSS 107.09(3)(p);

6. Initial and subsequent continued stay review dates described under HSS 105.11(5)(j) and (k).

7. Reasons and plan for continued stay, if the attending physician or qualified mental retardation professional believes continued stay is necessary.

8. Other supporting material that the UR group believes appropriate to be included in the record.

(f) Records and reports. The UR plan must describe:

1. The types of records that are kept by the group performing UR; and

2. The type and frequency of reports made by the UR group, and arrangements for distribution of the reports to appropriate individuals.

(g) Confidentiality. The UR plan must provide that the identities of individual recipients in all UR records and reports are kept confidential.

(h) Continued stay review required.

1. The UR plan must provide for a review of each recipient's continued stay in the ICF at least every 6 months to decide whether it is needed.

2. The UR plan requirement for continued stay review may be met by:

a. Reviews that are performed in accordance with the requirements of HSS 105.11(5)(i) through (n); or

b. Reviews that meet on-site inspection requirements under HSS 105.10(19) if:

i. The composition of the independent professional review team under Subpart I meets the requirements of HSS 105.11(5)(c); and

ii. Reviews are conducted as frequently as required under HSS 105.10(18)(i) and (j).

(i) Evaluation criteria for continued stay. The UR plan must provide that:

1. The group performing UR develops written criteria to assess the need for continued stay.

2. The group develops more extensive written criteria for cases that its experience shows are:

a. Associated with high costs;

b. Associated with frequent furnishing of excessive services; or

c. Attended by physicians whose patterns of care are frequently found to be questionable.

(j) Initial continued stay review date. The UR plan must provide that:

1. When a recipient is admitted to the ICF under admission review requirements of this subpart, the group performing UR assigns a specified date by which the need for his continued stay will be reviewed;

2. The group performing UR bases its assignment of the initial continued stay review date on the methods and criteria required to be described under HSS 105.11(5)(l);

3. The initial continued stay review date is:

a. Not later than 6 months after admission; or

b. Earlier than 6 months after admission, if indicated at the time of admission; and

4. The group performing UR insures that the initial continued stay review date is recorded in the recipient's record.

(k) Subsequent continued stay review dates. The UR plan must provide that:

1. The group performing UR assigns subsequent continued stay review dates in accordance with HSS 105.11(5)(l).

2. The group assigns a subsequent continued stay review date each time it decides under HSS 105.11(5)(m) that the continued stay is needed:

a. At least every 6 months; or

b. More frequently than every six months if indicated at the time of continued stay review; and

3. The group insures that each continued stay review date it assigns is recorded in the recipeint's record.

(l) Description of methods and criteria; Continued stay review dates. The UR plan must describe the methods and criteria that the group performing UR uses to assign initial and subsequent continued stay review dates under HSS 105.11(5)(j) and (k).

(m) Continued stay review process. The UR plan must provide that

1. Review of continued stay cases is conducted by:

a. The group performing UR; or

b. A designee of the UR group;

2. The group or its designee reviews a recipient's continued stay on or before the expiration of each assigned continued stay review date.

3. For each continued stay of a recipient in the ICF, the group or its designee reviews and evaluates the documentation described under HSS 105.11(5)(e) against the criteria developed under HSS 105.11(5)(i) and applies close professional scrutiny to cases described under HSS 105.11(5)(i)2;

4. If the group or its designee finds that a recipient's continued stay in the ICF is needed, the group assigns a new continued stay review date in accordance with HSS 105.11(5)(k);

5. If the group or its designee finds that a continued stay case does not meet the criteria, the group or a subgroup that includes at least one physician reviews the case to decide the need for continued stay;

6. If the group or subgroup making the review under paragraph 5 of this section finds that a continued stay is not needed, it notifies the recipient's attending physician or, in institutions for the mentally retarded, the recipient's qualified mental retardation professional, within 1 working day of its decision, and gives the physician or the professional 2 working days from the notification date to present the person's views before it makes a final decision on the need for the continued stay;

7. If the attending physician or qualified mental retardation professional does not present additional information or clarification of the need for the continued stay, the decision of the UR group is final;

8. If the attending physician or qualified mental retardation professional presents additional information or clarification, the need for continued stay is reviewed by:

a. The physician member(s) of the UR group, in cases involving a medical determination; and

9. If the individuals performing the review under paragraph (h) of this section find that the recipient no longer needs ICF services, their decision is final.

(n) Notification of adverse decision. The UR plan must provide that written notice of any adverse final decision on the need for continued stay under HSS 105.11(5)(m)7 through 9 is sent to:

1. The ICF administrator;
2. The attending physician;
3. The qualified mental retardation professional, if applicable;
4. The medicaid agency;
5. The recipient; and
6. If possible, the next of kin or sponsor.

(o) Time limits for notification of adverse decision. The UR plan must provide that the group gives notice under HSS 105.11(5)(n) of an adverse decision not later than 2 days after the date of the final decision.

HSS 105.115 Standards for Intermediate Care Facilities Other Than Facilities for the Mentally Retarded. This subpart prescribes standards for care, safety, and sanitation in intermediate care facilities. It applies to ICF's other than ICF's/MR.

(1) Methods of administration. An ICF must have methods of administrative management that insure that it meets the requirements of HSS 105.115(2) through (15).

(2) Staffing. The ICF must have staff on duty 24 hours a day sufficient in number and qualifications to carry out the policies, responsibilities, and programs of the ICF.

(3) Administrator.

(a) The ICF must have an administrator who is:

1. A nursing home administrator with a current state license; or

2. A hospital administrator, if the ICF is a hospital qualifying as an intermediate care facility.

(b) The administrator's responsibilities must include:

1. Managing the ICF; and
2. Implementing established policies and procedures.

(4) Resident services director.

(a) The ICF must designate the administrator or a professional staff member as resident services director.

(b) The duties of the resident services director must include coordinating and monitoring each resident's overall plan of care.

(5) Written policies and procedures: General requirements. The ICF must have written policies and procedures that:

(a) Govern all services provided by the ICF; and

(b) Are available to the staff, residents, members of the family and legal representatives of residents, and the public.

(6) Written policies and procedures: Admission. The ICF must have written policies and procedures that insure that it admits as residents only those individuals whose needs can be met:

(a) By the ICF itself;

(b) By the ICF in cooperation with community resources; or

(c) By the ICF in cooperation with other providers of care affiliated with or under contract to the ICF.

(7) Written policies and procedures: Transfer and discharge. The ICF must have written policies and procedures that insure that:

(a) It transfers a resident promptly to a hospital, skilled nursing facility, or other appropriate facility, when a change occurs in the resident's physical or mental condition that requires care or service that the ICF cannot adequately provide; and

(b) Except in an emergency, it:

1. Consults the resident, next of kin, the attending physician, and the responsible agency, if any, at least five days before a transfer or discharge; and

2. Uses casework services or other means to insure that adequate arrangements are made to meet the resident's needs through other resources.

(c) In the case of a transfer, a copy of the plans of care and medical records shall be maintained in the facility from which the patient is transferred. The records of transferral patients shall be retained for 5 years from date of transfer.

(8) Written policies and procedures: Chemical and physical restraints. The ICF must have written policies and procedures that:

(a) Define the uses of chemical and physical restraints;

(b) Identify the professional personnel who may, under s.50.09(1)(k), Stats., authorize use of these restraints in emergencies; and

(c) Describe the procedures for monitoring and controlling the use of these restraints.

(9) Written policies and procedures: Resident complaints and recommendations. The ICF must have written policies and procedures that:

(a) Describe the procedures the ICF uses to receive complaints and recommendations from its residents; and

(b) Insure that the ICF responds to these complaints and recommendations. All such policies and procedures shall comply with the requirements of s.50.09(6) Stats.

(10) Written policies and procedures: Resident records. The ICF must have written policies and procedures governing access to, duplication of, and dissemination of information from the resident's record.

(11) Written policies and procedures: Residents' bill of rights. The facility shall comply with the requirements governing residents' rights enumerated in s.50.09, Stats. and Wis. Adm. Code H32.055. The facility shall have written policies and procedures governing residents' rights.

(12) Written policies and procedures: Delegation of rights and responsibilities. Pursuant to s.50.09(3), Stats., the ICF must have written policies and procedures that provide that all rights and responsibilities of a resident pass to the resident's guardian, next of kin, or sponsoring agency or agencies if the resident is adjudicated incompetent under Ch. 51 or 880, Stats.

(13) Emergencies. The ICF must:

(a) Have a written plan for staff and residents to follow in case of an emergency such as a fire or an explosion and must rehearse the plan regularly; and

(b) Have written procedure for the staff to follow in case of an emergency involving a resident. These emergency procedures must include directions for:

1. Caring for the resident;

2. Notifying the attending physician and other individuals responsible for the resident; and

3. Arranging for transportation, hospitalization, or other appropriate services.

(14) Staff training programs. The ICF must:

(a) Conduct an orientation program for all new employees that includes a review of all its policies;

(b) Plan and conduct an inservice staff development program for all personnel to assist them in developing and improving their skills; and

(c) Maintain a record of each orientation and staff development program it conducts. The record must include the content of the program and the names of the participants.

(15) Health and safety laws. The ICF must meet all federal, state and local laws, regulations, and codes pertaining to health and safety, such as provisions regulating:

(a) Buying, dispensing, safeguarding, administering, and disposing of medications and controlled substances;

(b) Construction, maintenance, and equipment for the ICF;

(c) Sanitation;

(d) Communicable and reportable diseases; and

(e) Post mortem procedures.

(16) Transfer agreements.

(a) Except as provided in paragraph (b) of this section, the ICF must have in effect a transfer agreement with one or more hospitals sufficiently close by to make feasible the prompt transfer of the resident and records to the hospital and to support a working arrangement between the ICF and the hospital for providing inpatient hospital services to residents when needed.

(b) If the department finds that the ICF tried in good faith to enter into an agreement but could not, the ICF will be considered to meet the requirements of paragraph (a) as long as the survey agency finds that it is in the public interest and essential to assuring ICF services for eligible individuals in the community.

(17) Arrangements with outside resources.

(a) If the ICF does not employ a qualified professional to furnish a required institutional service, it must have in effect a written agreement with a qualified professional outside the ICF to furnish the required service.

(b) The agreement must:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by the ICF and the qualified professional; and

2. Be signed by the administrator or his representative and by the qualified professional.

(c) The ICF must maintain effective arrangements with outside resources for promptly providing medical and remedial services required by a resident but not regularly provided within the ICF.

(18) Resident record system.

(a) The ICF must maintain an organized resident record system that contains a record for each resident. The original copy of the record shall be maintained on the premises of the nursing home.

(b) The ICF must make resident records available to staff directly involved with the resident and to appropriate representatives of the department.

(c) Each resident's record must contain:

1. Identification information;

2. Admission information, including the medical and social history of the resident;

3. The original copy of the overall plan of care as described in HSS 105.115(19);

4. Copies of the initial and periodic examinations, evaluations, progress notes, all plans of care with subsequent changes, and discharge summaries;

5. Description of treatments and services provided and medications administered; and

6. All indications of illness or injury including the date, time, and action taken regarding each.

(d) The ICF must protect the resident records against destruction, loss, and unauthorized use.

(e) The ICF must keep a resident's record for at least 5 years after the date the resident is discharged.

(19) Overall plan of care. The overall plan of care required by HSS 105.115(18) must:

(a) Set the goals to be accomplished by the resident;

(b) Prescribe an integrated program of activities, therapies, and treatments designed to help each resident achieve treatment goals; and

(c) Indicate which professional service or individual is responsible for each service prescribed in the plan.

(20) Resident financial records.

(a) The ICF must maintain a current, written financial record for each resident that includes written receipts for:

1. All personal possessions and funds received by or deposited with the ICF; and

2. All disbursements made to or for the resident.

(b) The financial record must be available to the resident and his family.

(21) Fire protection. Except as provided in HSS 105.115 (22) and (23), the ICF must meet the provisions of the Life Safety Code of the National Fire Protection Association, 1967 edition, that apply to institutional occupancies.

(22) Fire protection: Exception for smaller ICF's. The department may apply the lodgings or rooming houses section of the residential occupancy requirements of the Life Safety Code of the National Fire Protection Association, 1967 edition, instead of the institutional occupancy provisions required by HSS 105.115 (21) to an ICF that has 15 beds or less if the ICF is primarily engaged in the treatment of alcoholism and drug abuse and a physician certifies that each resident is:

(a) Ambulatory;

(b) Engaged in an active program for rehabilitation designed to and reasonably expected to lead to independent living; and

(c) Capable of following directions and taking appropriate action for self-preservation under emergency conditions.

(23) Fire protection: Waivers.

(a) The department may waive specific provisions of the Life Safety Code required by HSS 105.115 (21), for as long as it considers appropriate, if:

1. The waiver would not adversely affect the health and safety of the residents;

2. Rigid application of specific provisions of the Code would result in unreasonable hardship for the ICF as determined under guidelines contained in the HCFA Long Term Care Manual; and

3. The waiver is granted in accordance with criteria contained in the Long Term Care Manual.

(b) If the department waives provisions of the Code for an existing building of two or more stories that is not built of at least 2-hour fire-resistive construction, the ICF may not house a blind, nonambulatory, or physically handicapped resident above the street-level floor unless it is built of:

1. One-hour protected, noncumbustible construction as defined in National Fire Protection Association Standard No. 220;

2. Fully sprinklered, 1-hour protected, ordinary construction; or

3. Fully sprinklered, 1-hour protected, wood frame construction.

(24) Resident living areas. The ICF must:

(a) Design and equip the resident living areas for the comfort and privacy of each resident; and

(b) Have handrails that are firmly attached to the walls in all corridors used by residents.

(25) Residents' rooms.

(a) Each resident room must:

1. Be equipped with or conveniently located near toilet and bathing facilities;

2. Be at or above grade level;

3. Contain a suitable bed for each resident and other appropriate furniture;

4. Have closet space that provides security and privacy for clothing and personal belongings;

5. Contain no more than four beds;

6. Measure at least 100 square feet for a single-resident room or 80 square feet for each resident for a multiresident room; and

7. Be equipped with a device for calling the staff member on duty.

(b) For an existing building, the department may waive the space and occupancy requirements of paragraphs (a)(5) and (6) of this section for as long as it is considered appropriate if it finds that:

1. The requirements would result in unreasonable hardship on the ICF if strictly enforced; and

2. The waiver serves the particular needs of the residents and does not adversely affect their health and safety.

(26) Bathroom facilities. The ICF must:

(a) Have toilet and bathing facilities that are located in or near residents' rooms and are appropriate in number, size, and design to meet the needs of the residents;

(b) Provide an adequate supply of hot water at all times for resident use; and

(c) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by residents.

(27) Linen supplies. The ICF must have available at all times enough linen for the proper care and comfort of the residents and have clean linen on each bed.

(28) Therapy and isolation areas.

(a) The ICF's therapy area must be of sufficient size and appropriate design to:

1. Accommodate the necessary equipment;

2. Conduct an examination; and

3. Provide treatment.

(b) The ICF must make provision for isolating residents with infectious diseases.

(29) Dining, recreation, and social rooms.

(a) The ICF must provide one or more areas, not used for corridor traffic, for dining, recreation, and social activities.

(b) A multipurpose room may be used if it is large enough to accommodate all of the activities without their interfering with each other.

(30) Building accessibility and use.

(a) The ICF must:

1. Be accessible to and usable by all residents, personnel, and the public, including individuals with disabilities; and

2. Meet the requirements of American National Standards Institute (ANSI) standard No. A117.1 (1961), American standard specifications for making building and facilities accessible to and usable by the physically handicapped.

(b) The department may waive, for as long as it considers appropriate, provisions of ANSI standard No. A117.1 (1961) if:

1. The construction plans for the ICF or a part of it were approved and stamped by the department before March 18, 1974;

2. The provisions would result in unreasonable hardship on the ICF if strictly enforced; and

3. The waiver does not adversely affect the health and safety of the residents.

(31) Meal service. The ICF must:

(a) Serve at least three meals or their equivalent each day at regular times, not more than 14 hours between a substantial evening meal and breakfast;

(b) Procure, store, prepare, distribute, and serve all food under sanitary conditions; and

(c) Provide special eating equipment and utensils for residents who need them.

(32) Menu planning and supervision.

(a) The ICF must have a staff member trained or experienced in food management or nutrition who is responsible for:

1. Planning menus that meet the nutritional needs of each resident, following the orders of the resident's physician and, to the extent medically possible, the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. (Recommended Dietary Allowances (8th ed., 1974) is available from the Printing and Publications Office, National Academy of Sciences, Washington, D.C. 20418); and

2. Supervising the meal preparation and service to insure that the menu plan is followed.

(b) If the ICF has residents who require medically prescribed special diets, the ICF must:

1. Have the menus for those residents planned by a professionally qualified dietitian, or reviewed and approved by the attending physician; and

2. Supervise the preparation and serving of meals to insure that the resident accepts the special diet.

(c) The ICF must keep for 30 days a record of each menu as served.

(33) Licensed pharmacist. The ICF must either:

(a) Employ a licensed pharmacist; or

(b) Have a formal arrangement with a licensed pharmacist to advise the ICF on ordering, storage, administration, disposal, and recordkeeping of drugs and biologicals.

(34) Orders for medications.

(a) The resident's attending or staff physician must order all medications for the resident.

(b) The order may be either oral or written.

(c) If the order is oral:

1. The physician must give it only to a licensed nurse, pharmacist, or another physician; and

2. The individual receiving the order must record and sign it immediately and have the attending physician sign it in a manner consistent with good medical practice.

(35) Methods to control medication dosage. The ICF must have written policies and procedures for controlling medication dosage, by automatic stop orders or other methods, when the physician does not include in the order a specific limit on the time or number of doses. These procedures must include notice to the attending physician that the medication is being stopped as of a certain date or after a certain number of doses.

(36) Review of medications.

(a) A registered nurse must review medications monthly for each resident and notify the physician if changes are appropriate.

(b) The attending or staff physician must review the medications quarterly.

(37) Administering medications.

(a) Before administering any medication to a resident, a staff member must complete a state-approved training program in medication administration.

(b) The ICF may allow a resident to give to self a medication only if the attending physician gives permission.

(38) Health services.

(a) The ICF must provide for each resident health services that:

1. Meet the requirements of HSS 105.115(39) through (42); and

2. Include treatment, medications, diet, and any other health service prescribed or planned for the resident.

(b) The ICF must provide these services 24 hours a day.

(39) Supervision.

(a) The ICF must have a registered nurse or a licensed practical or vocational nurse to supervise the ICF's health services full time, 7 days a week, on the day shift.

(b) The nurse must have a current licensed to practice in the state.

(c) If the ICF employs a licensed practical or vocational nurse to supervise health services, the ICF must have a formal contract with a registered nurse to consult with the licensed practical or vocational nurse at regular intervals, but not less than four hours each week.

(d) To be qualified to serve as a health services supervisor, a licensed practical or vocational nurse must be licensed pursuant to s.441.10, Stats.

(40) 24-Hour staffing. The ICF must have responsible staff members on duty and awake 24 hours a day to take prompt, appropriate action in case of injury, illness, fire, or other emergency.

(41) Individual health care plan.

(a) Appropriate staff must develop and implement a written health care plan for each resident according to the instructions of the attending or staff physician.

(b) The plan must be reviewed and revised as needed but at least quarterly.

(42) Nursing care. The ICF must provide nursing care for each resident as needed, including restorative nursing care that enables each resident to achieve and maintain the highest possible degree of function, self-care, and independence.

(43) Rehabilitative services.

(a) The ICF must provide rehabilitative services for each resident as needed.

(b) The ICF must either provide these services itself or arrange for them with qualified outside resources.

(c) The rehabilitative services must be designed to:

1. Maintain and improve the resident's ability to function independently;

2. Prevent, as much as possible, advancement of progressive disabilities; and

3. Restore maximum function.

(d) The rehabilitative services must be provided by:

1. Qualified therapists or qualified assistants, as defined in HSS 101, in accordance with accepted professional practices, or

2. Other supportive personnel under appropriate supervision.

(e) The rehabilitative services must be provided under a written plan of care that is:

1. Developed in consultation with the attending physician and, if necessary, an appropriate therapist; and

2. Based on the attending physician's orders and an assessment of the resident's needs.

(f) The resident's progress under the plan must be reviewed regularly and the plan must be changed as necessary.

(44) Social services.

(a) The ICF must provide social services for each resident as needed.

(b) The ICF must either provide these services itself or arrange for them with qualified outside resources.

(c) The ICF must designate one staff member, qualified by training or experience, to be responsible for:

1. Arranging for social services; and

2. Integrating social services with other elements of the plan of care.

(d) These services must be provided under a written plan of care that is:

1. Placed in the resident's record; and

2. Evaluated periodically in conjunction with the resident's overall plan of care.

(45) Activities program. The ICF must:

(a) Provide an activities program designed to encourage each resident to maintain normal activity and to return to self-care;

(b) Designate one staff member, qualified by training or experience in directing group activity, to be responsible for it;

(c) Have a plan for independent and group activities for each resident that is:

1. Developed according to his needs and interests;

2. Incorporated in his overall plan of care;

3. Reviewed, with his participation, at least quarterly; and

4. Changed as needed.

(d) Provide adequate recreation areas with sufficient equipment and materials to support the program.

(46) Physician services.

(a) The ICF must have policies and procedures to insure that the health care of each resident is under the continuing supervision of a physician.

(b) The physician must see the resident whenever necessary but at least every 60 days unless the physician decides that this frequency is unnecessary and records the reasons for that decision.

(47) Other requirements. The requirements in HSS 105.10(19) and HSS 105.106 shall apply to ICFs where applicable.

HSS 105.12 Requirements for Certification of Intermediate Care Facility services in an institution for the mentally retarded or persons with related conditions. Institutions for the mentally retarded or persons with related conditions are required to be licensed pursuant to s. 50.03, Stats., and to meet the standards in this section.

[Note: The following rules are a codification of 42 CFR Subpart G. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the federal regulations shall hold. These rules will be placed into the next complete revision of Wis. Adm. Code Chapter H-32, at which time these rules will be repealed.]

(1) Philosophy, objectives, and goals.

(a) The ICF/MR must have a written outline of the philosophy, objectives, and goals it is striving to achieve that includes, at least:

1. The ICF/MR's role in the state comprehensive program for the mentally retarded;

2. The ICF/MR's goals for its residents; and

3. The ICF/MR's concept of its relationship to the parents or legal guardians of its residents.

(b) The outline must be available for distribution to staff, consumer representatives, and the interested public.

(2) Resident's civil rights. The ICF/MR must have written policies and procedures that insure the civil rights of all residents.

(3) Residents' bill of rights. The facility shall comply with the requirements governing residents' rights enumerated in s.50.09, Stats. and Wis. Adm. Code H 32.055. The facility must have written policies and procedures that insure residents' rights are met.

(4) Delegation of rights and responsibilities. Pursuant to s.50.09(3), Stats., the ICF/MR must have written policies and procedures that provide that all rights and responsibilities of a resident pass to the resident's guardian, next of kin, or sponsoring agency or agencies if the resident is adjudicated incompetent under Ch.51 or 880, Stats.

(5) Resident finances.

(a) The ICF/MR must have written policies and procedures that protect the financial interests of each resident.

(b) If large sums accrue to a resident, the policies and procedures must provide for appropriate protection of these funds and for counseling the resident concerning their use.

(c) Each resident must be allowed to possess and use money in normal ways or be learning to do so.

(d) The ICF/MR must maintain a current, written financial record for each resident that includes written receipts for:

1. All personal possessions and funds received by or deposited with the ICF/MR; and

2. All disbursements made to or for the resident.

(e) The financial record must be available to the resident and his family.

(6) Policy and procedure manuals. The ICF/MR must have manuals that:

(a) Describe the policies and procedures in the major operating units of the ICF/MR;

(b) Are current, relevant, and available; and

(c) Are complied with by the units.

(7) Management audit plan. The ICF/MR must have a plan for a continuing management audit to insure that the ICF/MR:

(a) Complies with state laws and regulations; and

(b) Effectively implements its policies and procedures.

(8) Governing body.

(a) The ICF/MR must have a governing body that:

1. Exercises general direction over the affairs of the ICF/MR;

2. Establishes policies concerning the operation of the ICF/MR and the welfare of the individuals it serves;

3. Establishes qualifications for the chief executive officer in the following areas: education, experience; personal factors; skills; and

4. Appoints the chief executive officer.

(b) The governing body may consist of one individual or a group.

(9) Chief executive officer.

(a) The chief executive officer must:

1. Act for the governing body in the overall management of the ICF/MR; and

2. Arrange for one individual to be responsible for the administrative direction of the ICF/MR at all times.

(b) The chief executive officer must be an individual licensed in the state as a nursing home administrator or a qualified mental retardation professional except:

1. If the ICF/MR is licensed as a nursing home, the chief executive officer must be an individual licensed in the state as a nursing home administrator;

2. If the ICF/MR is a hospital qualifying as an institution for the mentally retarded or persons with related conditions, the chief executive officer must be a hospital administrator.

(c) Job titles for the chief executive officer may include any of the following: superintendent, director, and administrator.

(10) Qualified mental retardation professional. The ICF/MR must have a qualified mental retardation professional who is responsible for:

(a) Supervising the delivery of each resident's individual plan of care;

(b) Supervising the delivery of training and habilitation services;

(c) Integrating the various aspects of the ICF/MR's program;

(d) Recording each resident's progress; and

(e) Initiating a periodic review of each individual plan of care for necessary changes.

(11) Organization chart. The ICF/MR must have an organization chart that shows:

(a) The major operating programs of the ICF/MR;

(b) The staff divisions of the ICF/MR;
(c) The administrative personnel in charge of the programs and divisions; and
(d) The lines of authority, responsibility, and communication for administrative personnel.

(12) Staff-resident communications. The ICF/MR must provide for effective staff and resident participation and communication in the following manners:
(a) The ICF/MR must establish appropriate standing committees such as human rights, research review, and infection.
(b) The committees must meet regularly and include direct-care staff whenever appropriate.
(c) Reports of staff meetings and standing and ad hoc committee meetings must include recommendations and their implementation, and be filed.

(13) Communication with residents and parents.
(a) The ICF/MR must have an active program of communication with the residents and their families, that includes:
1. Keeping residents' families or legal guardians informed of resident activities that may be of interest to them or of significant changes in the resident's condition;
2. Answering communications from resident's relatives promptly and appropriately;
3. Allowing close relatives and guardians to visit at any reasonable hour, without prior notice, unless the resident's needs limit visits;
4. Allowing parents to visit any part of the ICF/MR that provides services to residents;
5. Encouraging frequent and informal visits home by the residents; and
6. Having rules that make it easy to arrange visits home.
(b) The ICF/MR must insure that individuals allowed to visit the ICF/MR under paragraph (a)(3) of this section do not infringe on the privacy and rights of the other residents.

(14) Health and safety laws. The ICF/MR must meet all federal, state, and local laws, regulations and codes pertaining to health and safety, such as provisions regulating:
(a) Buying, dispensing, safeguarding, administering, and disposing of medications and controlled substances;
(b) Construction, maintenance, and equipment for the ICF/MR;
(c) Sanitation;
(d) Communicable and reportable diseases; and
(e) Post-mortem procedures.

(15) Research statement. If the ICF/MR conducts research, it must comply with the statement of assurance on research involving human subjects required by 45 CFR 46.104 through 46.108.

(16) Agreements with outside resources.

(a) If the ICF/MR does not employ a qualified professional to furnish a required institutional service, it must have in effect a written agreement with a qualified professional outside the ICF/MR to furnish the required service.

(b) The agreement must:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by the ICF/MR and the qualified professional; and

2. Be signed by the administrator or his representative and by the qualified professional.

(17) Admission criteria and evaluations.

(a) Except as provided in paragraph (c) of this section, an ICF/MR may not admit an individual as a resident unless the person's needs can be met and an interdisciplinary professional team has determined that admission is the best available plan for that individual.

(b) The team must:

1. Conduct a comprehensive evaluation of the individual covering the physical, emotional, social, and cognitive factors; and

2. Before the individual's admission:

a. Define the need for service without regard to the availability of those services; and

b. Review all available and applicable programs of care, treatment, and training and record its findings.

(c) If admission is not the best plan but the individual must be admitted nevertheless, the ICF/MR must:

1. Clearly acknowledge that the admission is inappropriate; and

2. Initiate plans to actively explore alternatives.

(18) Availability of rules and procedures. The facility must make available for distribution a summary of the laws, regulations, and procedures concerning admission, readmission, and release of a resident.

(19) Number of residents. The ICF/MR must admit only that number of individuals that does not exceed:

(a) Its rated capacity; and

(b) Its capability to provide adequate programming.

(20) Review of preadmission evaluation. Within 1 month after admission, the interdisciplinary professional team must:

(a) Review and update the preadmission evaluation with the participation of direct care personnel;

(b) Develop, with the participation of direct care personnel, a prognosis that can be used for programming and placement;

(c) Record the results of the evaluation in the resident's record kept in the living unit; and

(d) Write an interpretation of the evaluation in terms of specific actions to be taken for:

1. The direct care personnel and the special services staff responsible for carrying out the resident's program; and

2. The resident's parents or legal guardian.

(21) Annual review of resident's status.

(a) All relevant personnel of the ICF/MR, including personnel in the living unit, must jointly review the status of each resident at least once a year and produce program recommendations.

(b) This review must include consideration of the following:

1. The advisability of continued residence and alternative programs.

2. When the resident legally becomes an adult:

a. The need for guardianship; and

b. How the resident may exercise civil and legal rights.

(22) Record and reports of reviews. The results of the reviews required by HSS 105.12 (20) and (21) must be:

(a) Recorded in the resident's record kept in the living unit;

(b) Made available to personnel involved in the direct care of the resident;

(c) Interpreted to the resident's parents or legal guardian who are involved in planning and decisionmaking; and

(d) Interpreted to the resident, when appropriate.

(23) Release from the ICF/MR.

(a) The ICF/MR must establish procedures for counseling a parent or guardian who requests the release of a resident concerning the advantages and disadvantages of the release.

(b) Planning for release of a resident must include providing for appropriate services in the resident's new environment, including protective supervision and other followup services.

(c) When a resident is permanently released, the ICF/MR must prepare and place in the resident's record a summary of findings, progress, and plans.

(24) Transfer to another facility.

(a) Except as provided in paragraph (b) of this section, the ICF/MR must have in effect a transfer agreement with one or more hospitals sufficiently close by to make feasible the prompt transfer of the resident and his records to the hospital and to support a working arrangement between the ICF/MR and the hospital for providing inpatient hospital services to residents when needed.

(b) If the department finds that the ICF/MR tried in good faith to enter into an agreement but could not, the ICF/MR will not be considered to meet the requirements of paragraph (a) as long as the department finds that it is in the public interest and essential to assuring ICF/MR services for eligible individuals in the community.

(c) When a resident is transferred to another facility, the ICF/MR making the transfer must:

1. Record the reason for the transfer and a summary of findings, progress, and plans;

2. Except in an emergency, inform the resident and parent or guardian in advance and obtain their written consent to transfer; and

3. Retain a copy of the resident's records, including plans of care and other pertinent medical records for 5 years from the date of transfer.

(25) Emergencies or death of a resident.

(a) The ICF/MR must notify promptly the resident's next of kin or guardian of any unusual occurrence concerning the resident, including serious illness, accident, or death.

(b) If any autopsy is performed after a resident's death:

1. A qualified physician who has no conflict of interest or loyalty to the ICF/MR must perform the autopsy; and

2. The resident's family must be told of the autopsy findings if they so desire.

(26) Written policies. The ICF/MR must:

(a) Have written personnel policies that are available to all employees;

(b) Make written job descriptions available for all positions; and

(c) Have written policies that prohibit employees with symptoms or signs of a communicable disease from working.

(27) Licensure and professional standards. The ICF/MR must:

(a) Require the same licensure, certification, or standards for positions in the facility as are required for comparable positions in community practice; and

(b) Take into account in its personnel activities the ethical standards of professional conduct developed by professional societies.

(28) Suspension and dismissal. The ICF/MR must have an authorized procedure, consistent with due process, for suspending or dismissing an employee.

(29) Staff treatment of residents.

(a) The ICF/MR must have written policies that prohibit mistreatment, neglect, or abuse of a resident by an employee of the ICF/MR.

(b) The ICF/MR must insure that all alleged violations of these policies are reported immediately.

(c) The ICF/MR must have evidence that:

1. All violations are investigated thoroughly;

2. The results of the investigation are reported to the chief executive or a designated representative within 24 hours of the report of the incident; and

3. If the alleged violation is verified, the chief executive officer imposes an appropriate penalty.

(30) Sufficient staffing and resident work.

(a) The ICF/MR must have a staff of sufficient size that the ICF/MR does not depend on residents or volunteers for services.

(b) The ICF/MR must have a written policy to protect residents from exploitation if they engage in productive work.

(31) Staff training program.

(a) The ICF/MR must have a staff training program, appropriate to the size and nature of the ICF/MR, that includes:

1. Orientation for each new employee to acquaint the employee with the philosophy, organization, program, practices, and goals of the ICF/MR;

2. Inservice training for any employee who has not achieved the desired level of competence;

3. Continuing inservice training for all employees to update and improve their skills; and

4. Supervisory and management training for each employee who is in, or a candidate for, a supervisor position.

(b) If appropriate to the size and nature of the ICF/MR it must have someone designated to be responsible for staff development and training.

(32) Responsibilities of living unit staff.

(a) The living unit staff must make care and development of the residents their primary responsibility. This includes training each resident in the activities of daily living and in the development of self-help and social skills.

(b) The ICF/MR must insure that the staff are not diverted from their primary responsibilities by excessive housekeeping or clerical duties or other activities not related to resident care.

(c) Members of the living unit staff from all shifts must participate in appropriate activities relating to the care and development of the resident including, at least, referral, planning, initiation, coordination, implementation, followthrough, monitoring, and evaluation.

(33) Resident evaluation and program plans. The ICF/MR must have specific evaluation and program plans for each resident that are:

(a) Available to direct care staff in each living unit; and

(b) Reviewed by a member or members of an interdisciplinary professional team at least monthly with documentation of the review entered in the resident's record.

(34) Resident activities.

(a) The ICF/MR must develop an activity schedule for each resident that:

1. Does not allow periods of unscheduled activity to extend longer than 3 continuous hours;

2. Allows free time for individual or group activities using appropriate materials, as specified by the program team; and

3. Includes planned outdoor periods all year round.

(b) Each resident's activity schedule must be available to direct care staff and be carried out daily.

(c) The ICF/MR must insure that a multiple-handicapped or non-ambulatory resident:

1. Spends a major portion of the waking day out of bed;

2. Spends a portion of the waking day out of his bedroom area;

3. Has planned daily activity and exercise periods; and

4. Moves around by various methods and devices whenever possible.

(35) Personal possessions. The ICF/MR must allow the residents to have personal possessions such as toys, books, pictures, games, radios, arts and crafts materials, religious articles, toiletries, jewelry, and letters.

(36) Control and discipline of residents.

(a) The ICF/MR must have written policies and procedures for the control and discipline of residents that are available in each living unit and to parents and guardians.

(b) If appropriate, residents must participate in formulating these policies and procedures.

(c) The ICF/MR may not allow:

1. Corporal punishment of a resident;

2. A resident to discipline another resident, unless it is done as part of an organized self-government program conducted in accordance with written policy; or

3. A resident to be place alone in a locked room.

(37) Physical restraint of residents.

(a) Pursuant to s.50.09(1)(k), Stats., the ICF/MR may allow the use of physical restraint on a resident in an emergency if absolutely necessary to protect the resident from injuring self or others or property. All other provisions of s.50.09(1)(k), Stats., regarding physical restraints shall be complied with. The facility's policies governing the use of physical restraints shall be in written form.

(b) Appropriately trained staff must check a resident placed in a physical restraint at least every 30 minutes and keep a record of these checks.

(c) A resident who is in a physical restraint must be given an opportunity for motion and exercise for a period of not less than 10 minutes during each 2 hours of restraint.

(38) Mechanical devices used for physical restraint.

(a) Mechanical devices used for physical restraint must be designed and used in a way that causes the resident no physical injury and the least possible physical discomfort.

(b) A totally enclosed crib or a barred enclosure is a physical restraint.

(c) Mechanical supports used to achieve proper body position and balance are not physical restraints. However, mechanical supports must be designed and applied:

1. Under the supervision of a qualified professional; and

2. In accordance with principles of good body alignment, concern for circulation, and allowance for change of position.

(39) Chemical restraint of residents. The ICF/MR shall comply with the provisions of s.50.09(1)(k), Stats. regarding chemical restraints. In addition, the ICF/MR may not use chemical restraint:

(a) Excessively;

(b) As punishment;

(c) For the convenience of the staff;

(d) As a substitute for the activities or treatment; or

(e) In quantities that interfere with a resident's habilitation program.

(40) Behavior modification programs.

(a) For purposes of this section: "Aversive stimuli" means things or events that the resident finds unpleasant or painful that are used to immediately discourage undesired behavior. "Time-out" means a procedure designed to improve a resident's behavior by removing positive reinforcement when the behavior is undesirable.

(b) Behavior modification programs involving the use of aversive stimuli or time-out devices must be:

1. Reviewed and approved by the ICF/MR's human rights committee or the qualified mental retardation professional;

2. Conducted only with the consent of the affected resident's parents or legal guardian; and

3. Described in written plans that are kept on file in the ICF/MR.

(c) A physical restraint used as a time-out device may be applied only during behavior modification exercises and only in the presence of the trainer.

(d) For time-out purposes, time-out devices and aversive stimuli may not be used for longer than one hour, and then only during the behavior modification program and only under the supervision of the trainer.

(41) Resident clothing. The ICF/MR must insure that each resident:

(a) Has enough neat, clean, suitable, and seasonable clothing;

(b) Has the resident's own clothing marked with the resident's name when necessary;

(c) Is dressed daily in the resident's own clothes unless this is contraindicated in written medical orders;

(d) Is trained and encouraged, as appropriate, to:

1. Select daily clothing;

2. Dress self;

3. Change clothes to suit activities; and

(e) Has storage space for clothing that is accessible even if the resident is in a wheelchair.

(42) Health, hygiene, grooming and toilet training.

(a) Each resident must be trained to be as independent as possible in health, hygiene, and grooming practices, including bathing, brushing teeth, shampooing, combing and brushing hair, shaving, and caring for toenails and fingernails.

(b) Each resident who does not eliminate appropriately and independently must be in a regular, systematic toilet training program and a record must be kept of progress in the program.

(c) A resident who is incontinent must be bathed or cleaned immediately upon voiding or soiling, unless specifically contraindicated by the training program, and all soiled items must be changed.

(d) The ICF/MR must establish procedures for:

1. Weighing each resident monthly, unless the special needs of the resident require more frequent weighing;

2. Measuring the height of each resident every 3 months until the resident reaches the age of maximum growth;

3. Maintaining weight and height records for each resident; and

4. Insuring that each resident maintains a normal weight.

(e) At least every 3 days, a physician must review orders prescribing bed rest or prohibiting a resident from being outdoors.

(f) The ICF/MR must furnish, maintain in good repair, and encourage the use of dentures, eyeglasses, hearing aids, braces, and other aids prescribed for a resident by an appropriate specialist.

(43) Grouping and organization of living units.

(a) The ICF/MR may not house residents of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(b) The ICF/MR may not segregate residents on the basis of their physical handicaps. It must integrate residents who are mobile non-ambulatory, deaf, blind, epileptic, and so forth with others of comparable social and intellectual development.

(44) Resident living staff.

(a) Each resident living unit must have sufficient, appropriately qualified, and adequately trained personnel to conduct the resident living program as required by this subpart.

(b) The ICF/MR must have an individual, whose training and experience is appropriate to the program, who is administratively responsible for resident living personnel.

(c) Each resident living unit, regardless of organization or design, must have, as a minimum, overall staff-resident ratios (allowing for a 5-day work week plus holiday, vacation, and sick time) as follows unless program needs justify otherwise:

1. For units serving children under the age of 6 years, severely and profoundly retarded, severely physically handicapped, or residents who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the overall ratio is 1 to 2.

2. For units serving moderately retarded residents requiring habit training, the overall ratio is 1 to 2.5.

3. For units serving residents in vocational training programs and adults who work in sheltered employment situations, the overall ratio is 1 to 5.

(45) Resident living areas. The ICF/MR must design and equip the resident living areas for the comfort and privacy of each resident.

(46) Resident bedrooms: Space and occupancy.

(a) Bedrooms must:

1. Be at or above street grade level;

2. Be outside rooms;

3. Be equipped with or located near adequate toilet and bathing facilities;

4. Accommodate no more than 4 residents unless granted a variance under paragraph (b) of this section; and

5. Measure at least 60 square feet per resident in multiple resident bedrooms and at least 80 square feet in single resident bedrooms.

(b) The survey agency may grant a variance from the limit of 4 residents per room if it finds that:

1. A physician or psychologist who meets the definition of a qualified mental retardation professional in HSS 101 has justified in each affected resident's plan of care that assignment to a bedroom of more than 4 residents is in accordance with the program needs of that resident; and

2. The variance does not adversely affect the health or safety of the residents.

(c) The variance may be granted only for the period of a specific certification.

(47) Resident bedrooms: Furniture and bedding. The ICF/MR must provide each resident with:

(a) A separate bed of proper size and height for the convenience of the resident;

(b) A clean, comfortable mattress;

(c) Bedding appropriate to the weather and climate; and

(d) Appropriate furniture, such as a chest of drawers, a table or desk, and an individual closet with clothes racks and shelves accessible to the resident.

(48) Storage space in living units. The ICF/MR must provide:

(a) Space for equipment for daily out-of-bed activity for all residents who are not yet mobile, except those who have a short-term illness or those few residents for whom out-of-bed activity is a threat to life;

(b) Suitable storage space, accessible to the resident, for personal possessions, such as toys and prosthetic equipment; and

(c) Adequate clean linen and dirty linen storage areas for each living unit.

(49) Resident bathrooms.

(a) The ICF/MR must:

1. Have toilet and bathing facilities appropriate in number, size, and design to meet the needs of the residents;

2. Provide for individual privacy in toilets, bathtubs, and showers unless specifically contraindicated by program needs;

3. Equip bathrooms and bathroom appliances for use by the physically handicapped; and

4. Control the temperature of the hot water at all taps to which residents have access, by using thermostatically controlled mixing valves or other means, so that the water does not exceed 110 degrees fahrenheit.

(b) The survey agency may grant a variance from the requirement in paragraph (a) (4) of this section if:

1. The hot water taps are in supervised areas; and

2. The purpose of the variance is to train residents in the use of hot water.

(c) The variance must be part of the survey record.

(50) Heating and ventilation in living units.

(a) Each habitable room in the ICF/MR must have:

1. At least one window; and

2. Direct outside ventilation by means of windows, louvers, air conditioning, or mechanical ventilation horizontally and vertically.

(b) The ICF/MR must:

1. Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and

2. Use a heating apparatus that does not constitute a burn hazard to residents.

(51) Floors in living units. The ICF/MR must have:

(a) Floors that have a resilient, nonabrasive, and slip-resistant surface; and

(b) Nonabrasive carpeting, if the living unit is carpeted and serves residents who crawl.

(52) Emergency lighting. If a living unit houses more than 15 residents, it must have emergency lighting with automatic switches for stairs and exits.

(53) Needed services. In addition to the resident living services detailed in Subsections (32) through (52), the ICF/MR must provide professional and special programs and services to residents based upon their needs for these programs and services.

(54) Quality standards for outside resources.

(a) Programs and services provided by the ICF/MR or to the ICF/MR by outside agencies or individuals must meet the standards for quality of services required in this subpart.

(b) All contracts for these services must state that these standards will be met.

(55) Planning and evaluation. Interdisciplinary teams consisting of individuals respresentative of the professions or service areas included in this subpart that are relevant in each particular case, must:

(a) Evaluate each resident's needs;

(b) Plan an individualized habilitation program to meet each resident's responses to his program and revise the program accordingly.

(c) Periodically review each resident's responses to the program and revise the program accordingly.

(56) Diagnostic services.

(a) The ICF/MR must provide each resident with comprehensive diagnostic dental services that include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the resident's oral condition, not later than 1 month after a resident's admission to the ICF/MR unless the resident received the examination within 6 months before admission.

(b) The ICF/MR must review the results of the examination and enter them in the resident's record.

(57) Treatment. The ICF/MR must provide each resident with comprehensive dental treatment that includes:

(a) Provision for emergency dental treatment on a 24-hour-a-day basis by a qualified dentist; and

(b) A system that assures that each resident is reexamined as needed but at least once a year.

(58) Education and training. The ICF/MR must provide education and training in the maintenance of oral health that includes:

(a) A dental hygiene program that informs residents and all staff on nutrition and diet control measures and residents and living unit staff on proper oral hygiene methods; and

(b) Instruction of parents or guardians in the maintenance of proper oral hygiene in appropriate instances, for example when a resident leaves the ICF/MR.

(59) Records. The ICF/MR must:

(a) Keep a permanent dental record for each resident;

(b) Enter a summary dental progress report at stated intervals in each resident's record kept in the living unit;

(c) Provide a copy of the permanent dental record to any facility to which the resident is transferred.

(60) Formal arrangements. The ICF/MR must have a formal arrangement for providing each resident with the dental services required under this subpart.

(61) Staff.

(a) The ICF/MR must have enough qualified dental personnel and support staff to carry out the dental services program.

(b) Each dentist and dental hygienist providing services to the facility must be licensed to practice in the state.

(62) Required services.

(a) The ICF/MR must provide training and habilitation services to all residents, regardless of age, degree of retardation, or accompanying disabilities or handicaps.

(b) Individual evaluations of residents must:

1. Be based upon the use of empirically reliable and valid instruments, whenever these instruments are available; and

2. Provide the basis for prescribing an appropriate program of training experiences for the resident.

(c) The ICF/MR must have written training and habilitation objectives for each resident that are:

1. Based upon complete and relevant diagnostic and prognostic data; and

2. Stated in specific behavioral terms that permit the progress each resident to be assessed.

(d) The ICF/MR must provide evidence of services designed to meet the training and habilitation objectives for each resident.

(e) The training and habilitation staff must:

1. Maintain a functional training and habilitation record for each resident; and

2. Provide training and habilitation services to residents with hearing, vision, perceptual, or motor impairments.

(63) Staff. The ICF/MR must have enough qualified training and habilitation personnel and support staff, supervised by a qualified mental retardation professional, to carry out the training and habilitation program.

(64) Required services. The ICF/MR's food services must include:

(a) Menu planning;

(b) Initiating food orders or requisitions;

(c) Establishing specifications for food purchases and insuring that the specifications are met;

(d) Storing and handling food;

(e) Preparing and serving food;

(f) Maintaining sanitary standards in compliance with State and local regulations; and

(g) Orienting, training, and supervising food service personnel.

(65) Diet requirements.

(a) The ICF/MR must provide each resident with a nourishing, well-balanced diet.

(b) Modified diets must be:

1. Prescribed by the resident's interdisciplinary team with a record of the prescription kept on file;

2. Planned, prepared, and served by individuals who have received adequate instruction; and

3. Periodically reviewed and adjusted as needed.

(c) The ICF/MR must furnish a nourishing, well-balanced diet, in accordance with the recommended daily allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, activity, and disability, unless otherwise required by medical needs. (Recommended Dietary Allowances (8th ed., 1974) is available from the Printing and Publication Office, National Academy of Sciences, Washington, D.C. 20418.)

(d) A resident may not be denied a nutritionally adequate diet as a form of punishment.

(66) Meal service.

(a) The ICF/MR must serve at least three meals daily, at regular times comparable to normal mealtimes in the community with:

1. Not more than 14 hours between a substantial evening meal and breakfast of the following day; and

2. Not less than 10 hours between breakfast and the evening meal of the same day.

(b) Food must be served:

1. In appropriate quantity;

2. At appropriate temperature;

3. In a form consistent with the developmental level of the resident; and

4. With appropriate utensils.

(c) Food served and uneaten must be discarded.

(67) Menus.

(a) Menus must:

1. Be written in advance;

2. Provide a variety of foods at each meal; and

3. Be different for the same days of each week and adjusted for seasonal changes.

(b) The ICF/MR must keep on file, for at least 30 days, records of menus as served and of food purchased.

(68) Food storage. The ICF/MR must store:

(a) Dry or staple food items at least 12 inches above the floor, in a ventilated room not subject ot sewage or waste water backflow or contamination by condensation, leakage, rodents or vermin; and

(b) Perishable foods at proper temperatures to conserve nutritive values.

(69) Work areas. The ICF/MR must:

(a) Have effective procedures for cleaning all equipment and work areas; and

(b) Provide handwashing facilities, including hot and cold water, soap, and paper towels adjacent to work areas.

(70) Dining areas and service. The ICF/MR must:

(a) Serve meals for all residents, including the mobile nonambulatory, in dining rooms, unless otherwise required for health reasons or by decision of the team responsible for the resident's program;

(b) Provide table service for all residents who can and will eat at a table, including residents in wheelchairs;

(c) Equip areas with table, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident; and

(d) Supervise and staff dining rooms adequately to direct self-help dining procedures and to assure that each resident receives enough food.

(71) Training of residents and direct-care staff.

(a) The ICF/MR must provide residents with systematic training to develop appropriate eating skills, using special eating equipment and utensils if it serves the developmental process.

(b) Direct-care staff must be trained in and use proper feeding techniques.

(c) The ICF/MR must insure that residents eat in an upright position, unless medically contraindicated, and in a manner consistent with their developmental needs.

(72) Staff.

(a) The ICF/MR must have enough competent personnel to meet the food and nutrition needs of residents.

(b) A dietition who directs food and nutrition services in ICF's/MR of 20 beds or more must meet the qualification requirements of HSS 101.03.

(c) The ICF/MR must designate a staff member who is trained or experienced in food management or nutrition to direct food and nutrition services in an ICF/MR with less than 20 beds.

(73) Required services. The ICF/MR must:

(a) Provide medical services through contact between physicians and residents and through contact between physicians and individuals working with the residents;

(b) Provide health services including treatment, medications, diet, and any other health service prescribed or planned for the resident, 24 hours a day;

(c) Have available electroencephalographic services as needed;

(d) Have enough space, facilities, and equipment to fulfill the medical needs of residents; and

(e) Provide evidence, such as utilization review committee records, that hospital and laboratory services are used in accordance with professional standards.

(74) Goals and evaluations.

(a) Physicians must participate, when appropriate, in:

1. The continuing interdisciplinary evaluation of individual residents for the purposes of beginning, monitoring, and following up on individualized habilitation programs; and

2. The development for each resident of a detailed, written statement of:

a. Case management goals for physical and mental health, education, and functional and social competence; and

b. A management plan detailing the various habilitation or rehabilitation services to achieve those goals, with clear designation of responsibility for implementation.

(b) The ICF/MR must review and update the statement of treatment goals and management plans as needed, but at least annually, to insure:

1. Continuing appropriateness of the goals;

2. Consistency of management methods with the goals; and

3. The achievement of progress toward the goals.

(75) Arrangements with outside resources. The ICF/MR must:

(a) Have a formal arrangement for providing each resident with medical care that includes care for medical emergencies on a 24-hour-a-day basis;

(b) Designate a physician, licensed to practice medicine in the state, to be responsible for maintaining the general health conditions and practices of the ICF/MR; and

(c) Maintain effective arrangements, for residents to receive prompt medical and remedial services that they require but that the ICF/MR does not regularly provide.

(76) Preventive health services. The ICF/MR must have preventive health services for residents that include:

(a) Means for the prompt detection and referral of health problems, through adequate medical surveillance, periodic inspection, and regular medical examinations;

(b) Annual physical examinations that include:

1. Examination of vision and hearing; and

2. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed;

(c) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices and of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics;

(d) Tuberculosis control, appropriate to the ICF/MR's population, in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics or both; and

(e) Reporting of communicable diseases and infections in accordance with law.

(77) Required services. The ICF/MR must provide residents with nursing services, in accordance with their needs, that include, as appropriate, the following:

(a) Registered nurse participation in:

1. The preadmission evaluation study and plan;

2. The evaluation study, program design, and placement of the resident at the time of admission;

3. The periodic reevaluation of the type, extent, and quality of services and programming;

4. The development of the discharge plan; and

5. The referral to appropriate community resources.

(b) Training in habits of personal hygiene, family life, and sex education that includes but is not limited to family planning and venereal disease counseling.

(c) Control of communicable diseases and infections through:

1. Identification and assessment;

2. Reporting to medical authorities; and

3. Implementation of appropriate protective and preventive measures.

4. Development of a written nursing services plan for each resident as part of the total habilitation program.

5. Modification of the nursing plan, in terms of the resident's daily needs, at least annually for adults and more frequently for children, in accordance with developmental changes.

(78) Training.

(a) A registered nurse must participate, as appropriate, in the planning and implementation of training of the ICF/MR's personnel.

(b) The ICF/MR must have direct-care personnel trained in:

1. Detecting signs of illness or dysfunction that warrant medical or nursing intervention;

2. Basic skills required to meet the health needs and problems of the residents; and

3. First aid for accident or illness.

(79) Staff.

(a) The ICF/MR must have available enough nursing staff, which may include currently licensed practical nurses and other supporting personnel, to carry out the various nursing services.

(b) The individual responsible for the delivery of nursing services must have knowledge and experience in the field of developmental disabilities.

(c) Nursing service personnel at all levels of experience and competence must be:

1. Assigned responsibilities in accordance with their qualifications;

2. Delegated authority commensurate with their responsibility; and

3. Provided appropriate professional nursing supervision.

(80) Supervision of health services.

(a) The ICF/MR must have a registered nurse or licensed practical or vocational nurse to supervise the health services full time, 7 days a week, on the day shift.

(b) The nurse must have a current license to practice in the state.

(c) If the ICF/MR employes a licensed practical or vocational nurse to supervise health services, it must have a formal arrangement with a registered nurse to consult with the licensed practical or vocational nurse at regular intervals, but not less than 4 hours each week.

(d) To be qualified to serve as a health services supervisor, a licensed practical nurse must be licensed pursuant to s.441.10, Stats.

(e) The ICF/MR must have responsible staff members on duty and awake 24 hours a day to take prompt, appropriate action in case of injury, illness, fire, or other emergency.

(f) An ICF/MR that has 15 beds or less, and only admits residents certified by a physician as not in need of professional nursing services, may meet the requirements of paragraphs (a) through (e) of this section by:

1. Contracting for the services of a public health nurse or other registered nurse to care for minor illnesses, injuries, or emergencies, and to consult on the health aspects of the individual plan of care; and

2. Having a responsible staff member on duty 24 hours a day who is immediately accessible to the residents to take reports of injuries, symptoms of illness, and emergencies.

(g) The health services supervisor is responsible for developing, supervising the implementation of, reviewing, and revising a written health care plan for each resident that is:

1. Developed and implemented according to the instructions of the attending or staff physician; and

2. Reviewed and revised as needed but not less often than quarterly.

(81) Required services. The ICF/MR must:

(a) Make formal arrangements for qualified pharmacy services, including provision for emergency service.

(b) Have a current pharmacy manual that:

1. Includes policies and procedures and defines the functions and responsibilities relating to pharmacy services; and

2. Is revised annually to keep abreast of current developments in services and management techniques; and

(c) Have a formulary system approved by a responsible physician and pharmacist and other appropriate staff. Copies of the ICF/MR's formulary system and of the American Hospital Formulary Service must be located and available in the facility.

(82) Pharmacist.

(a) Pharmacy services must be provided under the direction of a qualified licensed pharmacist.

(b) The pharmacist must:

1. When a resident is admitted, obtain, if possible, a history of prescription and nonprescription drugs used and enter this information in the resident's record;

2. Receive the original, or a direct copy, of the physician's drug treatment order;

3. Maintain for each resident an individual record of all prescription and nonprescription medications dispensed, including quantities and frequency of refills;

4. Participate, as appropriate, in the continuing interdisciplinary evaluation of individual residents for the purposes of beginning, monitoring, and following up on individualized habilitation programs; and

5. Establish quality specifications for drug purchases and insure that they are met.

(c) A pharmacist or registered nurse must regularly review the medication record of each resident for potential adverse reactions, allergies, interactions, contraindications, rationality and laboratory test modifications and advise the physician of any recommended changes with reasons and with an alternate drug regimen.

(d) As appropriate to the ICF/MR, the responsible pharmacist, physician, nurse, and other professional staff must write policies and procedures that govern the safe administration and handling of all drugs. The following policies and procedures must be included:

1. There must be a written policy governing the self administration of drugs, whether prescribed or not.

2. The pharmacist or an individual under the pharmacist's supervision must compound, package, label, and dispense drugs including samples and investigational drugs. Proper controls and records must be kept of these processes.

3. Each drug must be identified up the the point of administration.

4. Whenever possible, the pharmacist must dispense drugs that require dosage measurements in a form ready to be administered to the resident.

(83) Drugs and medications.

(a) A medication must be used only by the resident for whom it is issued. Only appropriately trained staff may administer drugs.

(b) Any drug that is discontinued or outdated and any container with a worn, illegible, or missing label must be returned to the pharmacy for proper disposition.

(c) The ICF/MR must have:

1. An automatic stop order on all drugs;

2. A drug recall procedure that can be readily used;

3. A procedure for reporting adverse drug reactions to the Food and Drug Administration; and

4. An emergency kit available to each living unit and appropriate to the needs of its residents.

(d) Medication errors and drug reactions must be recorded and reported immediately to the practitioner who ordered the drug.

(84) Drug storage. The ICF/MR must:

(a) Store drugs under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

(b) Store poisons, drugs used externally, and drugs taken internally on separate shelves or in separate cabinets, at all locations;

(c) Keep medication that is stored in a refrigerator containing other items in a separate compartment with proper security;

(d) Keep all drugs under lock and key unless an authorized individual is in attendance;

(e) If there is a drug storeroom separate from the pharmacy, keep a perpetual inventory of receipts and issues of all drugs from that storeroom; and

(f) Meet the drug security requirements of federal and state laws that apply to storerooms, pharmacies, and living units.

(85) Required services.

(a) The ICF/MR must provide physical and occupational therapy services through direct contact between therapists and residents and through contact between therapists and individuals involved with the residents.

(b) Physical and occupational therapy staff must provide treatment training programs that are designed to:

1. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living; and

2. Prevent, insofar as possible, irreducible or progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.

(c) The therapist must:

1. Work closely with the resident's primary physician and with other medical specialists;

2. Record regularly and evaluate periodically the treatment training progress; and

3. Use the treatment training progress as the basis for continuation or change in the resident's program.

(86) Records and evaluations. The ICF/MR must have evaluation results, treatment objectives, plans and procedure, and continuing observations of treatment progress:

(a) Recorded accurately, summarized, and communicated to all relevant parties;

(b) Used in evaluating progress; and

(c) Included in the resident's record kept in the living unit.

(87) Staff and facilities.

(a) The ICF/MR must have available enough qualified staff and support personnel to carry out the various physical and occupational therapy services in accordance with stated goals and objectives.

(b) Physical and occupational therapy personnel must be:

1. Assigned responsibilities in accordance with their qualifications;

2. Delegated authority commensurate with their responsibilities; and

3. Provided professional direction and consultation.

(c) Therapy assistants must work under the supervision of a qualified therapist.

(d) Physical and occupational therapists and therapy assistants must meet the qualification requirements of HSS 105.27 through 105.285, except that when occupational therapy assistants are working as habilitation staff or resident living staff (i.e. not directly providing occupational therapy) they do not need direct on-site supervision by an OTR.

(e) The ICF/MR must provide enough space and equipment and supplies for efficient and effective physical and occupational therapy services.

(88) Required services. The ICF/MR must:

(a) Provide psychological services through personal contact between psychologists and residents and through contact between psychologists and individuals involved with the residents; and

(b) Have available enough qualified staff and support personnel to furnish the following psychological services based on need:

1. Psychological services for residents, including evaluation, consultation, therapy, and program development.

2. Administration and supervision of psychological services.

3. Staff training.

(89) Psychologist. Psychologists must:

(a) Have at least a master's degree from an accredited program and experience or training in the field of mental retardation;

(b) Participate, when appropriate, in the continuing interdisciplinary evaluation of each individual resident, for the purposes of beginning, monitoring, and following up on the resident's individualized habilitation program;

(c) Report and disseminate evaluation results in a manner that:

1. Promptly provides information useful to staff working directly with the resident; and

2. Maintains accepted standards of confidentiality.

(d) Participate, when appropriate, in the development of written, detailed, specific, and individualized habilitation program plans that:

1. Provide for periodic review, followup, and updating; and

2. Are designed to maximize each resident's development and acquisition of the following: Perceptual skills, sensorimotor skills, self-help skills, communication skills, social skills, self-direction, emotional stability, and effective use of time, including leisure time.

(90) Required services. The ICF/MR must:

(a) Coordinate recreational services with other services and programs provided to each resident, in order to:

1. Make the fullest possible use of the ICF/MR's resources; and

2. Maximize benefits to the residents;

(b) Design and construct or modify recreation areas and facilities so that all residents, regardless of their disabilities, have access to them; and

(c) Provide recreation equipment and supplies in a quantity and variety that is sufficient to carry out the state objectives of the activities programs.

(91) Records. The ICF/MR's resident records must include:

(a) Periodic surveys of the resident's recreation interests; and

(b) The extent and level of the residents' participation in the recreation program.

(92) Staff.

(a) The ICF/MR must have enough qualified staff and support personnel available to carry out the various recreation services in accordance with stated goals and objectives.

(b) Staff conducting the recreation program must have:

1. A bachelor's degree in recreation, or in a speciality area, such as art, music, or physical education;

2. An associate degree in recreation and 1 year of experience in recreation;

3. A high school diploma, or an equivalency certificate and:

a. Two years of experience in recreation; or

b. One year of experience in recreation plus completion of comprehensive inservice training in recreation; or

4. Demonstrated proficiency and experience in conducting activities in one or more recreation program areas.

(93) Required services. The ICF/MR must provide, as part of an interdisciplinary set of services, social services to each resident directed toward:

(a) Maximizing the social functioning of each resident;

(b) Enhancing the coping capacity of each resident's family;

(c) Asserting and safeguarding the human and civil rights of the retarded and their families; and

(d) Fostering the human dignity and personal worth of each resident.

(94) Social workers.

(a) During the evaluation process to determine whether or not admission to the ICF/MR is necessary, social workers must help the resident and family:

1. Consider alternative services, based on the retarded individual's status and important family and community factors; and

2. Make a responsible choice as to whether and when residential placement is indicated.

(b) Social workers must participate, when appropriate, in the continuing interdisciplinary evaluation of individual residents for the purposes of beginning, monitoring, and following up on individualized habilitation programs.

(c) During the retarded individual's admission to, and residence in the facility, social workers must, as appropriate, provide liaison between him, the ICF/MR, the family, and the community, in order to:

1. Help the staff:

a. Individualize and understand the needs of the resident and family in relation to each other;

b. Understand social factors in the resident's day-to-day behavior, including staff-resident relationships; and

c. Prepare the resident for changes in the living situation;

2. Help the family develop constructive and personally meaningful ways to support the resident's experience in the ICF/MR through:

a. Counseling concerning the problems of changes in family structure and functioning; and

b. Referral to specific services, as appropriate; and

3. Help the family participate in planning for the resident's return to home or other community placement.

(d) After the resident leaves the ICF/MR, social workers must provide systematic followup to assure referral to appropriate community agencies.

(e) The ICF/MR must have available enough qualified staff and support personnel to carry out the various social services activities.

(f) Social workers providing service to the ICF/MR must meet the qualification requirements of HSS 101.103.

(g) Social work assistants or aides employed by the ICF/MR must be supervised by a social worker.

(95) Required services.

(a) The ICF/MR must provide speech pathology and audiology services through direct contact between speech pathologists and audiologists and residents, and working with other personnel, including but not limited to teachers and direct-care staff.

(b) Speech pathology and audiology services available to the ICF/MR must include:

1. Screening and evaluation of residents with respect to speech and hearing functions;

2. Comprehensive audiological assessment of residents, as indicated by screening results, that include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and the assessment of the use of visual cues;

3. Assessment of the use of amplification;

4. Provision for procurement, maintenance, and replacement of hearing aids, as specified by a qualified audiologist;

5. Comprehensive speech and language evaluation of residents, as indicated by screening results, including appraisal of articulation, voice, rhythm, and language;

6. Participation in the continuing interdisciplinary evaluation of individual residents for purposes of beginning, monitoring, and following up on individualized habilitation programs;

7. Treatment services as an extension of the evaluation process, that include:

a. Direct counseling with residents;

b. Consultation with appropriate staff for speech improvement and speech education activities; and

c. Work with appropriate staff to develop specialized programs for developing each resident's communication skills in comprehension, including speech, reading, auditory training, and hearing aid utilization, and skills in expression, including improvement in articulation, voice, rhythm, and language; and

8. Participation in inservice training programs for direct-care and other staff.

(96) Evaluations and assessments.

(a) Speech pathologists and audiologists must accurately and systematically report evaluation and assessment results in order to:

1. Provide information, when appropriate, that is useful to other staff working directly with the resident; and

2. Include evaluative and summary reports in the resident's record kept in the living unit.

(b) Continuing observations of treatment progress must be:

1. Recorded accurately, summarized, and communicated; and

2. Used in evaluating progress.

(97) Staff and facilities.

(a) The ICF/MR must have available enough qualified staff and support personnel to carry out the various speech pathology and audiology services, in accordance with stated goals and objectives.

(b) Staff who assume independent responsibilities for clinical services must meet the qualification requirements for their provider type.

(c) The ICF/MR must provide adequate, direct, and continuing supervision to personnel, volunteers, or support personnel used in providing clinical services.

(d) The ICF/MR must have enough space, equipment, and supplies to provide efficient and effective speech pathology and audiology services.

(98) Maintenance of resident records.

(a) The ICF/MR must maintain a record for each resident that is adequate for:

1. Planning and continuous evaluation of the resident's habilitation program;

2. Furnishing documentary evidence of each resident's progress and response to his habilitation program; and

3. Protecting the legal rights of the residents, the ICF/MR, and the staff.

(b) Any individual who makes an entry in a resident's record must make it legibly, date it, and sign it.

(c) The ICF/MR must provide a legend to explain any symbol or abbreviation used in a resident's record.

(d) The original copy of the resident's records shall be maintained on the premises of the nursing home.

(99) Admission records. At the time a resident is admitted, the ICF/MR must enter in the individual's record the following information:

(a) Name, date of admission, birth date and place, citizenship status, marital status, and social security number.

(b) Father's name and birthplace, mother's maiden name and birthplace, and parents' marital status.

(c) Name and address of parents, legal guardian, and next of kin if needed.

(d) Sex, race, height, weight, color of hair, color of eyes, identifying marks, and recent photograph.

(e) Reason for admission or referral problem.

(f) Type and legal status of admission.

(g) Legal competency status.

(h) Language spoken or understood.

(i) Sources of support, including social security, veterans' benefits, and insurance.

(j) Religious affiliation, if any.

(k) Reports of the preadmission evaluations.

(l) Reports of previous histories and evaluations, if any.

(100) Record entries during residence.

(a) Within 1 month after the admission of each resident, the ICF/MR must enter in the resident's record:

1. A report of the review and updating of the preadmission evaluation;

2. A prognosis that can be used for programming and placement; and

3. A comprehensive evaluation and individual program plan, designed by an interdisciplinary team.

(b) The ICF/MR must enter the following information in a resident's record during residence:

1. Reports of accidents, seizures, illnesses, and treatments for these conditions.

2. Records of immunizations.

3. Records of all periods that restraints were used, with justification and authorization for each.

4. Reports of regular, at least annual, review and evaluation of the program developmental progress, and status of each resident.

5. Enough observations of the resident's response to his program to enable evaluation of its effectiveness.

6. Records of significant behavior incidents.

7. Records of family visits and contacts.

8. Records of attendance and absences.

9. Correspondence pertaining to the resident.

10. Periodic updates of the information recorded at the time of admission.

11. Appropriate authorizations and consents.

(c) The ICF/MR must enter a discharge summary in the resident's record at the time of discharge.

(101) Confidentiality.

(a) The ICF/MR must keep confidential all information contained in a resident's records, including information contained in an automated data bank.

(b) The record is the property of the ICF/MR which must protect it from loss, damage, tampering, or use by unauthorized individuals.

(c) The ICF/MR must have written policies governing access to, duplication of, and release of information from the record.

(d) The ICF/MR must obtain written consent of the resident, if competent, or a guardian before it releases information to individuals not otherwise authorized to receive it.

(102) Central record service. The ICF/MR must:

(a) Maintain an organized central record service for the collection and release of resident information;

(b) Make records readily accessible to authorized personnel if a centralized system is used;

(c) Have appropriate records available in the resident living units;

(d) Have a master alphabetical index of all residents admitted to the ICF/MR; and

(e) Retain records for 5 years from date of discharge or transfer of recipient to another facility.

(103) Staff and facilities. The ICF/MR must have:

(a) Enough qualified staff and support personnel to accurately process, check, index, file, and retrieve records and record data promptly; and

(b) Adequate space, equipment, and supplies to provide efficient and effective record services.

(104) Emergency plan and procedures.

(a) The ICF/MR must have a written staff organization plan and detailed written procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing residents.

(b) The ICF/MR must:

1. Clearly communicate and periodically review the plan and procedures with the staff; and

2. Post the plan and procedures at suitable locations throughout the facility.

(105) Evacuation drills.

(a) The ICF/MR must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:

1. Insure that all personnel on all shifts are trained to perform assigned tasks;

2. Insure that all personnel on all shifts are familier with the use of the ICF/MR's firefighting equipment; and

3. Evaluate the effectiveness of emergency and disaster plans and procedures.

(b) The ICF/MR must:

1. Actually evacuate residents to safe areas during at least one evacuation drill each year, on each shift;

2. Make special provisions for the evacuation of the physically handicapped, such as fire chutes and mattressloops with poles;

3. Write and file a report and evaluation of each evacuation drill; and

4. Investigate all accidents and take corrective action to prevent similar accidents in the future.

(106) Fire protection. Except as provided in HSS 105.12(107) and (108), the ICF/MR must meet the provisions of the Life Safety Code of the National Fire Protection Association, 1967 edition, that apply to institutional occupancies.

(107) Fire protection exceptions for smaller ICF's/MR. The department may apply the lodgings or rooming houses section of the residential occupancy requirements of the Life Safety Code of the National Fire Protection Association, 1967 edition, instead of the institutional occupancy provisions required by subsection (106), to an ICF/MR that has 15 beds or less if a physician or psychologist who meets the definition of qualified mental retardation professional in subsection 1.03 certifies that each resident is:

(a) Ambulatory;

(b) Receiving active treatment; and

(c) Capable of following directions and taking appropriate action for self-preservation under emergency conditions.

(108) Fire protection waivers.

(a) The department may waive specific provisions of the Life Safety Code required by HSS 105.12(106), for as long as it considers appropriate, if:

1. The waiver would not adversely affect the health and safety of the residents;

2. Rigid application of specific provisions would result in unreasonable hardship for the ICF/MR as determined under guidelines contained in the HCFA long-term care manual; and

3. The waiver is granted in accordance with criteria contained in the long-term care manual.

(b) If the department waives provisions of the Code for an existing building of two or more stories that is not built of at least 2-hour fire-resistive construction, the ICF/MR may not house a blind, nonambulatory, or physically handicapped resident above the street-level floor unless it is built of:

1. One-hour protected, noncumbustible construction as defined in National Fire Protection Association Standard No. 220;

2. Full sprinklered, 1-hour protected, ordinary construction;

3. Full sprinklered, 1-hour protected, wood frame construction.

(109) Paint. The ICF/MR must:

(a) Use lead-free paint inside the facility; and

(b) Remove or cover old paint or plaster containing lead so that it is not accessible to residents.

(110) Building accessibility and use.

(a) The ICF/MR must:

1. Be accessible to and usable by all residents, personnel, and the public, including individuals with disabilities; and

2. Meet the requirements of American National Standards Institute (ANSI) Standard No. A117.1 (1961) American Standard Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped.

(b) The State survey agency may waive, for as long as it considers appropriate, specific provisions of ANSI Standard No. A117.1(1961) if:

1. The construction plans for the ICF/MR or a part of it were approved and stamped by the department before March 18, 1974;

2. The provision would result in unreasonable hardship on the ICF/MR if strictly enforced; and

3. The waiver does not adversely affect the health and safety of the residents.

(111) Sanitation records and reports. The ICF/MR must keep:

(a) Records that document compliance with sanitation, health, and environmental safety codes of the state or local authorities having primary jurisdiction over the ICF/MR; and

(b) Written reports of inspections by state or local health authorities, and records of action taken on their recommendations.

(112) Support services.

(a) The ICF/MR must provide adequate, modern administrative support to efficiently meet the needs of residents and facilitate attainment of the ICF/MR's goals and objectives.

(b) The ICF/MR must:

1. Document its purchasing process;

2. Adequately operate its inventory control system and stockroom;

3. Have appropriate storage facilities for all supplies and surplus equipment; and

4. Have enough trained and experienced personnel to do purchase, supply, and property control functions.

(113) Communication system.

(a) The ICF/MR must have an adequate communication system, including telephone service, that insures:

1. Prompt contact of onduty personnel; and
2. Prompt notification of responsible personnel in an emergency.

(114) Engineering and maintenance. The ICF/MR must have:
(a) An appropriate, written preventive maintenance program; and
(b) Enough trained and experienced personnel for engineering and maintenance functions.

(115) Laundry services. The ICF/MR must manage its laundry services so that it meets daily clothing and linen needs without delay.

(116) Other requirements. The requirements found in HSS 105.10(19) and HSS 105.106 shall apply to ICF/MRs where applicable.

5.13 Requirements for Certification of Tuberculosis Public Health Dispensaries. Dispensaries defined in section 149.06, Wis. Stats. shall meet the requirements of Wis. Adm. Code section H 46.07, and be operated by or under the direction of a licensed physician.

5.14 Requirements for Certification of Christian Science Sanitoria. Christian Science Sanitoria shall be operated by or listed and certified by the First Church of Christ Scientist, Boston, Mass. and shall meet the requirements of Wis. Adm. Code sections H 32.18, 32.27-32.30, and 32.32.

5.15 Requirements for Certification of Pharmacies. Pharmacies shall meet the requirements for registration and practice enumerated in sections 450.02, and 450.04, Wis. Stats., and shall meet the requirements in Wis. Adm. Code chapter Pharm 1 to 6.

5.16 Requirements for Certification of Home Health Agencies. Home health agencies are required to meet the conditions of participation enumerated in this section. (NOTE: The following rules are a codification of 42 CFR 405.1201 through 42 CFR 405.1230. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the federal regulations shall hold).

(1) Compliance with federal, state, and local laws. An agency shall be eligible for certification by the department if it meets the standards in this section. In addition, a proprietary organization which is not exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954 shall be licensed as a home health agency pursuant to section 141.15, Wis. Stats.

(2) Organization, services, administration. Organization, services provided, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be clearly set forth in writing and shall be readily identifiable. Administrative and supervisory functions shall not be delegated to another agency or organization. All services not provided directly shall be monitored and controlled by the primary agency, including services provided through subunits of the parent agency. If an agency has subunits, appropriate administrative records shall be maintained for each subunit.

(a) Services provided. Part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech, or occupational therapy; medical social services; or home health aide services) shall be made available on a visiting basis, in a place of residence used as a patient's home. A public or nonprofit home health agency shall provide at least one of the qualifying services directly through agency employees but may provide the second qualifying service and additional services under arrangements with another agency or organization. A proprietary home health agency, however, shall provide all services directly, through agency employees.

(b) Governing body. A governing body (or designated persons so functioning) shall assume full legal authority and responsibility for the operation of the agency. The governing body shall appoint a qualified administrator, arrange for professional advice, adopt and periodically review written bylaws or an acceptable equivalent, and oversee the management and fiscal affairs of the agency. The name and address of each officer, director, and owner shall be disclosed. If the agency is a corporation, all ownership interests of 10 percent or more (direct and indirect) shall also be disclosed.

(c) Administrator. The administrator, who may also be the supervising physician or registered nurse shall organize and direct the agency's ongoing functions; maintain ongoing liaison among the governing body, the group of professional personnel, and the staff; employ qualified personnel and ensure adequate staff education and evaluations; ensure the accuracy of public information materials and activities; and implement an effective budgeting and accounting system. A qualified person shall be authorized in writing to act in this capacity in the absence of the administrator.

(d) Supervising physician or registered nurse. The skilled nursing and other therapeutic services provided shall be under the supervision and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse). This

person or similarly qualified alternate, shall be available at all times during operating hours and shall participate in all activities relevant to the professional services provided, including the developing of qualifications and assignments of personnel.

(e) Personnel policies. Personnel practices and patient care shall be supported by appropriate, written personnel policies. Personnel records shall include job descriptions, qualifications, licensure, performance evaluations, and health examinations, and shall be kept current.

(f) Personnel under hourly or per visit contracts.

1. If personnel under hourly or per visit contracts are utilized by the home health agency, there shall be a written contract between such personnel and the agency clearly designating:

a. That patients are accepted for care only by the primary home health agency,

b. The services to be provided,

c. The necessity to conform to all applicable agency policies including personnel qualifications,

d. The responsibility for participating in developing plans of treatment,

e. The manner in which services shall be controlled, coordinated, and evaluated by the primary agency.

f. The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation, and

g. The procedures for determining charges and reimbursement.

(g) Coordination of patient services. All personnel providing services shall maintain liaison with each other to assure that their efforts effectively complement one another and support the objectives outlined in the plan of treatment as explained in subsection 5.16(4). The clinical record or minutes of case conferences shall establish that effective interchange, reporting, and coordinated patient evaluation does occur. A written summary report for each patient shall be sent to the attending physician at least every 60 days.

(h) Services under arrangements. Services provided under arrangements shall be subject to a written contract conforming with the requirements specified in paragraph (f) of this section, and with the requirements of section 1861(w) of the Social Security Act (42 USC 1395x(w)).

(i) Institutional planning. The home health agency, under the direction of the governing body, shall prepare an overall plan and budget which provides for an annual operating budget and a capital expenditure plan.

1. Annual operating budget. There shall be an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense).

2. Capital expenditure plan. The capital expenditure plan shall be in compliance with chapter 150, Wis. Stats. Records relating to the capital expenditure plan shall comply with the requirements of subsection 5.02(2) and (3).

3. Preparation of plan and budget. The overall plan and budget shall be prepared under the direction of the governing body of the home health agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the home health agency.

4. Annual review of plan and budget. The overall plan and budget shall be reviewed and updated at least annually under the direction of the governing body of the home health agency, by the committee referred to in subsection 5.16(2)(i)(3).

(3) Group of professional personnel.

(a) A group of professional personnel, which shall include at least one physician and one registered nurse (preferably a public health nurse), with appropriate representation from other professional disciplines, shall establish and annually review the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group shall be neither an owner nor an employee of the agency.

(b) Advisory and evaluation function. The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, to assist the agency in maintaining liaison with other health care providers in the community, and to assist the agency in its community information program. Its meetings shall be documented by minutes, which shall be dated.

(4) Acceptance of patients, plan of treatment, medical supervision. Patients shall be accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Care shall follow a written plan of treatment established and periodically reviewed by a physician, and care shall continue under the supervision of a physician.

(a) Plan of treatment. The plan of treatment developed in consultation with the agency staff shall cover all pertinent diagnoses, including mental state, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatment, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of treatment which cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel shall participate in developing the plan of treatment.

(b) Periodic review of plan of treatment. The total plan of treatment shall be reviewed by the attending physician and home health agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days. Agency professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of treatment.

(c) Conformance with physician's orders. Drugs and treatments shall be administered by agency staff only as ordered by the physician. The nurse or therapist immediately shall record and sign oral orders and obtain the physician's countersignature. Agency staff shall check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication. Any problems shall be reported promptly to the physician.

(5) Skilled nursing service. The home health agency shall provide skilled nursing service by or under the supervision of a registered nurse and in accordance with the plan of treatment.

(a) Duties of the registered nurse. The registered nurse shall make the initial evaluation visit, shall regularly reevaluate the patient's nursing needs, shall initiate the plan of treatment and necessary revisions, shall provide those services requiring substantial specialized nursing skill, shall initiate appropriate preventive and rehabilitative nursing procedures, shall prepare clinical and progress notes, shall coordinate services, shall inform the physician and other personnel of changes in the patient's condition and needs, shall counsel the patient and family in meeting nursing and related needs, shall participate in inservice programs, and shall supervise and teach other nursing personnel.

(b) Duties of the licensed practical nurse. The licensed practical nurse shall provide services in accordance with agency policies, shall prepare clinical and progress notes, shall assist the physician or registered nurse in performing specialized procedures, shall prepare equipment and materials for treatments observing aseptic technique as required, and shall assist the patient in learning appropriate self-care techniques.

(6) Therapy services. Any therapy services offered by the home health agency directly or under arrangement shall be given by a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist in accordance with the plan of treatment. The qualified therapist shall assist the physician in evaluating level of function, shall help develop the plan of treatment (revising as necessary), shall prepare clinical and progress notes, shall advise and consult with the family and other agency personnel, and shall participate in inservice programs.

(a) Supervision of physical therapist assistant and occupational therapy assistant. Services provided by a qualified physical therapist assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapist assistant or occupational therapy assistant shall perform services planned, delegated, and supervised by the therapist, shall assist in preparing clinical notes and progress reports, and shall participate in educating the patient and family, and in inservice programs.

(b) Supervision of speech therapy services. Speech therapy services shall be provided only by or under supervision of a qualified speech pathologist or audiologist.

(7) Medical social services. Medical social services, when provided, shall be given by a qualified social worker or by a qualified social work

assistant under the supervision of a qualified social worker, and in accordance with the plan of treatment. The social worker shall assist the physician and other team members in understanding the significant social and emotional factors related to the health problems, shall participate in the development of the plan of treatment, shall prepare clinical and progress notes, shall work with the family, shall utilize appropriate community resources, shall participate in discharge planning and inservice programs, and shall act as a consultant to other agency personnel.

(8) Home health aide services. Home health aides shall be selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. Aides shall be carefully trained in methods of assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, procedures for maintaining a clean, healthful, and pleasant environment, changes in patient's condition that sould be reported, work of the agency and the health team, ethics, confidentiality, and recordkeeping. They shall be closely supervised to assure their competence in providing care.

(a) Assignment and duties of the home health aide. The home health aide shall be assigned to a particular patient by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate. Duties include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs, and completing appropriate records.

(b) Supervision. The registered nurse, or appropriate professional staff member, if other services are provided, shall make a supervisory visit to the patient's residence at least once every 30 days, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

(9) Clinical records. A clinical record containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient receiving home health services. In addition to the plan of treatment, the record shall contain appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes (clinical notes shall be written the day service is rendered and shall be incorporated no less often than weekly); copies of summary reports sent to the physician; and a discharge summary.

(10) Evaluation. The home health agency shall have written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), home health agency staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation program shall be appropriate, adequate, effective, and efficient. Results of the evaluations shall be reported to and acted upon by those responsible for the operation of the agency and shall be maintained separately in administrative records.

(a) Policy and administrative review. As part of the evaluation process the policies and administrative practices of the agency shall be reviewed to determine the extent to which they promote appropriate, adequate, effective, and efficient patient care. Mechanisms shall be established in writing for the collection of pertinent data to assist in evaluation. The data to be considered may include but are not limited to: number of patients receiving each service offered, number of patient visits, reasons for discharge, breakdown by diagnosis, sources of referral, number of patients not accepted and reasons, and total staff days for each service offered.

(b) Clinical record review. At least quarterly, appropriate health professionals, representing at least the scope of the program, shall review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct services as well as services under arrangement). There shall be continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of treatment and appropriateness of continuation of care.

(11) Qualifying to provide outpatient physical therapy or speech pathology services. As a provider of services, a home health agency may qualify to provide outpatient physical therapy or speech pathology services if the agency meets the statutory requirements of section 1861(o) of the Social Security Act and complies with other health and safety requirements prescribed by the Secretary of DHEW for home health agencies. The agency shall also comply with applicable health and safety requirements of sections 5.34(3), (4), (5), (7), (9), and (11) pertaining to provision of outpatient physical therapy or speech pathology services.

(12) Home health agencies shall provide or make available part time or intermittent nursing services, home health aide services and medical supplies, equipment and appliances suitable for use in the home.

5.17 Requirements for Certification of Social Service Agencies Providing Personal Care Services.

Social service agencies shall be eligible for certification by the department as providers of the personal care services enumerated in section 7.12 if they meet the following requirements:

(1) Documentation. The social service agency shall, each year it provides personal care services, document that it provided those services to the following target populations (In the case of agencies in the first year of service, the agency shall maintain projection of its case load for these populations.):

(a) Disabled persons maintaining their private home residences;
(b) Convalescent and chronically ill persons; and
(c) The elderly.

(2) Personnel policies. All personnel policies for the personal care services program shall be in written form.

(3) Agency eligibility. County social service agencies may provide personal care services for the target population in the following manner:

(a) A county social service agency may employ staff to meet the requirements of this section.

(b) A county social service agency may enter into an agreement with an agency to meet the staffing requirements of this section. Under this option, the county social service agency must provide justification to the department for the agreement. Approval of the agreement must be obtained from the department before an agency will be eligible for certification.

(4) Training. Each personal care worker shall be trained in the provision of personal care services. Training shall consist of a minimum of 40 classroom hours, 25 of which shall cover personal and restorative care subjects. The 40 classroom hours shall include the subjects listed in the "Curriculum Guidelines for Training Homemakers in the Provision of Personal Care Services" ~~included in the County Administrative Manual of~~ which may be obtained from the Division of Community Services. Training shall emphasize techniques and aspects of caring for the target populations.

(5) Supervision by Registered Nurse. Each personal care worker shall be supervised by a registered nurse oriented to or experienced in providing nursing care in the home. The social service agency shall either employ a nurse directly or enter into a written agreement with a solo nurse, a public health nurse, or a health agency, (e.g. certified home health agency, public health agency, rural health clinic, etc.) for the required supervision.

1. If the agreement is with a solo registered nurse, the quality of the nursing supervision shall be assessed periodically by the department. If the solo nurse has not had experience in providing care in a person's home, the nurse shall receive an orientation to care in the home from a public health nurse.

2. If the agreement is with a certified home health agency or a public health agency, there shall be joint planning on the part of the certified home health agency or public health agency and the social service agency, for both the nursing supervision and for the delivery of personal care services by the personal care worker.

(6) Agreements. All agreements between social service agencies and other agencies for provision of personal care services and professional nursing supervision shall be in written form.

(7) Requests for Services. Requests for personal care services may be made by the recipient, the recipient's physician, social service agency personnel or other individuals or organizations acting on behalf of the recipient. When the request for services is made, the social service agency shall obtain an evaluation by a registered nurse of the need for personal care services before the services are commenced. If it is determined that the level of care needed is personal care, a physician's prescription or orders shall be obtained by the registered nurse, and a plan of care shall be developed by the registered nurse, in consultation with the physician.

(8) Other Requirements of the social services agency. In addition to requirements stated elsewhere in this section, the social service agency shall:

(a) Provide the personal care worker with the basic materials and equipment to deliver personal care services;

(b) Maintain time sheets documenting, by funding source, the type and duration of services provided by the personal care worker;

(c) Retain basic responsibility for overall social work case management.

(d) The social service agency shall maintain a health care record for each recipient receiving personal care services through the agency. The record shall be kept up to date, and shall include all health services provided by the agency. The record shall include:

1. Nursing assessment, medical plan of care, nursing plan of care, personal care worker's assignment, recording of all assignments whether completed or not and general remarks.

2. The record shall be signed by both the personal care worker and the supervising registered nurse.

3. The personal care worker shall record each visit with the recipient on the health care record, including observations made, activities carried out and not carried out.

4. The personal care worker shall report promptly to the registered nurse supervisor any significant changes in the condition of the recipient.

5. A copy of the written agreement with the health agency or registered nurse providing supervision shall be on file at the social service agency.

(e) The social service agency shall cooperate with health and other social service agencies in the area and with interested community referral groups in an attempt to avoid duplication of services and in an attempt to provide the best possible coordination of personal care services to area recipients.

(f) Requirements of the registered nurse supervisor. The registered nurse providing the health-care supervision shall:

1. Evaluate the need of the recipient for personal care services before assignment is made (If the need is for another level of care, the nurse shall make appropriate referrals.);

2. Secure from the physician the necessary written orders;

3. Develop a plan of care in consultation with the physician, prepare the assignment in writing, interpret this assignment to the personal care worker, if necessary, and provide a copy of the physician's plan of care to the social service agency for the health record;

4. Develop an appropriate time and services reporting mechanism for the personal care worker and instruct the personal care worker in the use of reporting mechanism;

5. Identify in the plan of care the frequency and anticipated duration of personal care services;

6. Give written instructions or if necessary a demonstration to the personal care worker of the services to be performed;

7. Teach or arrange for the teaching of personal care services to family members, if available and appropriate;

8. Confer with the social service agency staff, the personal care worker, the physician, and other involved professionals in regard to the recipient's progress;

9. Judge the competency of the personal care worker to perform the personal care services; and

10. Review the plan of care and perform an evaluation of the patient's condition not less frequently than every 60 days. The evaluation includes at least one visit to the home and a review of the personal care worker's daily written record, and discussion with the physician of any need for changes in type or level of care or discontinuance of care. If a change is necessary, appropriate referrals shall be made.

(g) Requirements of the personal care worker. The personal care worker who shall not be a responsible relative as legally defined under section 52.01(1)(a), Wis. Stats., or a child of the client receiving services, shall:

1. Perform tasks assigned by the registered nurse for which appropriate training has been received;

2. Report in writing to the supervising registered nurse on each assignment;

3. Report promptly to the registered nurse any changes in the recipient's condition; and

4. Confer with the registered nurse regarding the recipient's progress.

(h) Records. The following records shall be made available by the social service agency to the approved survey team and other authorized department personnel:

1. Written personnel policies;

2. Written job descriptions for all positions which are part of the personal care services program;

3. Written plan indicating total process for referral through delivery of services and follow-up;

4. Written statement defining scope of personal care services (The statement shall include: target population, service needs of target population, service priorities and hours the services are available.);

5. Record of each personal care worker's 40 hours of training in personal care;

6. Personal care worker's daily time sheets;

7. Health care record;

8. Medical assistance billings;

9. Cost reports; and

10. Contracts with agencies.

5.18 Requirements for Certification of Christian Science Nurses. Christian Science nurses are required to be graduated from a 3-year course in a Christian Science school of nursing approved by the First Church of Christ Scientist, Boston, Mass., and shall be listed and certified as a graduate nurse by the same church.

5.19 Requirements for Certification of Licensed Practical Nurses. Licensed practical nurses are required to be licensed pursuant to section 441.10, Wis. Stats.

5.20 Requirements for Certification of Registered nurses.

(1) Registered nurses are required to be registered pursuant to section 441.06, Wis. Stats.

(2) Nurse Practitioners.

(a) Until the effective date of any permanent administrative rule promulgated by the state department of regulation and licensing which certifies and specifies standards and procedures of practice for nurse practitioners, nurse practitioners shall be eligible to participate only when employed by a rural health clinic.

(b) A nurse practitioner shall be registered and shall meet one of the following requirements:

1. Certification as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or

2. Satisfactory completion of a formal one-year academic program which prepares registered nurses to perform an expanded role in the delivery of primary care, which includes at least four months of classroom instruction and a component of supervised clinical practice, and which awards a degree, diploma, or a certificate to persons who successfully complete the program; or

3. Successful completion of a formal education program intended to prepare registered nurses to perform an expanded role in the delivery of primary care but which does not meet the requirements of section (a) 2. above, and performance of an expanded role in the delivery of primary care for a total of twelve months during the eighteen-month period immediately preceeding July 1, 1978, the effective date of federal regulations governing Medicaid certification of rural health clinics.

(c) A nurse practitioner certified as a Medicaid provider shall develop and maintain with a licensed physician a written protocol of services provided and procedures to follow. Such joint protocol shall include but not be limited to, explicit agreements on the expanded primary care services which can be provided by the nurse practitioner. The protocol also shall include arrangements for: communication of directions, consultation with the physician, assistance with medical emergencies, patient referrals, and other agreed-to provisions. In rural health clinics, the written policies incorporated as subsection 5.35(10)(b) of this rule shall be considered sufficient evidence of a joint written protocol.

(d) All written protocols shall be reviewed and approved by the interdisciplinary professional team enumerated in subsection 5.35(10)(b)4.

5.21 Requirements for Certification of Psychiatric Hospitals.

(NOTE: The following rules are a codification of 42 CFR 405.1037 and 1038. For the sake of readability, some editing has been done. In the event of any conflict of meaning the meaning of the original federal regulations shall hold).

Psychiatric hospitals shall be eligible for certification if they are approved pursuant to section 50.35 Wis. Stats. as meeting the rules and standards promulgated under Wis. Adm. Code chapter H 24 and if they have a certificate of participation in Medicare or a certificate of accreditation from the Joint Commission on Accreditation of Hospitals (or if they meet requirements equivalent to those for certification or accreditation). Psychiatric hospitals are required to have a utilization review plan that meets the requirements of section 5.09 of this rule. Hospitals participating in the PSRO review program shall meet the requirements of that program instead of those enumerated in section 5.09.

(1) Only a distinct part of an institution which is primarily engaged in furnishing psychiatric care shall meet the definition of a psychiatric hospital. A distinct part of a general hospital which primarily or exclusively treats psychiatric cases, shall be considered a general hospital because it is part of a general hospital. Therefore, none of the restrictions which apply to payments for inpatient hospital services in psychiatric hospitals apply. A psychiatric facility which is part of a general hospital or a large medical center or complex will be included within the certification of the overall institution unless the psychiatric facility operates as a separate functioning entity, that is, is located in a separate building, wing, or part of a building, has its own administration, and maintains separate fiscal records. Any institution which is primarily for the care and treatment of mental diseases cannot qualify as a "hospital" unless it meets the special requirements of a psychiatric hospital as enumerated in this section.

(2) Special medical record requirements for psychiatric hospitals. Medical records maintained by a psychiatric hospital shall stress the psychiatric components of the record, including history of findings and treatment rendered for the psychiatric condition(s) for which the patient is hospitalized. Medical records shall meet the following standards:

(a) Identification data shall include the patient's legal status.

(b) A provisional or admitting diagnosis shall be made on every patient at the time of admission and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(c) The complaint of others regarding the patient shall be included as well as the patient's comments.

(d) The psychiatric evaluation, including a medical history, shall contain a record of mental status and shall note the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative, fashion.

(e) A complete neurological examination shall be recorded at the time of the admission physical examination, when indicated.

(f) The social service records, including reports of interviews with patients, family members and others, shall provide an assessment of home plans, family attitudes, and community resource contacts as well as a social history.

(g) Reports of consultations, psychological evaluations, reports of electroencephalograms, dental records and reports of special studies shall be included in the record.

(h) The individual comprehensive treatment plan shall be recorded, based on an inventory of the patient's strengths and disabilities, and shall include a substantiated diagnosis in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual. The plan also shall include short-term and long-range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team. The plan shall provide adequate justification and documentation for the diagnoses and for the treatment and rehabilitation activities carried out.

(i) The treatment received by the patient shall be documented in such a manner and with such frequency as to assure that all active therapeutic efforts such as individual and group psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, industrial or work therapy, nursing care and other therapeutic interventions are included.

(j) Progress notes shall be recorded by the physician, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. Frequency of such notes shall be determined by the condition of the patient but should be recorded at least weekly for the first 2 months and at least once a month thereafter, and should contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

(k) The discharge summary shall include a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up as well as a brief summary of the patient's condition on discharge.

(l) The psychiatric diagnoses contained in the final diagnoses shall be written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual.

(3) Special staff requirements for psychiatric hospitals.

(a) Inpatient psychiatric facilities (psychiatric hospitals, distinct parts of psychiatric hospitals or inpatient components of community mental health centers) shall be staffed with the number of qualified professional, technical and supporting personnel and consultants required to carry out an intensive and comprehensive treatment program; Such program shall include evaluation of individual needs, establishment of treatment and rehabilitation goals, and implementation, directly or by arrangement, of a broad range therapeutic programs including at least professional psychiatric, medical, surgical, nursing, social work, psychological and activity therapies as required to carry out an individual treatment plan for each patient.

1. Qualified professional, technical, and consultant personnel shall be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for such evaluation include laboratory, radiological and other diagnostic tests, obtaining psychosocial data, carrying out psychiatric and psychological evaluations, and completing a physical examination, including a complete neurological examination when indicated, shortly after admission.

2. The number of qualified professional personnel, including consultants and technical and supporting personnel, shall be adequate to assure representation of the disciplines necessary to establish short-term and long-range goals; and to plan, carry out, and periodically revise a written individualized treatment program. Such treatment plan shall be based on scientific interpretation of:

a. Degree of physical disability and indicated remedial or restorative measures, including nutrition, nursing, physical medicine, and pharmacological therapeutic interventions;

b. Degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found;

c. Capacity for social interaction and appropriate nursing measures and milieu therapy to be undertaken, including group living experiences, occupational and recreational therapy, and other prescribed rehabilitative activities to maintain or increase the individual's capacity to manage activities of daily living;

d. Environmental and physical limitations required to safeguard the individual's health and safety, with a plan to compensate for these deficiencies and required to develop the individual's potential for return home, or to a foster home, an extended care facility, a community mental health center, or to another alternative type of facility.

(b) Director of Inpatient Psychiatric services. Inpatient psychiatric services shall be under the supervision of a clinical director, service chief or equivalent who is qualified to provider the leadership required for an intensive treatment program. The number and qualifications of physicians shall be adequate to provide essential psychiatric services.

1. The clinical director, service chief or equivalent shall be certified by the American Board of Psychiatry and Neurology, or shall meet the training and experience requirements for examination by the board ("board eligible"). In the event the psychiatrist in charge of the clinical program is board eligible, there shall be evidence of consultation given to the clinical program on a continuing basis from a psychiatrist certified by the American Board of Psychiatry and Neurology.

2. The medical staff shall be qualified legally, professionally and ethically for the positions to which they are appointed.

3. The number of physicians shall be commensurate with the size and scope of the treatment program.

4. Residency training shall be under the direction of a properly qualified psychiatrist.

(c) Availability of physicians and other personnel. Physicians and other appropriate professional personnel shall be available at all times to provide necessary medical and surgical diagnostic and treatment services including specialized services. If such services are not available within the institution, qualified consultants or attending physicians shall be immediately available, or a satisfactory arrangement shall be established for transferring patients to a certified general hospital.

(d) Nursing services. Nursing services shall be under the direct supervision of a registered professional nurse who is qualified by education and experience for the position. The number of registered professional nurses, licensed practical nurses, and other nursing personnel shall be adequate to formulate and carry out the nursing components of the individual treatment plan for each patient.

1. The registered professional nurse supervising the nursing services shall have a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or shall be qualified (by education, experience in the care of the mentally ill, and demonstrated competence to participate in interdisciplinary formulation of individual treatment plans) to give skilled nursing care and therapy, and to direct, supervise and train others who assist in implementing and carrying out the nursing components of each patient's treatment plan.

2. The staffing pattern shall insure the availability of a registered professional nurse 24 hours each day: for direct care, for supervising care performed by other nursing personnel, and for assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel. Such assignment shall be according to the patient's needs and according to the preparation and competence of the nursing staff available.

3. The number of registered professional nurses, including nurse consultants, shall be adequate to formulate in writing a nursing care plan for each patient and shall be adequate to assure that each nursing care plan is carried out.

4. Registered professional nurses and other nursing personnel shall be prepared by continuing inservice and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients. Such programs shall include preparation for participation in diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.

(e) Psychological services. Psychological services shall be under the supervision of a qualified psychologist. The psychology staff, including consultants, shall be adequate in numbers and qualifications to plan and carry out assigned responsibilities.

1. The psychology department or service shall be under a psychologist with a doctoral degree in psychology from an American Psychological Association-approved program in clinical psychology or its adjudged equivalent. Where a psychologist who does not hold the doctoral degree directs the program, the psychologist shall have attained recognition of competency through the American Board of Examiners for Professional Psychology, through state licensing, or through endorsement by the state psychological association.

2. Psychologists, consultants and supporting personnel shall be adequate in number and qualifications: to assist in essential diagnostic formulations; and to participate in program development and evaluation of program effectiveness, training and research activities, therapeutic interventions such as milieu, individual or group therapy, and interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs.

(f) Social work services and staff. Social work services shall be under the supervision of a qualified social worker. The social work staff shall be adequate in numbers and qualifications to fulfill specific needs of individual patients and their families; to develop community resources and to consult with other staff and community agencies.

1. The director of the social work department or service shall have a master's degree from an accredited school of social work and meet the experience requirements for certification by the Academy of Certified Social Workers.

2. Social work staff, including other social workers, consultants and other assistants or case aides, shall be qualified and numerically adequate to conduct prehospitalization studies; to provide psychosocial data for diagnosis and treatment planning; to provide direct therapeutic services to patients, patient groups or families; to develop community resources, including family or foster care programs; to conduct appropriate social work research and training activities; and to participate in interdisciplinary conferences and meetings concerning diagnostic formulation and treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.

(g) Qualified therapists and others. Qualified therapists, consultants, volunteers, assistants or aides shall be sufficient in number to provide comprehensive therapeutic activites, including at least occupational, recreational and physical therapy, as needed, to assure that appropriate treatment is rendered for each patient, and to establish and maintain a therapeutic milieu.

1. Occupational therapy services shall be under the supervision of an occupational therapist meeting the requirements of HSS 105.28. In the absence of a full-time, qualified occupational therapist, an occupational therapy assistant meeting the requirements of HSS 105.285 may function as the director of the activities program, with consultation from a fully qualified occupational therapist.

2. When physical therapy services are offered, the services shall be given by or under the supervision of a physical therapist who meets the requirements of HSS 105.27. In the absence of a full-time, qualified physical therapist, physical therapy services shall be available by arrangement with a certified general hospital or by either consultation or part-time services furnished by a fully qualified physical therapist.

3. Recreational or activity therapy services shall be available under the direct supervision of a member of the staff who has demonstrated competence in therapeutic recreation programs.

4. Other occupational therapy, recreational therapy, activity therapy and physical therapy assistants or aides shall be directly responsible to qualified supervisors and shall be provided special on-the-job training to fulfill assigned functions.

5. The total number of rehabilitation personnel, including consultants, shall be sufficient to permit adequate representation and participation in interdisciplinary conferences and meetings affecting the planning and implementation of activity and rehabilitation programs, including diagnostic conferences; and to maintain all daily scheduled and prescribed activities including maintenance of appropriate progress of records for individual patients.

6. Voluntary service workers shall be under the direction of a paid professional supervisor of volunteers, shall be provided appropriate orientation and training, and shall be available daily in sufficient numbers to be of assistance to patients and their families in support of therapeutic activities.

(4) Inspections of care. The pertinent sections of HSS 105.10(19) which relate to inspections of care in psychiatric facilities shall apply.

5.22 Requirements for Certification of Psychotherapy Providers.

(1) (The former Wis. Adm. Code chapter PW-MA 25 is repealed and partially recreated in this section for purposes of certification.) Psychotherapy providers are required to be either:

(a) A licensed physician who has completed a residency in psychiatry,

or who is certified by the American Board of Family Practice; or

(b) A licensed psychologist who is listed or eligible to be listed in the National Register of Health Services Providers in Psychology; or

(c) An outpatient facility operated by a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats.; or

(d) An outpatient facility operated by a provider hospital which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and which is accredited by JCAH, Accreditation Program for Psychiatric Facilities; or

(e) At the discretion of the department, an outpatient facility under contract to a "board" as defined in chapter one of this rule which is certified under Chapter PW-MH 60.65 (and 60.72 if applicable), Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and which has made substantial effort to comply with the requirements for accreditation by JCAH, Accreditation Program for Psychiatric Facilities.

(2) Staffing requirements for outpatient facilities.

(a) To provide psychotherapy reimbursable under the medical assistance program, personnel employed by an outpatient facility as defined in 5.22(1) (c), (d) or (e) shall be required to meet provider certification standards specified in this subsection and shall be under the supervision of a licensed physician or licensed psychologist who meets the requirements of 5.22(1)(a) or (b). (Such persons shall not however be required to be individually certified as providers and may provide psychotherapy services upon the department's issuance of certification to the facility by which they are employed.) Persons eligible in this subsection shall be:

1. A person with any of the following masters degrees and course work emphasis in clinical psychology: counseling and guidance, counseling psychology, clinical psychology, psychology or school psychology; or

2. A person with a masters degree in social work from a graduate school of social work accredited by the Council on Social Work Education, with course work emphasis in case work or clinical social work; or

3. A person with a masters degree in psychiatric mental health nursing from a graduate school of nursing accredited by the National League for Nursing. Providers defined by subparagraphs 1 through 3 shall also have 2,000 hours of supervised experience in clinical practice. Supervised during the 2,000 hour period means a minimum of one hour per week of face-to-face supervision by another person meeting the minimum qualifications to be a provider.

4. A licensed psychologist or licensed physician.

(b) The facility shall provide a list naming personnel employed by the facility who shall be performing psychotherapy services for which reimbursement shall be claimed under the medical assistance program. Such listing shall certify the credentials possessed by the named persons which would qualify them for certification under the standards specified in subsection (a) above. A facility, once certified, shall be under a

continuing obligation to promptly advise the department in writing of the procurement or termination of employees who shall be, or have been, providing psychotherapy services under the medical assistance program.

(3) Reimbursement for outpatient psychotherapy services. Outpatient psychotherapy services shall be reimbursed according to medicare profiles or other mechanisms established by the department for the applicable provider and shall be as follows:

(a) For the services of any provider working in a certified outpatient facility, reimbursement shall be to the facility;

(b) For the services of any provider in private practice who is licensed and certified according to Sec. 5.22(1)(a) or (b), reimbursement shall be to that provider.

(4) Reimbursement for inpatient psychotherapy services. Reimbursement shall be made to providers defined in 5.22(1)(a) and (b) who provide psychotherapy services to a recipient while the recipient is an inpatient in a general, acute care hospital or in a psychiatric facility. Psychotherapy services provided to such inpatients shall be reimbursed according to medicare profiles or other mechanisms established by the department for the applicable provider and shall be as follows:

(a) For the services of an provider who is a licensed physician defined in 5.22(1)(a) or a licensed psychologist defined in 5.22(1)(b) employed by or under contract to an outpatient facility, reimbursement shall be to the facility;

(b) For the services of any provider who is a licensed physician defined in 5.22(1)(a) or a licensed psychologist defined in 5.22(1)(b) in private practice, reimbursement shall be to the physician or psychologist.

5.23 Requirements for Certification for Alcohol and Other Drug Abuse Treatment Providers

(1) Outpatient alcohol and other drug abuse treatment providers are required to be:

(a) An outpatient facility operated by a "board" as defined in chpater one of this rule which is certified under Chapter PW-MH 61.03 Wis. Adm. Code and section 632.89(1)(a), Wis. Stats.; or

(b) An outpatient facility operated by a hospital which is certified under PW-MH 61.03 Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and which is accredited by JCAH; or

(c) At the discretion of the department, an outpatient facility under contract to a "board" as defined in chapter one of this rule which is certified under PW-MH 61.03 Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and has made substantial effort to comply with the requirements for accreditation by JCAH.

(d) Providers defined in 5.22(1)(a) and (b) are eligible for reimbursement for AODA services if provider has a written agreement with a facility defined in 5.23(1)(a), (b) or (c) and the recipient being treated is enrolled in an AODA program at such facility.

(2) Staffing requirements for AODA outpatient facilities.

(a) To provide AODA services reimbursable under the medical assistance program, personnel employed by an outpatient facility defined in 5.23(1)(a), (b) and (c) shall meet the requirements in subsection 5.22(2)(a)(1)(2)(3); or

(b) Shall be an alcohol and drug abuse counselor certified by the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board, Inc.

AODA counselors shall work under the supervision of a provider who is a licensed physician or licensed psychologist, employed by the same facility.

(c) The facility shall provide a list naming personnel employed by the facility performing AODA services for which reimbursement shall be claimed under the medical assistance program. Such listing shall certify the credentials possessed by the named persons which would qualify them for certification under the standards specified in subsection 5.23(2) (a) and (b). A facility, once certified, shall be under a continuing obligation to promptly advise the department in writing of the procurement or termination of employees who shall be, or have been, providing psychotherapy services under the medical assistance program.

(3) Reimbursement for AODA services. Reimbursement for outpatient alcohol and other drug abuse treatment services shall be according to medicare profiles or other mechanisms established by the department for the applicable providers as follows:

(a) For the services of any provider employed by or under contract to a certified AODA facility, reimbursement will be made to the facility;

(b) For ther services of any provider who is a physician or licensed psychologist defined in 5.23(1)(d) in private practice, reimbursement shall be to the physician or psychologist.

5.245 Day Treatment or Day Hospital Services

(1) Day treatment or day hospital service providers are required to be either:

(a) A medical program operated by a "board" as defined in chpater one of this rule which is certified under Chapter PW-MH 60.67 (and 60.73 or 61.03 if applicable) Wis. Adm. Code and section 632.89(1)(a), Wis. Stats.; or

(b) A medical program operated by a hospital which is certified under PW-MH 60.67 (and 60.73 or 61.03 if applicable), Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and which is accredited by JCAH; or

(c) At the discretion of the department, a medical program under contract to a "board" as defined in chpater one of this rule which is certified under Chapter PW-MH 60.67 (and 60.73 or 61.03 if applicable), Wis. Adm. Code and section 632.89(1)(a), Wis. Stats. and which has made substantial effort to comply with the requirements for accreditation by JCAH, Accreditation Program for Psychiatric Facilities.

(2) Program personnel and staffing.

(a) A registered nurse and a registered occupational therapist shall be on duty to participate in program planning [redacted] program implementation and daily program coordination.

(b) The day treatment program shall be planned for and directed by designated members of the interdisciplinary team including but not limited to a social worker, a psychologist, an occupational therapist and a registered nurse (or other appropriate health care professional, e.g. physician, physician's assistant).

(c) A written patient evaluation involving an assessment of the patient's progress by each member of the multidisciplinary team shall be made once very 60 days.

(d) For the purposes of daily program performance, coordination, guidance and evaluation, there shall be:

1. One qualified professional staff (e.g. OTR, MSW, RN, licensed psychologist, MS psychologist) per group; or

2. One certified occupational therapist assistant and one other paraprofessional per group; and

3. Other appropriate staff, including volunteer staff.

(e) The program shall have written agreements for ongoing working arrangement with other support groups (e.g. residential facility activity programs, sheltered workshops.)

(3) Reimbursement for day treatment or day hospital services. Reimbursement for medical day treatment or day hospital services will be according to a rate established by the Wisconsin Hospital Rate Review Program (for hospital operated programs) or, for non-hospital based programs at a rate established and approved by the department.

5.25 Requirements for Certification of Podiatrists. Podiatrists are requried to be licensed pursuant to section 448.04 (1)(d), Wis. Stats., and registered pursuant to section 448.07, Wis. Stats. and Wis. Adm. Code chapter Med 30.

5.26 Requirements for Certification of Chiropractors. Chiropractors are required to be licensed pursuant to section 446.02, Wis. Stats.

5.27 Requirements for Certification of Physical Therapists. Physical therapists are required to be licensed pursuant to sections 448.07 and 448.05, Wis. Stats. and Wis. Adm. Code chapter Med 7.

5.275 Requirements for Certification of Physical Therapist Assistants. Physical therapist assistants are required to be graduated from a two-year college-level program approved by the American Physical Therapy Association, and to provide their services under the direct, immediate on-premises supervision of a physical therapist certified pursuant to section 5.27 of this rule. Physical therapist assistants are not eligible to bill or to be reimbursed directly for their services.

5.28 Requirements for Certification of Occupational Therapists. Occupational therapists are required to be certified by the American Occupational Therapy Association as occupational therapists, registered; or to be graduated from a program in occupational therapy accredited by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association and to have completed the required supplemental field work experience, and to have made application to the American Occupational Therapy Association for the certification examination for occupational therapist, registered.

5.285 Requirements for Certification of Occupational Therapy Assistants. Occupational therapy assistants are required to be certified by the American Occupational Therapy Association as certified occupational therapy assistants, and shall provide services under the direct, immediate on-premises supervision of an occupational therapist certified pursuant to section 5.28. Occupational therapy assistants are not eligible to bill directly or to be reimbursed directly for their services.

5.29 Requirements for Certification of Speech and Hearing Clinics. Speech and hearing clinics are required to be accredited by the American Speech and Hearing Association (ASHA) pursuant to the guidelines of "Accreditation of Professional Services Programs in Speech Pathology and Audiology" published by ASHA.

5.30 Requirements for Certification of Speech Pathologists.

(1) Speech pathologists are required to possess a Certificate of Clinical Competence from the American Speech and Hearing Association or to have completed the equivalent educational requirements and work experience necessary for such a certificate, or shall have completed the academic program and be in the process of accumulating the supervised work experience required to qualify for such a certificate.

(2) Speech pathologists having a bachelor's degree with a major emphasis in speech pathology from an accredited college or university are eligible to participate in the program if supervised by a speech pathologist certified pursuant to section 5.30(1). Such speech pathologists are not eligible to bill or to be reimbursed directly for their services.

5.31 Requirements for Certification of Audiologists. Audiologists are required to possess a Certificate of Clinical Competence from the American Speech and Hearing Association (ASHA) or to have completed the equivalent educational requirements and work experience necessary for such a certificate, or shall have completed the academic program and be in the process of accumulating the work experience required to qualify for such a certificate.

5.32 Requirements for Certification of Optometrists. Optometrists are required to be licensed and registered pursuant to sections 449.04, and 449.06, Wis. Stats.

5.33 Requirements for Certification of Opticians. Opticians are eligible to participate in the program.

5.34 Requirements for Certification of Clinics, Rehabilitation Agencies and Public Health Agencies providing outpatient physical therapy or speech pathology services, or both. Clinics, rehabilitation agencies and public health agencies providing outpatient physical therapy or speech pathology are required to be certified to participate in Medicare. (For purposes of program administration, the following rules, which are a codification of 42 CFR 405.1702 through 1726, are adopted. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the federal regulations shall hold).

(1) Compliance with federal, state and local laws. All organization staff shall be licensed or registered pursuant to applicable Wisconsin law.

(2) Administrative management.

(a) Governing body. There shall be a governing body (or designated person(s) so functioning) which shall assume full legal responsibility for the overall conduct of the clinic or agency and for compliance with applicable laws and regulations. The name of the owner(s) of the organization, (or if the organization is a corporation, the names of the corporate officers) shall be disclosed to the department.

(b) Administrator. The governing body shall appoint a full time administrator to direct the internal operation of the clinic or agency in accordance with established written policies. The administrator's responsibilities for procurement and direction of personnel shall be clearly defined. Such person shall have a bachelor's degree and:

1. Experience or specialized training in the administration of health institutions or agencies; or

2. Qualifications and experience in one of the professional health disciplines.

(c) Personnel policies. Personnel policies and records shall be documented in writing and kept current. Personnel records include job descriptions, qualifications, licensure, performance evaluations, and health examinations.

(d) Patient care policies. Patient care policies shall be established by a group of one or more physicians associated with the organization and one or more physical therapists (if physical therapy services are provided) and one or more speech pathologists (if speech pathology services are provided). Patient care policies shall be documented in writing. Policies shall cover scope of services offered, admission and discharge policies, physicians' services, patient care plans and methods of implemention, care of patient in an emergency, clinical records, administrative records, use and maintenance of plant and equipment and program evaluation. Policies shall be reviewed annually.

(3) Physician's direction and plan of care.

(a) The organization shall have available a physician to furnish medical care in case of emergencies. Each recipient shall be under the general medical direction of a physician, who shall provide appropriate medical information concerning the recipient's condition. The physician is responsible for general medical direction of services. Outpatient physical therapy or speech pathology services shall be provided only upon order by such physician.

(b) The following items shall be made available to the organization before or at the time of initiation of treatment: patient's significant past history; current medical findings; diagnosis(es); physician's orders; rehabilitation goals, if determined; contraindications, if any; the extent to which the patient is aware of diagnosis(es); prognosis and where appropriate, summary of treatment provided and results achieved during previous periods of physical therapy or speech pathology services or institutionalization.

(c) A written plan of care shall be established by the physician and amended as necessary for each recipient. Plan of care shall include goals of treatment and type, amount, frequency and duration of therapy. Plan of care shall be reviewed at least every 30 days by the physician.

(d) The patient in need of therapy shall be seen by the physician at least once every 30 days. The organization is responsible for contacting the physician if the patient has not been seen by the physician within a 30-day period. There shall be evidence in the clinical record that the physician has seen the recipient.

(e) A recipient's attending physician or another responsible physician shall be promptly notified of any changes in the recipient's condition. If changes are required, they shall be approved by the physician and noted in the clinical record.

(f) One or more physicians shall be available on call to provide emergency medical care. A list of names and phone numbers of these physicians on call shall be posted. There shall be established procedures to be followed in case of an emergency.

(4) Physical therapy services.

(a) If the clinic or agency provides physical therapy services, the organization shall provide physical therapy staff qualified to perform a full range of services, including evaluations, tests, exercises and other customary treatments and equipment necessary to provide services. If services are provided off the premises by a qualified physical therapist assistant, supervision shall comply with the provisions of s. 448.3 Stats.

(b) The agency or clinic shall have the facilities and equipment necessary to carry out its physical therapy program.

(c) Physical therapy services shall be provided by or under the supervision of a physical therapist. A physical therapist shall be on the premises or readily available during operating hours.

(d) Supportive personnel shall be instructed in patient care techniques by a physical therapist.

(5) Speech pathology services.

(a) If the clinic or agency provides speech pathology services, the speech pathology program shall include effective diagnostic and treatment services.

(b) The clinic or agency shall have the facilities and equipment necessary to carry out its speech pathology program.

(c) Speech pathology services shall be provided or supervised by a speech pathologist, who shall be present whenever speech pathology services are provided.

(6) Rehabilitation program. In addition to either physical therapy services or speech pathology services, or both, the organization shall provide a rehabilitation program that includes social or vocational adjustment. Qualified staff shall be available for the rehabilitation program.

(a) A qualified vocational specialist may provide vocational adjustment services. Either a psychologist or a social worker may provide vocational or social adjustment services.

(b) If a rehabilitation agency does not provide social or rehabilitation services through salaried employees, it may provide such services by means of a written contract with others. Such contract shall:

1. Require development of an appropriate regimen of services by physician and professional staff;

2. Specify the geographical areas in which the services are to be provided;

3. Require that services are provided by appropriate qualified personnel;

4. Require that personnel under contract participate in patient care conferences;

5. Require that treatment records and notes be prepared and promptly incorporated into clinic or agency records;

6. Specify the effective dates and manner of termination or renewal of the contract;

7. Specify that the organization retains responsibility for and control and supervision of services.

(7) Arrangement for physical therapy or speech pathology services provided by other than salaried organization staff.

(a) If a clinic or agency provides outpatient physical therapy or speech pathology services, or both, under an arrangement with others,

such services shall be provided according to the terms of a written contract. Such contract shall stipulate that the organization retains professional and administrative responsibility for, and control and supervision of services, and shall:

1. Require that services be provided in accordance with a written plan of care as enumerated in subsection 5.34(3);

2. Specify the geographical areas in which services will be provided;

3. Provide that contracted services and personnel meet the same applicable requirements that would apply if the clinic or agency were directly providing the services;

4. Require that personnel under contract participate in patient care conferences;

5. Require that treatment records and notes be prepared and promptly incorporated into clinic or agency records;

6. Provide that only the contractor clinic or agency shall submit claims for services to the program, and that recipients shall not be billed for services covered by the program;

7. Specify the effective dates of the contract and the manner of termination or renewal;

8. Except as stated in subsection 5.34(7)(a)9, require that services be provided in the recipient's home, on the premises of the contractor organization or on the premises of a hospital or skilled nursing facility participating in the program;

9. If the contractor is a public health agency, allow services to be provided on the premises of the supplier of services if the following conditions are met:

a. The public health agency is not able to provide the required physical therapy or speech pathology services on its premises;

b. The required services are not provided on an outpatient basis in another accessible participating provider;

c. Only those services not available on the premises of the public health agency are provided on the premises of the supplier;

d. The public health agency notifies the department of the name of each supplier with whom it contracts for services; and

e. All records of patients of the public health agency who have been treated on the premises of the supplier are reviewed at least every 2 weeks by an appropriate health professional employed by the public health agency.

(8) Clinical records. Complete, accurate, accessible and organized clinical records shall be maintained on all patients.

(a) Written procedures shall be established to protect the confidentiality of clinical records. The patient's written consent is required for release of information not authorized by law.

(b) Clinical records shall contain sufficient information to clearly identify each patient, to justify all diagnoses and treatment, and to accurately document results.

(c) Clinical records shall be completed promptly, with all physicians' entries signed by the physician making the entry.

(d) Clinical records shall be retained for not less than 5 years.

(e) Clinical records shall be indexed at least according to patient name.

(f) The organization shall maintain adequate, conveniently located equipment and facilities to ensure efficient processing of clinical records.

(9) Physical environment.

(a) The clinic or agency shall comply with all applicable state and local building, fire and safety codes.

(b) The building shall have permanently attached automatic fire-extinguishing systems of adequate capacity in all areas considered to have special fire hazards. Fire extinguishers shall be conveniently located on each floor and fire regulations shall be prominently posted throughout the building.

(c) Doorways, passageways and stairwells negotiated by patients shall be:

1. Of adequate width to allow for easy movement of all patients, including those on stretchers or in wheelchairs;

2. Free from obstruction at all times; and

3. In the case of stairs, equipped with firmly attached handrails on at least one side.

(d) Lights shall be placed at exits and in corridors used by patients and shall be supported by an emergency power source.

(e) There shall be a functional fire alarm system with local alarm capability, and an emergency power source where applicable.

(f) At least 2 persons shall be on duty on the premises of the organization whenever a patient is being treated.

(g) No occupancies or activities which are undesirable or injurious to the health and safety of patients shall be located in the building.

(h) There shall be a written preventive-maintenance program to ensure that:

1. Equipment is operative and properly calibrated; and

2. The interior and exterior of the building are clean and orderly and maintained free of any defects that are a potential hazard to patients, personnel and the general public.

(i) Provision shall be made for adequate and comfortable lighting levels in all areas; a comfortable room temperature; and adequate ventilation through windows, mechanical means, or both.

(j) Toilet rooms, toilet stalls and lavatories shall be accessible and constructed to allow use by nonambulatory and semi-ambulatory persons.

(k) There shall be adequate space for services provided and for administrative functions.

(10) Infection control.

(a) There shall be an infection control committee which establishes policies and procedures for investigating, controlling and preventing infections, and monitors execution of the policies and procedures.

(b) Written effective procedures in aseptic techniques shall be followed by all personnel. Procedures shall be reviewed and revised annually for effectiveness and improvement.

(c) The agency or clinic shall employ sufficient housekeeping personnel and provide all necessary equipment to maintain a safe, clean and orderly interior. A full-time employee shall be responsible for housekeeping services and for supervision and training of housekeeping personnel. An organization that has a contract with an outside housekeeping service shall be considered to meet the requirements of this paragraph if the outside service meets the requirements of this paragraph.

(d) Pest control. A pest control program shall be in operation to maintain the organization free from insects and rodents.

(11) Disaster preparedness.

(a) Disaster plan. The organization shall have in operation a written plan with procedures to be followed in the event of fire, explosion or other disaster. Qualified fire, safety and other appropriate experts shall assist in the development and maintenance of the plan, which shall include:

1. Procedures for prompt transfer of casualties and records,
2. Instructions regarding the location and use of alarm systems and signals and firefighting equipment,
3. Information regarding methods of containing fire,
4. Procedures for notification of appropriate persons, and
5. Descriptions of evacuation routes and procedures.

(b) Staff training and drills. All employees shall be trained as part of their employment orientation, in all aspects of preparedness for any disaster. The disaster program shall include orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out an assigned role in case of a disaster.

(12) Program evaluation.

(a) Clinical record review. A sample of active and closed clinical records shall be reviewed quarterly by appropriate health professionals to assure that established policies are followed in providing services.

(b) Annual statistical evaluation. An evaluation shall be conducted annually of statistical data such as the number of different patients treated, number of patient visits, condition on admission and discharge, number of new patients, number of patients by diagnosis, sources of referral, number and cost of units of service by treatment given, and total staff days or work hours by discipline.

5.35 Requirements for Certification of Rural Health Clinics.

(1) Purpose. It is the intention of the Rural Health Clinic Services Act of 1977 (P.L. 95-210) to increase the availability of medical care and services to residents of areas that have a shortage of health manpower. The department, with the encouragement of the U.S. department of health, education and welfare, intends to implement the legislative intent, that is, the unique circumstance of these clinics shall be taken into account, and the clinics shall be subject to regulations which are more flexible and less complex than requirements applicable to hospitals and other large institutions. (NOTE: The following rules are a codiification of 42 CRF Part 481. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the federal regulations shall hold.)

(2) Certification of clinics. A clinic is required to be certified under Medicare in order to be eligible for participation under Medicaid. Certification by Medicare shall be considered as meeting the standards for certification under Medicaid.

(a) The clinic shall be licensed pursuant to all other local and state laws and regulations.

(b) The staff of the clinic shall be licensed, certified, or registered in accordance with appropriate state laws.

(c) Program evaluation.

1. The clinic shall carry out or arrange for an annual evaluation of its total program.

2. The evaluation shall include review of:

a. The utilization of clinic services, including at least the number of patients served and the volume of services;

b. A representative sample of both active and closed clinical records; and

c. The clinic's health care policies.

3. The purpose of the evaluation is to determine whether:

a. The utilization of services was appropriate;

b. The established policies were followed; and

c. Any changes are needed.

4. The clinic staff shall consider the findings of the evaluation and take corrective action if necessary.

(3) Location. A clinic must be located in a rural area meeting the conditions of a medically underserved area or a critical health manpower shortage area. It may be in either a permanent or a mobile unit.

(4) Criteria for determining a shortage area.

(a) The criteria for determination of shortage of personal health services (under section 1302(7) of the Public Health Services Act) are:

1. The ratio of primary care physicians practicing within the area to the resident population;

2. The infant mortality rate;

3. The percent of the population 65 years of age or older; and

4. The percent of the population with a family income below the poverty level. (See 42 CFR 110.203(g) and 41 FR 45718, October 15, 1976).

(b) The criteria for determination of shortage of primary medical care manpower (under section 332(a)(1)(A) of the Public Health Services Act) are:

1. The area served is a rational area for the delivery of primary medical care services;

2. The ratio of primary care physicians practicing within the area to the resident population; and

3. The primary medical care manpower in contiguous areas is overutilized, excessively distant, or inaccessible to the population in this area. (See 42 CFR Part 5; 42 FR 1586, January 10, 1978).

(5) Physical plant and environment.

(a) Construction. The clinic shall be constructed, arranged, and maintained to insure access to and safety of patients, and shall provide adequate space for the provision of direct services.

(b) Maintenance. The clinic shall have a preventive maintenance program to ensure that:

1. All essential mechanical, electrical and patient-care equipment is maintained in safe operating condition;

2. Drugs and biologicals are appropriately stored; and

3. The premises are clean and orderly.

(c) Emergency procedures. The clinic shall assure the safety of patients in case of non-medical emergencies, by:

1. Training staff in handling emergencies;

2. Placing exit signs in appropriate locations; and

3. Taking other appropriate measures that are consistent with the particular conditions of the area in which the clinic is located.

(6) Organizational structure.
(a) Basic requirements.
1. The clinic shall be under the medical direction of a physician, and shall have a health care staff that meets the requirements of 5.35(7).
2. The organization's policies and its lines of authority and responsibilities shall be clearly set forth in writing.
(b) Disclosure. The clinic shall disclose the names and addresses of:
1. Its owners, in accordance with Section 1124 of the Social Security Act (42 USC 132 A-3);
2. The person principally responsible for directing the operation of the clinic; and
3. The person responsible for medical direction.

(7) Staffing and staff responsibilities.
(a) Staffing.
1. The clinic shall have a health care staff that includes one or more physicians and one or more physician's assistant or nurse practitioners.
2. The physician's assistant shall be certified pursuant to section 5.075 of this rule.
3. Nurse practitioners shall be certified pursuant to section 5.20 of this rule, and any regulations promulgated in accordance with chapter 441, Wis. Stats.
4. The physician member of the staff may be the owner of the clinic, or may be working under agreement with the clinic to carry out the responsibilities required under this section.
5. The nurse practitioner member of the staff may be the owner of the clinic or an employee of the clinic.
6. The staff may also include ancillary personnel who are supervised by the professional staff.
7. The staff shall be sufficient to provide services essential to the operation of the clinic.

(8) Physician responsibilities. The physician shall:
(a) Provide medical direction for the clinic's health care activities, and shall provide consultation for and medical supervision of, the health care staff.
(b) In conjunction with the physician's assistant or nurse practitioner member(s), participate in developing, executing, and periodically reviewing the clinic's written policies and the services provided to medical assistance patients.
(c) Periodically review the clinic's patient records, provide medical orders, and provide medical care services to the patients of the clinic.
(d) Be present for sufficient periods of time, at least once in every 2 week period (except in extraordinary circumstances), to provide the medical direction, medical care services, consultation and supervision described in this subsection, and be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances shall be documented in the records of the clinic.

(9) Physician's assistant and nurse practitioner.
(a) The physician's assistant and the nurse practitioner members of the clinic's staff shall:

1. Participate in the development, execution and periodic review of the written policies governing services;

2. Participate with a physician in a periodic review of the patients' health records.

3. Be available to furnish patient care services at least 60% of the time the clinic operates.

(b) The physician's assistant or nurse practitioner shall perform the following functions, to the extent they are not being performed by a physician:

1. Provide services in accordance with the clinic's policies;

2. Arrange for, or refer patients to needed services that cannot be provided at the clinic; and

3. Assure that adequate patient health records are maintained and transferred as required when patients are referred.

(10) Provision of services.

(a) Basic requirements.

1. The clinic shall be primarily engaged in providing outpatient health services and shall meet all other conditions of this subsection.

(b) Patient care policies.

1. The clinic's health care services shall be furnished in accordance with appropriate written policies consistent with applicable state law.

2. The policies shall be developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician's assistants or nurse practitioners. At least one member shall not be a member of the clinic staff.

3. The policies shall include:

a. A description of the services the clinic furnishes directly and of those furnished through agreement or arrangement.

b. Guidelines for: the medical management of health problems including the conditions requiring medical consultation or patient referral; for the maintenance of health care records; and for procedures for the periodic review and evaluation of the services furnished by the clinic.

c. Rules for the storage, handling, and administration of drugs and biologicals.

4. Before certification of the rural health clinic, the written policies shall be reviewed and approved by a state inter-disciplinary professional team, including representatives from the medical profession (physician or physician assistant), the nursing profession (nurse or nurse practitioner), the pharmacy profession, the department, and at least two public members, one of whom shall be from a rural underserved population and the other of whom shall be from an urban underserved population.

5. These policies shall be reviewed at least annually by the group of professional personnel required under subsection 5.35 (10)(b)2, reviewed as necessary by the clinic, and reviewed and evaluated annually as part of the certification process by the state interdisciplinary team specified in subsection 5.35 10(b)4.

(c) Direct services.

1. General. The clinic staff shall furnish those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care delivery

system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

2. Laboratory. The clinic shall provide basic laboratory services essential to the immediate diagnosis and treatment of the patient, including:

a. Chemical examinations of urine by stick or tablet methods or both (including urine ketones);

b. Microscopic examinations of urine sediment;

c. Hemoglobin or hematacrit;

d. Blood sugar;

e. Gram stain;

f. Examination of stool specimens for occult blood;

g. Pregnancy tests;

h. Primary culturing for transmittal to a certified laboratory; and

i. Test for pinworm.

3. Emergency. The clinic shall provide medical emergency procedures as a first response to common life-threatening injury and acute illness, and shall have available the drugs and biologicals commonly used in life-saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids.

(d) Services provided through agreement or arrangements.

1. The clinic shall have agreements or arrangements with one or more certified providers or suppliers to furnish other services to its patients, including:

a. Inpatient hospital care;

b. Physicians services; and

c. Additional and specialized diagnostic and laboratory services that are not available at the clinic.

2. If the agreements are not in writing, there shall be evidence that patients referred by the clinic are being accepted and treated.

(11) Patient health records.

(a) Record system.

1. The clinic shall maintain a clinical record system in accordance with written policies and procedures.

2. A designated member of the professional staff shall be responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.

3. For each patient receiving health care services, the clinic shall maintain a record that includes, as applicable:

a. Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition and instructions to the patient;

b. Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;

c. All physician's orders, reports of treatments and medications and other pertinent information necessary to monitor the patient's progress;

d. Signatures of the physician or other health care professional.

(b) Protection of record information.

1. The clinic shall maintain the confidentiality of record information and shall provide safeguards against loss, destruction or unauthorized use.

2. Written policies and procedures shall govern the use and removal of records from the clinic, and the conditions for release of information.

(c) Retention of records. Records shall be retained for at least 6 years from date of last entry.

105.36 Requirements for Certification of Family Planning Clinics (agencies). Family planning clinics (agencies) are required to meet the following conditions:

(1) Certification. In order to qualify for medicaid reimbursement, family planning clinics must certify to the department that:

(a) All conditions for eligibility including income, assets and relative responsibility, as enumerated in HSS 103 have been verified;

(b) A medical assistance card has been shown before services were provided; and

(c) Services were prescribed by a physician.

(d) No sterilization procedures are available to persons who are incompetent, institutionalized or under the age of 21.

(2) Principles of operation.

(a) Family planning services shall be made available:

1. Upon referral from any source upon the patient's own application;

2. Without regard to race, nationality, religion, family size, marital status, maternity, paternity, handicap or age, in conformity with the spirit and intent of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973;

3. With respect for the dignity of the individual; and

4. With efficient administration, procedures for registration and delivery of services, avoiding prolonged waiting and multiple visits for registration. Patients shall be seen on an appointment basis whenever possible.

(b) Acceptance of family planning service shall be voluntary, and individuals shall not be subjected to coercion either to receive services or to employ or not to employ any particular methods of family planning. Acceptance or nonacceptance of family planning services shall not be a prerequisite to eligibility for or receipt of any other service funded by local, state, or federal tax revenue.

(c) A variety of medically approved methods of family planning, including the natural family planning method, shall be available to persons to whom family planning services are offered and provided.

(d) The clinic shall not provide abortion as a method of family planning.

(e) Diagnostic and treatment services for infertility shall be provided for in the family planning clinic. If such services are not available, the clinic shall make referrals to an appropriate, certified provider of such services.

(f) Efforts shall be made to obtain third party payments when available for services provided.

(g) All personal information obtained shall be treated as privileged communications, shall be held confidential, and shall be divulged only upon the recipient's written consent except when necessary to provide services to the individual or to seek reimbursement for such services. The agency director shall insure that all participating agencies preserve

the confidentiality of patient records. Information may be disclosed in summary, statistical, or other form which does not identify specific recipients.

(3) Administration.

(a) Governing body. The family planning clinic shall have a governing body which is responsible for the conduct of the staff and the operation of the clinic.

(b) Chief clinic officer. A designated person shall be responsible for the day-to-day operation of the clinic.

(c) Written policies and procedures shall be developed which govern the utilization of staff, services to patients, and the general operation of the clinic.

(d) Job descriptions for volunteer and paid staff shall be prepared to assist staff members in the performance of their duties.

(e) Each clinic shall have a record system that includes the following components:

1. Patient records;
   a. With pertinent medical and social history.
   b. With all patient contacts and outcomes.
   c. With accumulated data on supplies, staffing, appointments, and other administrative functions.
   d. For purposes of following up on patients for medical services or referrals to other community resources.
   e. For purposes of program evaluation.
2. Fiscal records accounting for cash flow;
3. Organizational records to document staff time, governing body meetings, administrative decisions, fund raising, etc.

(f) Each clinic shall engage in a continuing effort of evaluating, reporting, planning, and implementing changes in program operation.

(g) A system of appointments and referrals which is flexible enough to meet community needs shall be developed by each clinic.

(h) Provision shall be made for a medical back-up for patients who experience family planning related problems at a time when the clinic staff is unavailable.

(4) Staffing.

(a) Clinic staff, either paid or volunteer, shall perform the following functions:

1. Outreach workers or community health personnel shall have primary responsibility to contact appropriate individuals, initiate family planning counseling, and assist in receiving, successfully using, and continuing medical services.
2. Secretary or receptionist shall be responsible for greeting patients at the clinic, arranging for services, and performing a variety of necessary clerical duties.
3. Interviewer or counselor shall be responsible for taking social histories, providing family planning information to patients, and counseling patients regarding their family planning and related problems.
4. Nurse or clinic aide shall be responsible for assisting the physician in providing medical services to the patient.
5. Physician shall be responsible for provision of, or supervision over, all medical and related services provided to patients.
6. Clinic coordinator shall be responsible for overseeing the operation of the clinic.

(b) Training.

1. Training programs shall be available periodically to train new personnel.

2. For existing staff, time shall be allotted for staff conferences, and inservice training in new techniques and procedures.

(c) For volunteers, time shall be allocated for staff to coordinate, train, and supervise volunteers to be an effective, integral part of the clinic.

(d) Paraprofessionals. Paraprofessional personnel may be hired and trained.

(5) Patient and community outreach. Each clinic shall have an active outreach effort aimed at:

(a) Recruiting and retaining patients in the family planning clinic, through:

1. A system of identifying the primary target populations;

2. A method of contacting the target population;

3. Procedures for family planning counseling and motivating appropriate persons to avail themselves of family planning medical services;

4. Assisting individuals in receiving family planning medical services;

5. Activities designed to follow-up potential and actual family planning patients as indicated.

6. A record system sufficient to support the above functions (1 through 5).

(b) Meeting all human needs through appropriate and effective referral to other community resources;

(c) Increasing community awareness and acceptance of the family planning clinic through:

1. The use of mass media;

2. Presentations to community organizations and agencies;

3. Public information campaigns utilizing all channels of communication;

4. Development of formal referral arrangements with community resources;

5. Involvement of appropriate community residents in the operation of the family planning clinic.

(6) Patient education and counseling. At the time the patient is to receive family planning medical services, the following components of social services shall be provided:

(a) An intake interview designed to obtain pertinent information regarding the patient, to explain the conditions under which services are provided, and to create the opportunity for a discussion of the patient's problems;

(b) A group or individual information session which includes:

1. Reproductive anatomy and physiology;

2. Methods of contraception, including how they work, side effects and effectiveness;

3. An explanation of applicable medical procedures;

4. An opportunity for patients to ask questions and discuss their concerns;

5. An optional discussion of such topics as breast and cervical cancer, venereal disease, human sexuality or vaginopathies.

(c) An exit interview which is designed to:

1. Clarify any areas of concern or questions regarding medical services;

2. Elicit from the patient a complete understanding regarding the use of family planning methods;

3. Effectively inform the patient what procedures are to be followed if problems are experienced;

4. Inform the patient about the clinic's follow-up procedures and possible referral to other community resources;

5. Arrange for the next visit to the clinic.

(7) Medical services. All medical and related services shall be provided by or under the supervision and responsibility of a physician.

(a) The following medical services shall be made available:

1. Complete medical and obstetrical history;

2. Physical examination;

3. Laboratory evaluation;

4. Prescription of the family planning method of patient's choice unless medically contraindicated;

5. Instructions on the use of the chosen method, provision of supplies, and schedule for revisits;

6. Infertility screening and diagnosis;

7. Inpatient service referral when necessitated by complications of contraceptive services provided by the clinic.

(b) Equipment and supplies in the clinic shall be commensurate with the services offered. Sufficient first aid equipment shall be available for use when needed.

(c) Treatment for minor vaginal infections and venereal disease may be made available either by clinic staff or through referral.

(8) Facilities. The family planning clinic shall be designed to provide comfort and dignity for the patients and to facilitate the work of the staff. A clinic facility shall be adequate for the quantity of services provided, and shall include:

(a) A comfortable waiting room with an area for patient reception, record processing, and children's play;

(b) Private interviewing counseling areas;

(c) A group conference room for staff meetings and patient education;

(d) A work room or laboratory area with sufficient equipment and nearby storage space, none of which is accessible to the patient;

(e) A sufficient number of private and well-equipped examining rooms with proximal dressing areas which ensure the dignity of the patient;

(f) Adequate toilet facilities, preferably near the dressing room;

(g) Arrangements for routine and restorative facility maintenance.

5.37 Requirements for Certification of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Agencies.

(1) EPSDT outreach and follow-up services.

(a) In order to facilitate the delivery of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to individuals under the age of 21 who are eligible for medical assistance, outreach and follow-up providers shall be certified to provide the following services:

1. Identification of the target population within the provider's service area. The department and its agent shall assist providers in identifying the target population and in initially notifying the population of the availability of services.

2. Initial and periodic notification of eligible recipients, or their parents or guardians, of available program benefits;

3. Assistance to recipients in obtaining the screening, diagnosis, and treatment benefits available;

4. Necessary follow-up of initial contact to arrange for appointments, transportation, and other needed services to enable recipients to participate in the EPSDT program.

(b) Such providers shall enter into a provider contract with the department to provide both outreach and follow-up services, and shall meet the requirements of this rule.

(c) Experience and Orientation Requirements. Providers of outreach and follow-up services shall have demonstrated involvement with the EPSDT population as indicated by at least one year's active participation in one or more of the following programs:

1. Women and Infant Care;
2. Headstart;
3. Community Action;
4. Children and Youth;
5. Family Planning Clinics;
6. Food Stamp Outreach;
7. Other Title V or Title V-related programs which demonstrate experience applicable to the provision of EPSDT outreach and follow-up activities;
8. Local Public Health Agencies;
9. City and County Social Service Agencies;
10. Neighborhood Health Centers;
11. Private Clinics, HMO's, Hospital Outpatient Clinics, and Rural Health Clinics; or
12. Other providers actively performing EPSDT services as of July 1, 1979.

(d) Procedural and Personnel Requirements. Providers of outreach and follow-up services shall meet the following conditions:

1. Services shall be concentrated upon the target population compiled and identified by the department.

2. Providers shall employ or contract with skilled medical workers, outreach personnel, and other agency personnel to provide required services.

a. Skilled medical worker may include a physician, dentist, nurse, medical social worker, psychiatric social worker, medical administrator, hospital or public health administrator, nursing home administrator, or other specialized medical care personnel or professional health practitioner.

b. At least one skilled medical worker shall provide direct supervision of outreach personnel.

c. Other agency personnel shall include, but not be limited to field workers, secretarial and clerical workers. Other agency personnel shall be trained in their respective duties and shall complete a basic orientation, according to standards and criteria provided by the department. Duties of other agency personnel shall be in direct association with or in support of functions necessary for carrying out the duties of the medical professional.

3. Providers shall submit a detailed plan of operation including but not limited to a description of:

a. The physical plant and personnel which shall be adequate to serve the target population identified as that provider's caseload.

b. Ways to provide outreach services for clients, including those whose primary language is not English and those for whom written materials would be inappropriate.

c. Transportation arrangements to facilitate the use of screening, diagnosis and treatment services.

d. Cooperative written agreements with providers of screening, diagnosis, and treatment services.

e. Arrangements for transfer of necessary information to the appropriate agency and for notification of the department if the client moves to another location.

4. The services of outreach and follow-up where appropriate shall be delivered to each eligible client not more than once in any 12 month period, except where stipulated otherwise by the department's periodicity schedule.

5. a. Outreach and follow-up agencies shall inform eligible families and offer to provide or arrange for the provision of EPSDT services:

i. Through written material and face-to-face contact within 60 days of the time from which the client first becomes eligible for medical assistance or becomes eligible after a period of ineligibility;

ii. Through written material for families who have not requested EPSDT services within one year of the date from which they were last notified; and

iii. Through written material for families who have requested EPSDT services and for those children are eligible for a periodic screen based upon the periodicity schedule developed by the department.

b. If a family first notified makes no response requesting services, the outreach agency shall make at least one attempt to follow-up and obtain a response. Such attempt, to be made within 60 days of the date of initial notification, may be by mail, by face-to-face contact, or by telephone.

c. Both written and face to face means of notification shall specifically describe EPSDT services in clear, non-technical language and shall include at least the following information:

i. The nature and value of preventive health services;

ii. That screening services should be received periodically; that the family can request information specifying which screening services will be provided upon request; at what ages after an initial screening; and in the case of families notified according to the periodicity schedule, that it is time for a periodic screening for the family's children and that the family should tell the state whether it wants such periodic screening services;

iii. The elements of the screening package available under the program;

iv. That treatment services covered under the program will be provided for problems discovered through screening, including treatment for vision, hearing and dental problems;

v. How EPSDT services can be obtained, including an offer to schedule appointments, if requested, for EPSDT services, and to provide, if requested, necessary transportation as required;

vi. Where the family may obtain such services;

vii. That the family is entitled to EPSDT services covered under the program at no cost;

viii. That the department will assure that the family receives EPSDT services on a timely basis;

ix. That the family should tell the department whether it does or does not request EPSDT services and department assistance with scheduling and transportation;

x. This information shall be in accordance with the methods required by the department.

d. Written and face-to-face notification shall be adjusted to the language requirements of families who are blind, or illiterate, cannot read English, or are not conversant in English.

6. The outreach agency shall provide or arrange to provide EPSDT services for eligible recipients requesting services, as follows:

a. All requested initial and periodic screening services shall be completed within 120 days of the request for initial services;

b. All necessary follow-up treatment services covered shall be initiated within 120 days of the request for services;

c. Requested assistance with transportation shall be provided pursuant to this rule;

d. Initiation of treatment services for the EPSDT program shall occur with the first encounter between the eligible individual and the health care provider(s) to begin treatment and, as appropriate, diagnoses.

7. Exceptions to requirements for timely service delivery. The requirements under subsection 5.37(1)(d)6 do not apply when it can be shown that the following condition(s) exist:

a. In the case of necessary treatment services not initiated within the 120 day period, the eligible individual(s) declined the treatment service indicated to be necessary by screening.

b. The family requested EPSDT services but did not request assistance with scheduling appointments; the appointment(s) necessary to complete screening services or to initiate necessary treatment services were not scheduled or not kept; and the outreach provider made at least one attempt (after determining that such appointment(s) were not scheduled or kept) within 150 days of the request for EPSDT services to offer scheduling and transportation assistance for the necessary appointments;

c. Assistance requested with the scheduling of EPSDT appointments was provided, but the eligible individual failed to keep the appointment, and the outreach provider made at least one attempt (after determining that the appointment was not kept) within 150 days of the family's request for EPSDT to offer scheduling and transportation assistance for each of the appointments that were missed. In cases where the eligible individual misses two appointments scheduled by the outreach provider for the same service, no further assistance from the provider is required for that recorded request.

(e) Records and Documentation. Providers of outreach and follow-up services shall fulfill all of the following documentation requirements:

1. The written materials used by outreach agencies to notify families and the materials used or available to persons notifying families through face-to-face contact shall be available as part of the agency's records.

2. All necessary information shall be completed upon the case management form stipulated by the department. Such documentation shall include but need not be limited to the following items:

a. For each family, the date(s) of initial and annual or periodic notification through face-to-face contact or through written material;

b. For each family notified which has not requested EPSDT services, whether such family has specifically declined the services;

c. For each applicable family, the date of the attempt to obtain a response to notification;

d. For each eligible individual for whom initial and periodic, as applicable, EPSDT services are requested:

i. The date of the request(s) for EPSDT services, whether for initial or periodic services;

ii. That scheduling or transportation assistance was requested or declined (whether in response to notification to the follow-up attempt after such notification or to the follow-up attempt after missed appointments) and that such assistance was provided, if requested, or that no response has been made to the outreach providers offer(s) of such assistance;

iii. Where an appointment scheduled with the outreach provider's assistance is missed, that an attempt was made to offer scheduling and transportation assistance for a second appointment, and the date of such attempt;

iv. Where the outreach provider's assistance with scheduling has not been requested, and where it is determined that the screening services have not been completed or necessary follow-up treatment services not initiated within 120 days of request for EPSDT services, that the attempt was made to offer scheduling and transportation services and the date of such attempt;

v. The date of initiation of treatment service(s) covered under the program and provided as a result of positive screening (or, as appropriate, diagnostic) findings, or the date that such services were declined.

3. A provider may be decertified or suspended from the EPSDT program for:

a. Failure to file complete and accurate outreach claims for 90% of its designated caseload responsibility for two successive quarters; or

b. Non-compliance with other requirements in this rule.

(2) EPSDT Screening Services.

(a) The following providers shall be eligible to be certified to provide EPSDT screenings:

1. Physicians;
2. Outpatient hospital facilities;
3. Health maintenance organizations;
4. Visiting nurse associations;
5. Clinics operated under physician's supervision;
6. Local public health agencies;
7. Home health agencies;
8. Rural health clinics;
9. Indian health agencies; or
10. Neighborhood health centers.

(b) Procedures and Personnel Requirements.

1. Screening providers shall provide or arrange to provide and record the entire screening package, appropriate to the client's age and health needs, and shall explain the results to the recipient's parent or guardian or to the recipient, if appropriate.

2. EPSDT screening services shall be delivered under the supervision of skilled medical personnel, defined as physicians, nurse practioners, public health nurses, or registered nurses. Individual procedures may be completed by trained paraprofessional medical staff who are supervised by skilled medical personnel, provided that:

a. Successful completion of the training and orientation package developed by the department has been accomplished by the para-professional personnel; and

b. Such personnel receive continuing inservice education and training on a yearly basis as specified by the department.

3. All conditions uncovered which warrant further care as defined by department-approved referral levels and good medical practice, shall be diagnosed or treated or both by the provider, if appropriate, or referred to other appropriate providers. Such a referral may either be a direct referral (i.e. to the appropriate health care provider) recorded through the outreach provider, or a referral recommendation submitted through the outreach agency responsible for the patient's case management and advocacy.

(c) Records and Documentation.

1. Certified providers of EPSDT screening services shall:

a. Complete the department's EPSDT screening claim form; and

b. Maintain a file on each client receiving EPSDT screening services.

2. The screening provider shall release information on the results of screening to the outreach agency responsible for the client's case management, when authorized to do so.

(3) Diagnosis and Treatment Services

(a) Certification requirements. Providers of diagnosis and treatment services for EPSDT are required to be certified according to the appropriate provisions of this rule.

(b) Providers of such services shall be subject to all other appropriate conditions of participation pertaining to their provider type under this rule.

(c) Other limitations. Diagnosis and treatment services provided for EPSDT patients shall be covered in the same scope and with the same limitations as when those services are provided to the general medical assistance population.

5.38 Requirements for Certification of Ambulance Providers.

(1) Ambulance providers are required to be licensed pursuant to section 146.50, Wis. Stats., and shall meet the following requirements:

(a) The federal specifications contained in document KKK-A-1822, entitled "Federal Specification Ambulance, Emergency Medical Care Vehicle," issued by the U.S. General Services Administration, Federal Supply service;

(b) Definitions stated in section 340.01(3)(i), Wis. Stats.

(2) Equipment for patient care shall meet the requirements of the American College of Surgeons' equipment list.

(3) Emergency Medical Services Systems Development in the State Division of Health, Department of Health and Social Services, shall maintain copies of the documents referred to in section 5.38(1)(a) and section 5.38(2).

(4) Emergency vehicles may provide non-emergency services.

5.39 Requirements for Certification of Specialized Medical Transportation Services. Specialized medical transportation services shall meet the requirements of this section and shall sign an affidavit with the department stipulating that they are in compliance with the requirements of this section.

(1) Vehicles.

(a) There shall be insurance of not less than $100,000 personal liability per person and not less than $300,000 personal liability per occurrence on all vehicles used in transporting recipients.

(b) Vehicle inspections shall be performed not less frequently than every 7 days, by an assigned driver, to ensure:

1. The proper functioning of all headlights, emergency flasher lights, turn signal lights, tail lights, brake lights, clearance lights, windshield wipers, brakes, front suspension and steering mechanisms, shock absorbers, heater/ defroster systems, doors and ramps, moveable windows and passengers and driver restraint systems;

2. That all tires are properly inflated according to vehicle or tire manufacturers' recommendations and that all tires possess a minimum of 1/8 inch of tread at the point of greatest wear; and

3. That windshields and mirrors are free from cracks or breaks.

(c) The driver inspecting the vehicle shall document all vehicle inspections in writing, noting any deficiencies.

1. All deficiencies shall be corrected before any recipient is transported in the vehicle. Corrections shall be documented by the driver.

2. Documentation shall be retained for not less than 12 months, except as authorized by the department.

(d) Windows, windshield and mirrors shall be maintained in a clean condition with no obstruction to vision.

(e) No smoking shall be permitted in the vehicle.

(f) Police, sheriff's department and ambulance emergency telephone numbers shall be posted on the dash of the vehicle in an easily readable manner. If the vehicle is not equipped with a working two-way radio, sufficient money in suitable denominations shall be carried to enable not less than three local telephone calls to be made from a pay telephone.

(2) Vehicle equipment.

(a) The vehicle shall be equipped at all times with the following items: jack and lug wrench, flashlight in working condition, first aid kit containing 2 rolls of sterile gauze, sterile gauze compression bandages equal in number to the passenger-carrying capacity of the vehicle, 1 roll of adhesive tape and 1 tourniquet and a fire extinguisher. The fire extinguisher shall be periodically serviced as recommended by the local fire department.

(b) Passenger restraint devices, including restraint devices for wheelchair-bound recipients, if such recipients are carried, shall be provided and used.

1. Wheelchair restraints shall secure both the passenger and the wheelchair.

(c) Provision shall be made for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.

(3) Drivers.

(a) Each driver shall possess a valid Wisconsin chauffeur's license which shall be unrestricted, except that vision restrictions may be waived if driver's vision is corrected to an acuity of 20/30 or better by the use of eyeglasses. In this event, the driver shall wear corrective eyeglasses while transporting recipients.

(c) All drivers shall hold a current card issued as proof of successful completion of the American Red Cross (or equivalent) basic course in first aid.

(d) Within 30 days of the date of employment or the date the specialized transportation service is certified as a provider, all drivers shall receive specific instruction on care and handling of epileptics in seizure. Drivers who certify in writing that they have had prior training in the care and handling of seizure victims shall be considered to meet this requirement.

(4) Company policy. Company policy and procedure shall include:

(a) Compliance with all applicable state, county and city laws and regulations governing the conduct of company business.

(b) Establishment and implementation of scheduling policies that assure timely pick-up and delivery of passengers going to and returning from medical appointments.

(c) Documentation that transportation services for which medical assistance program reimbursement is sought are:

1. For medical purposes only.

2. Ordered by the attending provider of medical service.

3. Provided only to persons who require such transportation since they lack other means of transport, and who are also physically or mentally incapable of the use of public transportation.

(d) Maintenance of records of services for 5 years, unless otherwise authorized by the department.

(e) Making available for inspection, upon request of the department, records documenting both medical providers' orders for services and the actual provision of services.

(5) Affidavit. The provider shall submit to the department a notarized affidavit attesting that the provider meets the requirements listed in section 5.39. The affidavit shall be on a form developed by and available from the department, and shall contain the following:

(a) A statement of the requirements listed in section 5.39;

(b) The date the form is completed by the provider;

(c) The provider's business name, address, telephone number and type of ownership;

(d) The name and signature of a person authorized to act on behalf of the provider; and

(e) Notarizing information.

5.40 Requirements for Certification of Dealers of Medical Supplies and Equipment, Oxygen Supplies or Prosthetic and Orthotic Devices.

(1) Any individual, corporation, business or organization owning or selling medical equipment, medical supplies, oxygen supplies or prosthetic and orthotic devices is eligible to participate in the program, except as noted in (2) below.

(2) Orthotists and prosthetists who develop and fit appliances for recipients shall be certified by the American Board for Certification in Orthotics and Prosthetics (A.B.C.). Such certification shall be a result of successful participation in an A.B.C. examination in prosthetics, orthotics, or both, and shall be for one of the following classes:

(a) Certified Prosthetist (C.P.);
(b) Certified Orthotist (C.O.); or
(c) Certified Prosthetist and Orthostist (C.P.O.)

5.41 Requirements for Certification of Hearing Aid Dealers. Hearing aid dealers are required to be licensed pursuant to section 459.05 Wis. Stats.

5.42 Requirements for Certification of Physician Office Laboratories.

(1) Physician office laboratories, except as noted in (2) below, are required to be licensed pursuant to section 143.15, Wis. Stats. and shall meet the requirements in Wis. Adm. Code H 38.

(2) Exception: Physician office laboratories which serve no more than two physicians, podiatrists, chiropractors, or dentists and which do not accept specimens on referral from outside providers, shall not be required to be licensed or to meet the H-38 standards. These laboratories, however, shall submit an affidavit to the department specifying that they do not accept outside specimens.

(3) Physician office laboratories which accept referrals of 100 or more specimens a year in a specialty shall have (in addition to licensure under sec. 143.15 Wis. Stats.) a certificate of participation in the Medicare program or shall be qualified to participate in Medicare.

5.43 Requirements for Certification of Independent Clinical Laboratories.

Laboratories and clinical laboratories as defined in Wis. Adm. Code section H 38.02(1), are required to be licensed pursuant to section 143.15, Wis. Stats., and to have a certificate of participation in Medicare (or be qualified for such certificate).

[NOTE: The following rules, which are a codification of 42 CFR 405.1310 through 1317, are hereby adopted. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the **federal regulations shall hold.**]

(1) Laboratory director. The clinical laboratory shall be under the direction of a qualified person.

(a) Administration. The laboratory shall have a director who administers the technical and scientific operation of the laboratory including the reporting of findings of laboratory tests.

1. The director shall serve the laboratory either full time, or on a regular part-time basis. If the director serves on a regular part-time basis, the director shall not individually serve as director of more than three laboratories (hospital or independent) with one exception. If the director does serve as director of more than three laboratories, the director shall provide for an associate in subsection 5.43(1)(b), to serve as assistant director in each laboratory. Such assistant director shall not serve more than three laboratories.

2. Commensurate with the laboratory workload, the director shall spend an adequate amount of time in the laboratory to direct and supervise the technical performance of the staff and shall be readily available for personal or telephone consultation.

3. The director shall be responsible for the proper performance of all tests made in the laboratory.

4. The director shall be responsible for the employment of qualified laboratory personnel and for their inservice training.

5. If the director is to be continuously absent for more than one month, arrangements shall be made for a qualified substitute director.

(b) Laboratory director--qualifications. The laboratory director shall be one of the following:

1. A physician certified in anatomical or clinical pathology or both by the American Board of Pathology or the American Osteopathic Board of Pathology or possessing qualifications which are equivalent to those required for such certification (board eligible);

2. A physician who either is:

a. certified by the American Board of Pathology or the American Osteopathic Board of Pathology in at least one of the laboratory specialities, or

b. certified by the American Board of Medical Microbiology, the American Board of Clinical Chemistry, the American Board of Bioanalysis, or other national accrediting board in one of the laboratory specialties, or

c. certified by the American Society of Cytology to practice cytopathology or possesses qualifications which are equivalent to those required for such certification, or

d. subsequent to graduation, has had 4 or more years of full-time general laboratory training and experience, of which at least 2 years were spent acquiring proficiency in one of the laboratory specialties in an approved clinical laboratory;

3. For the specialty of oral pathology only, a dentist who is certified by the American Board of Oral Pathology or who possesses qualifications which are equivalent to those required for certification (board eligible);

4. A person holding an earned doctoral degree from an accredited institution with a chemical, physical, or biological science as a major subject who is either certified by the American Board of Medical Microbiology, the American Board of Clinical Chemistry, the American Board of Bioanalysis, or other national accrediting board acceptable to the department in one of the laboratory specialties. Such director may also be a person who subsequent to graduation, has had 4 years of full-time general clinical laboratory training and experience of which at least 2 years were spent acquiring proficiency in one of the laboratory specialties in an approved clinical laboratory.

5. With respect to individuals first qualifying prior to July 1, 1971, a person responsible for the direction of a clinical laboratory for 12 months between July 1, 1961, and January 1, 1968, and, in addition, who meets one of the following requirements:

a. Was a physician and subsequent to graduation has had at least 4 years of pertinent full-time clinical laboratory experience;

b. Held a master's degree from an accredited institution with a chemical, physical, or biological science as a major subject and, after graduation, has had at least 4 years of pertinent full-time clinical laboratory experience;

c. Held a bachelor's degree from an accredited institution with a chemical, physical, or biological science as a major subject and subsequent to graduation has had at least 6 years of pertinent full-time clinical laboratory experience; or

d. Achieved a satisfactory grade through an examination conducted by or under the sponsorship of the U. S. Public Health Service on or before July 1, 1970.

(2) Clinical Laboratory supervision. The clinical laboratory shall be supervised by qualified personnel.

(a) Supervision. The laboratory shall have one or more supervisors who, under the general direction of the laboratory director, supervise technical personnel and reports of findings, perform tests requiring special scientific skills, and, in the absence of the director, are held responsible for the proper performance of all laboratory procedures. A laboratory director who qualified under subsection 5.43(1)(b)1., 2., 4. or 5. is also qualified as a general supervisor; therefore, depending upon the size and functions of the laboratory, the laboratory director may also serve as the laboratory supervisor.

1. Required supervisors. There shall be a general supervisor and a technical supervisor. A general supervisor shall meet the requirements of subsection 5.43(2)(b) and shall be on the laboratory premises during all hours in which tests are being performed. With respect to the specialty of diagnostic cytology, cytotechnologists shall not examine slide preparations unless a supervisor who qualifies pursuant to the provisions of subsection 5.43(2)(b)4 or subsection 5.43(3)(b)9 is on the premises at all times. A technical supervisor who meets the pertinent requirements of subsection 5.43(3)(b) shall spend an adequate amount of time in the laboratory to supervise the technical performance of the staff in the specialty and shall be readily available for personal or telephone consultation. A general supervisor may also be a technical supervisor in those specialties in which the requirements of subsection 5.43(3)(b) are met.

2. Supervision of emergency procedures. When emergencies arise outside regularly scheduled hours of duty, an individual who qualifies as a general supervisor is not required to be on the premises if the technologist performing tests is qualified to perform such tests, and the supervisor responsible for the results of the work reviews them during the next duty period, and a record is maintained to reflect the actual review.

(b) General supervisor qualification. The laboratory supervisor shall be a person who either:

1. Is a physician, or has earned a doctoral degree from an accredited institution with a major in one of the chemical, physical or biological sciences and, after graduation, has had at least 2 years of experience in one of the laboratory specialties in an approved clinical laboratory; or

2. Holds a master's degree from an accredited institution with a major in one of the chemical, physical, or biological sciences and after graduation, has had at least 4 years of pertinent full-time laboratory experience, of which not less than 2 years have been spent working in the designated laboratory specialty in an approved clinical laboratory; or

3. Is qualified as a clinical laboratory technologist pursuant to the provisions of subsection 5.43(4)(b)1, 2, 3, 4, or 6 and, after qualifying as a clinical laboratory technologist, has had at least 6 years of pertinent full-time laboratory experience, of which not less than 2 years have been spent working in the designated laboratory specialty in an approved clinical laboratory; or

4. With respect to the specialty of diagnostic cytology, qualifies as a supervisory cytotechnologist by virtue of meeting the provisions of subsection 5.34(4)(c) and has had 4 years of full-time experience as a cytotechnologist in a laboratory directed or supervised by a pathologist or other physician recognized as a specialist in diagnostic cytology within the preceding 10 years; or

5. With respect to individuals qualifying before July 1, 1971, has had at least 15 years of pertinent full-time clinical laboratory experience before January 1, 1968. This required experience may be met by the substitution of education for experience.

(3) Tests performed. The clinical laboratory shall perform only those laboratory tests and procedures that are within the specialties or sub-specialties in which the laboratory director or supervisors are qualified.

(a) Proficiency testing. All clinical laboratories shall successfully participate in a proficiency testing program described in Wis. Adm. Code Section H 38.14 covering all tests in clinical laboratory and anatomical pathology specialties and subspecialties the laboratory makes available and is approved to perform.

(b) Competency. The laboratory shall perform only those laboratory procedures and tests that are within the specialties or subspecialties in which the laboratoy director or supervisors are qualified.

1. If the laboratory director or supervisor is a physician certified in both a. anatomical and b. clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possesses qualification which are equivalent to those required for certification (board eligible), the laboratory may perform anatomical and clinical laboratory procedures and tests in all specialties.

2. If the requirements of subsection 5.43(3)(b)1 are not met and the laboratory performs test in the specialty of microbiology, including the subspecialties of bacteriology, virology, mycology, and parasitology, the director or a supervisor shall hold an earned doctoral or master's degree in microbiology from an accredited institution, or shall have at least 4 years of experience in clinical microbiology gained after graduation.

3. If the requirements of subsection 5.43(3)(b)1 are not met and the laboratory performs tests in the specialty of serology, the director or a supervisor shall hold an earned doctoral or master's degree in biology, chemistry, immunology or microbiology from an accredited institution or shall be a physician who has had at least 4 years of experience in serology gained after graduation.

4. If the requirements of subsection 5.43(3)(b)1 are not met and the laboratory performs tests in the specialty of hematology, including gross and microscopic examination of the blood, the director or a supervisor shall hold a master's degree or a bachelor's degree in biology, immunology, microbiology, chemistry, or medical technology from an accredited institution, and, shall have had at least 4 years of experience in hematology gained after graduation.

5. a. If the requirements of subsection 5.43(3)(b)1 are not met and the laboratory performs tests in the specialty of immunohematology, the director or a supervisor shall be a physician with at least 2 years of experience in immunohematology gained after graduation; or

b. If such laboratory performs tests within the subspecialties of ABO grouping and Rh typing, antibody detection, identification, and titering only, the director or a supervisor shall hold a master's degree in biology, immunology, microbiology, chemistry, or medical technology from an accredited institution and shall have had at least 4 years of experience in immunohematology gained after graduation.

6. If the requirements of subsection 5.43(3)(b)1 are not met and the laboratory performs tests in the specialty of clinical chemistry, the director or a supervisor shall hold an earned doctoral or master's degree in chemistry from an accredited institution or shall be a physician who has had at least 4 years of experience in clinical chemistry gained after graduation.

7. If the requirements of subsection 5.43(3)(b)1 are not met and the laboratory performs tests in the specialty of radiobioassay, the director or a supervisor shall hold an earned doctoral, master's or bachelor's degree in chemistry, physics, biology, or medical technology from an accredited institution or shall be a physician who has had least 4 years of experience in radiobioassay gained after graduation.

8. If the laboratory performs tests in the specialty of tissue pathology, the director or a supervisor shall meet the requirements of subsection 5.43(3)(b)1. If the laboratory performs tests limited to skin pathology the director or a supervisor shall be certified in dermatopathology by the American Board of Dermatology and the American Board of Pathology or shall possess qualifications which are equivalent to those required for certification (board eligible).

9. If the requirements of subsection 5.43(3)(b)1.a. are not met and the laboratory performs tests in the specialty of diagnostic cytology, the director or a supervisor shall be either: a physician certified by the American Society of Cytology to practice cytopathology, or a physician who possesses qualifications which are equivalent to those required for certification (Under this provision the laboratory is qualifed to perform such tests only on that anatomic site for which the director or supervisor is certified.); or an individual who, pursuant to a request to establish qualifications filed before January 1, 1971, has demonstrated competency by all of the following means:

a. Through at least 7 years of experience accumulated in a position of diagnostic responsibility in the field of clinical cytology, or through 5 years of full-time training in diagnostic clinical cytology with suitable endorsement by a physician who has been supervisor in such activity; and

b. By the publishing of treatises, texts, or other publications on the subject of diagnostic cytology which are generally acknowledged and recognized by the medical profession as authoritative in the field; and

c. By appointment to and service in pertinent teaching and research positions in recognized schools of medicine; and

d. By acceptance into or award of membership and office in professional societies in this field; and

e. By receipt of other professional honors for excellence in the use of precedures in exfoliative cytology for the diagnosis of a pathological condition (under this provision the laboratory shall be qualified to perform such tests only on that anatomic site with respect to which such competency is so established). The department, with appropriate professional advice, shall make all determinations with respect to the requirements set forth in subsections 5.43(3)(b)9.a. through e. An individual who qualifies under the above subparagraphs shall be deemed to also meet the requirements of subsection 5.43(1)(b)2.c.

10. If the requirements of subsection 5.43(3)(b)1.a. are not met and the laboratory performs tests in oral pathology, the director or supervisor shall be a dentist who is certified in oral pathology by the American Board of Oral Pathology or who possesses qualifications which are equivalent to those required for certification (board eligible).

11. An exception to the requirements in subsections 5.43(3)(b)2., 3., 4., 5b., 6., and 7. is made with respect to an individual who qualified as a director under subsection 5.43(1)(b)5.c. A laboratory directed by such an individual may perform tests in:

a. Microbiology: If the director has a bachelor's degree in a biological science and at least 6 years of experience in microbiology gained after graduation;

b. Hematology: If the director has a bachelor's degree in biology, immunology or microbiology from an accredited institution and has had at least 6 years of clinical laboratory experience of which at least 4 years are in hematology, gained after graduation;

c. Serology: If the director has a bachelor's degree in biology, immunology, chemistry or microbiology and at least 6 years of experience in serology gained after graduation;

d. Radiobioassay: If the director has a bachelor's degree in a chemical, physical, or biological science and has had at least 6 years of laboratory experience, at least one year of which is in radiobioassay, all of which are gained after graduation;

e. Blood grouping and Rh typing, antibody detection, identification, and titering: If the director has a bachelor's degree in biology, immunology or microbiology from an accredited institution and at least 6 years of clinical laboratory experience of which at least 4 years are in immunohematology, all of which are gained after graduation;

f. Clinical chemistry: If the director has a bachelor's degree in a chemical science or its equivalent and at least 6 years of experience in clinical chemistry gained after graduation;

g. Any of the above specialties: If the director has a bachelor's degree in medical technology and at least the designated years of specialized experience gained after graduation.

12. A laboratory whose director qualifies under subsection 5.43(1)(b)5.d. may perform tests in the laboratory specialties in which director achieved a satisfactory grade in the examination conducted or sponsored by the Public Health Service. A director who achieved a satisfactory grade in chemistry or blood grouping and Rh typing is deemed to meet the requirements of subsection 5.43(3)(b)5. or 7.

13. Notwithstanding paragraph subsection 5.43(3)(b)1., if the laboratory performs tests in the specialty of histocompatibility testing, the director or supervisor shall hold an earned doctoral degree in a biological science or shall be a physician, with 4 years of experience in immunology, two of which have been in histocompatibility testing, and all of which are gained after graduation.

(4) Clinical laboratory--technical personnel. The clinical laboratory shall have a sufficient number of properly qualified technical personnel for the volume and diversity of tests performed.

(a) Technologist duties. The laboratory shall employ a sufficient number of clinical laboratory technologists or cytotechnologists or both to proficiently perform under general supervision the clinical laboratory tests which require the exercise of independent judgment.

1. The clinical laboratory technologists shall perform tests requiring the exercise of independent judgment and responsibility, with minimal supervision by the director or supervisors, only in those specialties or subspecialties in which the laboratory technologists are qualified by education, training, and experience.

2. Specialties in which the clinical laboratory technologist is not qualified by education, training, or experience shall be performed only under the direct supervision of the laboratory supervisor or qualified technologist.

3. Clinical laboratory technologists shall be in sufficient number to adequately supervise the work of technicians and trainees.

4. An individual qualified as a cytotechnologist solely under subsection 5.43(4)(c) shall supervise technicians and trainees only in the specialty of cytology.

(b) Technologist qualifications. Each clinical laboratory technologist shall:

1. Have successfully completed three years of academic study (a minimum of 90 semester hours or equivalent) in an accredited college or university, which met the specific requirements of entrance into a school of medical technology accredited by an accrediting agency approved by the department, and have successfully completed a course of training of at least 12 months in such a school; or

2. Have earned a bachelor's degree in medical technology from an accredited college or university; or

3. Have earned a bachelor's degree in one of the chemical, physical, or biological sciences and, in addition, have at least one year of pertinent full-time laboratory experience or training in the specialty of subspecialty in which the individual performs tests; or

4. Have successfully completed three years (90 semester hours or equivalent) in an accredited college or university with the following distribution of courses:

a. For those whose training was completed before September 15, 1963. At least 24 semester hours shall have been in chemistry and biology courses. At least six such semester hours shall have been in inorganic chemistry and at least three semester hours shall have been in other chemistry courses. At least 12 such semester hours shall have been in biology courses pertinent to the medical sciences.

b. For those whose training was completed after September 14, 1963. At least 16 semester hours shall have been in chemistry courses which included at least six semester hours in inorganic chemistry and which are acceptable toward a major in chemistry. At least 16 semester hours shall have been in biology courses which are pertinent to the medical sciences and are acceptable toward a major in the biological sciences. At least three semester hours shall have been in mathematics.

5. Have experience or training covering several fields of medical laboratory work of at least one year and of such quality as to provide the individual with education and training in medical technology equivalent to that described in subsections 5.43(4)(b)1. and 2.; or

6. With respect to individuals qualifying before July 1, 1971, the technologist:

a. Shall have performed the duties of a clinical laboratory technologist at any time between July 1, 1961, and January 1, 1968; and

b. Shall have had at least 10 years of pertinent clinical laboratory experience before January 1, 1968. This required experience may be met by the substitution of education for experience.

7. Have achieved a satisfactory grade in a proficiency examination approved by the department. However, after December 31, 1977, initial qualification as a technologist shall be in accordance with subsection 5.43(4)(b) 1., 2., 3., 4., or 5.

(c) Cytotechnologists qualifications. Each laboratory cytotechnologist shall:

1. Have successfully completed two years in an accredited college or university with at least 12 semester hours in science, eight hours of which are in biology, and have had 12 months of training in a school of cytotechnology accredited by an accrediting agency approved by the department, or

2. Have received six months of formal training in a school of cytotechnology accredited by an accrediting agency approved by the department and six months of full-time experience in cytotechnology in a laboratory acceptable to the pathologist who directed such formal six-month training, or

3. Before January 1, 1969, have graduated from high school, completed six months of training in cytotechnology in a laboratory directed by a pathologist or other physician recognized as a specialist in cytology, and completed two years of full-time supervised experience in cytotechnology, or

4. Have achieved a satisfactory grade in a proficiency examination approved by the department. However, after December 31, 1977, initial certification as a cytotechnologist must be in accordance with subsection 5.43(4)(c)1. or 2.

(d) Technician duties. Clinical laboratory technicians shall be employed in sufficient number to meet the workload demands of the laboratory and shall function only under direct supervision of a clinical laboratory technologist.

1. Each technician shall perform only those clinical laboratory procedures which require a degree of skill commensurate with education, training, and technical abilities and which involve limited exercise of independent judgment.

2. No clinical laboratory technician shall perform procedures in the absence of a qualified clinical laboratory technologist, supervisor, or director.

3. A technician trainee shall perform only repetitive procedures which require a minimal exercise of independent judgment, and the technician shall perform such procedures only under the personal and direct supervision of a qualified supervisor or technologist.

(e) Technician qualifications. Each clinical laboratory technician shall meet one of the following requirements:

1. Completion of 60 semester hours of academic credit including chemistry and biology as well as a structured curriculum in medical laboratory techniques at an accredited institution, or an associate degree from an accredited institution based on a course of study including those subjects.

2. High school graduation or equivalent and completion of at least one year in a technician training program in a school accredited by an accrediting agency approved by the department.

3. High school graduation or equivalent and two years of pertinent full-time laboratory experience as a technician trainee in an approved clinical laboratory.

4. High school graduation or equivalent and successful completion of an official military medical laboratory procedures course of at least 50 weeks' duration and holding of the military enlisted occupational specialty of Medical Laboratory Specialist (Laboratory Technician).

5. With respect to a technician not meeting the training and experience requirements defined in subsection 5.43(4)(d)1.,2.,3. or 4.,

a. The technician shall have performed the duties of a clinical laboratory technician any time between July 1, 1961, and January 1, 1968, and

b. The technician shall have had at least five years of pertinent clinical laboratory experience before January 1, 1968. (This required experience may be met by substitution of education for experience).

6. Achievement of a satisfactory grade in a proficiency examination approved by the department. However after December 31, 1977, initial certification as a technician must be in accordance with subsection 5.43(4)(e)1., 2., 3., or 4.

(f) Personnel Policies. There shall be written personnel policies, practices, and procedures that adequately support sound laboratory practice.

1. Current employee records shall be maintained and shall include a resume of each employee's training, experience, duties, and date(s) of employment.

2. Files shall contain evidence of adequate health supervision of employees, such as results of pre-employment physical examinations, including chest X-rays, immunization records, and records of all illnesses and accidents occurring on duty.

3. Work assignments shall be consistent with qualifications.

(5) Clinical laboratory management. The clinical laboratory shall maintain records and facilities which are adequate and appropriate for the services offered.

(a) Laboratory procedure manual. A compilation shall be kept of all automated and manual methods for tests which are performed in or offered by the laboratory. Each procedure shall be reviewed and dated by the technical supervisor at least annually. For those tests which are normally performed on automated test equipment, provision shall be made and documented for performing such tests by alternate methods, or for storing the test specimens, in the event this equipment becomes inoperable.

(b) Laboratory management. Space and facilities shall be adequate to properly perform the services which are performed in or offered by the laboratory.

1. Workbench space shall be ample, well-lighted, and convenient to sink, water, gas, and suction and electrical outlets as necessary.

2. Work areas shall be arranged so as to minimize problems in transportation and communications.

3. The laboratory shall be properly ventilated.

4. Volatile chemicals and inflammable solvents shall be properly stored in areas unlikely to ignite them or restricted from open flame or heat.

5. Temperature and humidity shall be controlled within limits required for proper performance of tests and operation of instruments affected by these variations.

6. Voltage levels at electrical sources to which automated equipment is connected shall be monitored and recorded.

7. Adequate fire precautions and occupational safety and health laws shall be known, posted, and observed, insuring that there is freedom from unnecessary physical, chemical, and biological hazards.

(c) Collection of specimens. No persons other than a licensed physician, or other authorized by law, shall manipulate a patient for the collection of specimens except that qualified technical personnel of the laboratory may collect blood or remove stomach contents and collect material for smears and culture under the direction or upon the written request of a licensed physician.

(d) Sterilization. Syringes, needles, lancets, or other blood-letting devices capable of transmitting infection from one person to another shall not be reused unless they are properly sterilized before each use and wrapped in a manner which will insure that they remain sterile until used. Appropriate sterilization and disinfection techniques shall be used, as required, for tests performed on potentially contaminated material, and for the protection of laboratory personnel. Disposable syringes, needles, pipettes, Petri dishes, and other disposable items shall be appropriately discarded immediately after use. Each sterilizing cycle shall contain a device which indicates proper sterilization, or an adequate recording thermometer shall be used and records kept of temperature readings. Proper operation of the autoclave shall be checked monthly with viable spores or appropriate indicators.

(e) Examination and reports. The laboratory shall examine specimens only at the request of a licensed physician, dentist, or other person authorized by law to use the findings of laboratory examinations and shall report only to those authorized by law to receive such results.

1. If the patient is sent to the laboratory, a written request for the desired laboratory procedures shall be obtained from a person authorized by law to use findings of laboratory examination.

2. If only a specimen is sent, it shall be accompanied by a written request.

3. If the laboratory receives reference specimens from another laboratory, the laboratory shall report back to the laboratory submitting the specimens.

(f) Specimen records. The laboratory shall maintain a record indicating the daily accession of specimens, each of which is numbered or otherwise appropriately identified. The records shall contain the following information:

1. The laboratory number or other identification of the specimen.

2. The name and other identification of the person from which the specimen was taken.

3. The name of the licensed physician or other authorized person or clinical laboratory which submitted the specimen.

4. The date the specimen was collected by the physician or other authorized person.

5. The date the specimen was received in the laboratory.

6. The condition of unsatisfactory specimens when received (e.g. broken, leaked, hemolyzed or turbid, etc.)

7. The type of test performed.

8. The date that test was performed.

9. The results of the laboratory test or cross-reference to results and the date of reporting.

10. The name and address of the laboratory to which forwarded if the procedure is not performed at this laboratory.

(g) Laboratory report and record. The laboratory report shall be sent promptly to the licensed physician or other authorized person who requested the test, and a suitable record of each test result shall be preserved by the laboratory for a period of five years.

1. The laboratory director shall be responsible for the laboratory report.

2. Duplicate copies or a suitable record of laboratory reports shall be filed in a manner which permits ready identification and accessibility.

3. Tissue pathology reports shall utilize acceptable terminology of a recognized system of disease nomenclature.

4. The results of laboratory tests or procedures or transcripts thereof shall not be sent to the patient concerned except with the written consent of the physician or other authorized person who requested the test.

5. Pertinent "normal" ranges as determined by the laboratory performing the tests shall be available to the physician requesting such tests.

6. A list of analytical methods employed by the laboratory and a basis for the listed "normal" range shall be maintained in the laboratory. The list shall be made available upon request to any physician ordering an examination.

7. If the laboratory refers specimens to another laboratory, the laboratory receiving the specimens shall meet the applicable conditions of this rule. Each physician ordering an examination shall be notified that the specimen was referred to another laboratory. Such notice shall show the name and address or other identification of the laboratory to which the specimen is referred. If the physician so requests, the referring laboratory may authorize the testing laboratory to report directly to the physician or other authorized person who requested the test, in which event the testing laboratory shall send a duplicate of the report to the referring laboratory.

(6) Quality control.

(a) Quality controls imposed and practiced by the laboratory shall provide for and assure:

1. Preventive maintenance, periodic inspection, and testing for proper operation of equipment and instruments as may be appropriate; validation of methods; evaluation of reagents and volumetric equipment; surveillance of results; and remedial action to be taken in response to detected defects.

2. Adequacy of facilities, equipment, instruments, and methods for performance of the procedure, or categories of procedures for which a certification is approved; proper lighting for accuracy and precision; convenient location of essential utilities; monitoring of temperature-controlled spaces and equipment, including water baths, incubators, sterilizers, and refrigerators, to assure proper performance; evaluation of analytical measuring devices, such as photometers and radioactivity counting equipment, with respect to all critical operating characteristics.

3. Labeling of all reagents and solutions to indicate identity, and when significant, titer, strength or concentration, recommended storage requirements, preparation or expiration date, and other pertinent information. Materials of substandard reactivity and deteriorated materials shall not be used.

4. The availability at all times, in the immediate bench area of personnel engaged in examining specimens and performing related procedures within a category (e.g. clinical chemistry, hematology, and pathology), of current laboratory manuals or other complete written descriptions and instructions relating to the analytical methods used by those personnel, properly designated and dated to reflect the most recent supervisory reviews; reagents, control and calibration procedures, and pertinent literature references. Textbooks shall be used as supplements to such written descriptions but shall not be used in lieu thereof.

5. Written approval by the director or supervisor of all changes in laboratory procedures.

6. Maintenance and availability to laboratory personnel and to the department of records reflecting dates and, where appropriate, the nature of inspection, validation, remedial action, monitoring, evaluation, and changes and dates of changes in laboratory procedures.

7. Solicitation designed to provide for collection, preservation, and transportation of specimens sufficiently stable to provide accurate and precise results suitable for clinical interpretation.

(b) Quality control system methodologies. Provision shall be made for an acceptable quality control program covering all types of analysis performed by the laboratory for verification and assessment of accuracy, measurement of precision, and detection of error.

1. Microbiology. Chemical and biological solutions, reagents, and antisera shall be tested and inspected each day of use for reactivity and deterioration.

a. Bacteriology and mycology. Staining materials shall be tested for intended reactivity by concurrent application to smears of micro-organisms with predictable staining characteristics. Each batch of medium shall be tested before or concurrently with use with selected organisms to confirm required growth characteristics, selectivity, enrichment, and biochemical response.

b. Parasitology. A reference collection of slides, photographs, or gross specimens of identified parasites shall be available and used in the laboratory for appropriate comparison with diagnostic specimens. A calibrated ocular micrometer shall be used for determining the size of ova and parasites, if size is a critical factor.

c. Virology. Systems for the isolation of viruses and reagents for the identification of viruses shall be available to cover the entire range of viruses which are etiologically related to clinical diseases for which services are offered. Records shall be maintained which reflect the systems used and the reactions observed. In tests for the identification of viruses, controls shall be employed which will identify erroneous results. If sero-diagnostic tests for virus diseases are performed, requirements for qualtiy control as specified for serology shall apply.

2. Serology. Serologic tests on unknown specimens shall be run concurrently with a positive control serum of known titer or controls of graded reactivity plus a negative control in order to detect variations in reactivity levels. Controls for all test components (antigens, complement, erythrocyte indicator systems, etc.) shall be employed to insure reactivity and uniform dosage. Test results shall not be reported unless the predetermined reactivity pattern of the controls is obtained.

a. Each new lot of reagent shall be tested concurrently with one of known acceptable reactivity before the new reagent is placed in routine use.

b. Equipment, glassware, reagents, controls, and techniques for tests for syphilis shall conform to those recommended in the "Manual of Tests for Syphilis 1969," U. S. Public Health Service Publication No. 411, January 1969.

3. Clinical chemistry. Each instrument or other device shall be recalibrated or rechecked at least once on each day of use. Records which document the routine precision of each method, automated or manual and its recalibration schedule shall be maintained and be available to laboratory personnel and the department. At least one standard and one reference sample (control) shall be included with each run of unknown specimens where such standards and reference samples are available. Control limits for standards and reference samples shall be recorded and displayed and shall include the course of action to be the results are outside the acceptable limits.

a. Screening or qualitative chemical urinalysis shall be checked daily by use of suitable reference samples.

4. Immuno-hematology. ABO grouping shall be performed by testing unknown red cells with anti-A and anti-B grouping serums licensed by the Federal Food and Drug Administration, or possessing equivalent potency, using the technique for which the serum is specifically designed to be effective. For confirmation of ABO grouping, the unknown serum shall be tested with known Al and B red cells.

a. The Rho(D) type shall be determined by testing unknown red cells with anti-RHo (anti-D) typing serum licensed by the Federal Food and Drug Administration, or possessing an equivalent potency, using the technique for which the serum is specifically designed to be effective. Anti-Rho' (CD), anti-RHo" (DE), and anti-RHO rh'rh" (CDE) serums licensed by the Federal Food and Drug Administration, or possessing an equivalent potency may be used for typing donor blood. All Rho negative donor and patient cells shall be tested for the Rho variant (Du). A control system of patient's cells suspended in the patient's own serum or in albumin shall be employed when the test is performed in a protein medium.

b. The potency and reliability of reagents (antisera known test cells, and antiglobulin-Coombs serum) which are used to ABO grouping, RH typing, antibody detection and compatability determinations must be tested for reactivity on each day of use and when a new lot of reagents if first used.

5. Hematology. Instruments and other devices used in hematological examination of specimens shall be recalibrated or retested or reinspected, as may be appropriate, each day of use. Each procedure for which standards and controls are available shall be rechecked each day of use with standards or controls covering the entire range of expected values. Tests such as the one-stage prothrombin time test shall be run in duplicate unless the laboratory can demonstrate that low frequency of random error or high precision makes such testing unnecessary. Reference materials, such as hemoglobin pools, and stabilized cells, shall be tested at least once each day of use to insure accuracy of results. Standard deviation, coefficient of variation, or other statistical estimates of precision shall be determined by random replicate testing of specimens. The accuracy and precision of blood cell counts and hematocrit and hemoglobin measurements shall be tested each day of use.

6. Exfoliative cytology; histopathology; oral pathology.

a. Exfoliative cytology. The laboratory director or supervisor qualified in cytology or cytotechnologist shall rescreen for proper staining and correct interpretation at least a ten-percent random sample of gynecological smears interpreted to be one of the benign categories, by personnel not possessing director or supervisor qualifications. All gynecological smears interpreted to be in the "suspicious" or positive categories by screeners shall be confirmed by the laboratory director or qualified supervisor, and the report shall be signed by a physician qualified in pathology or cytology. All non-gynecological cytological preparations, positive and negative, shall be reviewed by a director or supervisor qualified in cytology. Non-manual methods shall provide quality control similar to that provided in other non-manual laboratory procedures. All smears shall be retained for not less than two years from date of examination.

b. Histopathology and oral pathology. All special stains shall be controlled for intended reactivity by use of positive slides. Stained slides shall be retained for not less than two years from date of examination and blocks shall be retained for not less than one year from such date. Remnants of tissue specimens shall be retained in a fixative solution until those portions submitted for microscopy have been examined and a diagnosis made by a pathologist.

7. Radiobioassay. The counting equipment shall be checked for stability at least once on each day of use, with radioactive standards or reference sources. Reference samples with known activity and within expected levels of normal samples shall be processed in replicate quarterly. For each method, records which document the routine precision and the recalibration schedule shall be maintained and available to the staff and to the department.

8. Histocompatibility testing. In addition to the standards for quality control in immunohematology and serology which are applicable to the histocompatibility testing laboratory, the histocompatibility testing laboratory shall utilize the following control systems and validation methods for the performance of tests in the following:

a. For renal allotransplantation, crossmatching of potential recipients and donors before transplantation shall be performed with one or more techniques using the most reactive and most recent sera.

b. Also for renal allotransplantation, HLA serologic typing of both donor and recipient which includes at least those antigens detectable with serum capable of defining the same antigens as those definable by the National Institutes of Health serum tray(s).

c. Additionally for renal allotransplantation, characterization for antibody against histocompatibility antigens in serum from potential recipients of organ or tissue grafts.

d. For transfusions and bone marrow transplants, the tests in subsection 5.43 (6)(b)8.a. and b. are required.

e. For disease association studies, subsection 5.43 (6)(b)8.b. applies.

f. Mixed lymphocyte cultures or other recognized methods to detect cellular-defined antigens shall be performed in accordance with prescribed methods.

g. Procedures shall be established regarding freezing of lymphocytes and to provide for a comprehensive panel of fresh or frozen lymphocytes.

h. The reactivity of cell panels used for antibody detection shall be tested at least twice a month with appropriate known antisera.

i. The laboratory shall at least once each month have each person performing tests be given a previously tested specimen as an unknown to verify such person's ability to reproduce tests results. The results of such testing shall be recorded.

j. The laboratory shall participate in at least one national or regional cell exchange program, if available, or develop an exchange system with another laboratory in order to validate interlaboratory reproducibility.

5.44 Requirements for Certification of Radiology Providers. An x-ray facility is required to be owned and directed by a physician or group of physicians and shall be registered pursuant to section 140.54, Wis. Stats. and shall have a certificate of participation in Medicare (or shall be qualified for such certificate).

(NOTE: The following rules are a codification of 42 CFR 405.1411 through 405.1416. For the sake of readability, some editing has been done. In the event of any conflict of meaning, the meaning of the original federal regulations shall hold.)

(1) Registration. Providers of portable x-ray services shall be registered pursuant to section 140.54, Wis. Stats. and shall be approved as meeting the standards in Wis. Adm. Code, chapter H 57.

(2) Supervision by a Qualified Physician. Portable x-ray services shall be provided under the supervision of a qualified physician.

(a) Physician supervision. The performance of the roentgenologic procedures shall be supervised by a physician who meets the requirements of subsection 5.44(2)(b). In addition, either

1. The supervising physician shall own the equipment and the equipment is operated only by the physician's employees; or

2. The supervising physician shall certify annually that the physician periodically checks the procedural manuals and observes the operators' performance, that the physician has verified that equipment and personnel meet applicable registration requirements and that safe operating procedures are used.

(b) Qualifications of the physician supervisor. The supervising physician shall be either:

1. Certified in radiology by the American Board of Radiology or by the American Osteopathic Board of Radiology or in possession of qualifications which are equivalent to those required for such certification, or

2. Certified or meets the requirements for certification in a medical specialty in which the physician has become qualified by experience and training in the use of x-rays for diagnostic purposes, or

3. Specialized in radiology and recognized by the medical community as a specialist in radiology.

(3) Qualifications and Orientation of Technical Personnel and Employee Records. Portable x-ray services shall be provided by qualified technologists.

(a) Qualifications of technologists. All operators of the portable x-ray equipment shall meet one of the following requirements:

1. Successful completion of a program of formal training in x-ray technology of not less than 24 months' duration in a school approved by the Council on Education of the American Medical Association or by the American Osteopathic Association, or a bachelor's or associate degree in radiologic technology from an accredited college or university; or

2. For those whose training was complete before July 1, 1966 but on or after July 1, 1960: Successful completion of 24 full months of training or experience under the direct supervision of a physician who is certified in radiology by the American College of Radiology or possession of qualifications which are equivalent to those required for such certification, and at least 12 full months of pertinent portable x-ray equipment operation experience in the five years before January 1, 1968.

3. For those whose training was completed before July 1, 1960: Successful completion of 24 full months of training or experience or both, of which at least 12 full months were under the direct supervision of a physician who is certified in radiology by the American College of Radiology or who possesses qualifications which are equivalent to those required for such certification, and at least 12 full months of pertinent portable x-ray equipment operation experience in the five years before January 1, 1968.

(b) Personnel Orientation. The provider of portable x-ray services shall have an orientation program for personnel, based on a procedural manual. Such manual shall be available to all members of the staff, shall incorporate relevant portions of professionally recognized documents, and shall include instruction in all of the following:

1. Precautions to be followed to protect the patient from unnecessary exposure to radiation;

2. Precautions to be followed to protect an individual supporting the patient during x-ray procedures from unnecessary exposure to radiation;

3. Precautions to be followed to protect other individuals in the surrounding environment from exposure to radiation;

4. Precautions to be followed to protect the operator of portable x-ray equipment from unnecessary exposure to radiation;

5. Considerations in determining the area which will receive the primary beam;

6. Determination of the time interval at which to check personnel radiation monitors;

7. Use of the personnel radiation monitor in providing an addition check on safety of equipment;

8. Proper use and maintenance of equipment;

9. Proper maintenance of records;
10. Technical problems which may arise and methods of solution;
11. Protection against electrical hazards;
12. Hazards of excessive exposure to radiation.

(c) Employee Records. Current employee records shall be maintained and shall include a resume of each employee's training and experience. Records also shall contain evidence of adequate health supervision of employees, including records of all illness and accidents occurring on duty as well as results of a pre-employment and periodic physical examination.

(4) Referral for service and preservation of records. All portable xray services performed for recipients shall be ordered by a physician, and records of examinations performed shall be properly preserved.

(a) Referral by a physician. The supplier's records shall show that:

1. The x-ray test was ordered by a licensed physician, and
2. Such physician's written, signed order specifies the reason an x-ray tests is required, the area of the body to be exposed, the number of radiographs to be obtained, and the views needed; it also includes a statement concerning the condition of the patient which indicates why portable x-ray services are necessary.

(b) Records of examinations performed. The supplier shall make for each patient a record of the date of the x-ray examination, the name of the recipient, a description of the procedures ordered and performed, the referring physician, the operator(s) of the portable x-ray equipment who performed the examination, the physician to whom the radiograph was sent, and the date it was sent.

(c) Preservation of records. Records specified in subsection 5.44(4)(b) shall be maintained for a period of at least five years.

(5) Safety standards. X-ray examinations shall be conducted through the use of equipment which is free of unnecessary hazards for patients, personnel, and other persons in the immediate environment, and through operating procedures which provide minimum radiation exposure to patients, personnel, and other persons in the immediate environment.

(a) Tube housing and devices to restrict the useful beam. The tube housing shall be of diagnostic type. Diaphragms, cones or adjustable collimators capable of restricting the useful beam to the area of clinical interest shall be used and shall provide the same degree of protection as is required of the housing.

(b) Total filtration.

1. The aluminum equivalent of the total filtration in the primary beam shall not be less than that shown in the following table except when contraindicated for a particular diagnostic procedure.

Operating kVp	Total filtration (inherent plus added)
Below 50 kVp	0.5 millimeters aluminum.
50-70 kVp	1.5 millimeters aluminum.
Above 70 kVp	2.5 millimeters aluminum.

2. If the filter in the machine is not accessible for examination or the total filtration is unknown, it can be assumed that the requirements are met if the half-value layer is not less than that shown in the following table:

Operating kVp	Half-value layer
50kVp	0.6 millimeters aluminum.
70kVp	1.6 millimeters aluminum.
90kVp	2.6 millimeters aluminum.
100kVp	2.8 millimeters aluminum.
110kVp	3.0 millimeters aluminum.
120kVp	3.3 millimeters aluminum.

(c) Termination of exposure. A device shall be provided to terminate the exposure after a pre-set time or exposure.

(d) Control panel. The control panel shall provide a device (usually a milliammeter or a means for an audible signal to give positive indication of the production of x-rays whenever the x-ray tube is energized. The control panel shall include appropriate indicators (labelled control settings or meters) which show the physical factors (such as kVp, mA, exposure time or whether timing is automatic) used for the exposure.

(e) Exposure control switch. The exposure control switch shall be of the dead-man type and shall be so arranged that the operator can stand at least six feet from the patient and well away from the useful beam.

(f) Protection against electrical hazards. Only shockproof equipment shall be used. All electrical equipment shall be grounded.

(g) Mechanical supporting or restraining devices. Mechanical supporting or restraining devices shall be provided so that such devices can be used when a patient must be held in position for radiography.

(h) Protective gloves and aprons. Protective gloves and aprons shall be provided so that when the patient must be held by an individual, that individual is protected with these shielding devices.

(i) Restriction of the useful beam. Diaphragms, cones, or adjustable collimators shall be used to restrict the useful beam to the area of clinical interest.

(j) Personnel monitoring. A device which can be worn to monitor radiation exposure (e.g., a film badge) shall be provided to each individual who operates portable x-ray equipment. The device shall be evaluated for radiation exposure to the operator at least monthly, and appropriate records shall be maintained by the supplier of portable x-ray services of radiation exposure measured by such a device for each individual.

(k) Personnel and public protection. No individual occupationally exposed to radiation shall be permitted to hold patients during exposures except during emergencies, nor shall any other individual regularly be used for this service. Care shall be taken to assure that pregnant women do not assist in portable x-ray examinations.

(6) Inspection of equipment. Inspections of all x-ray equipment and shielding shall be made by qualified individuals at intervals not greater than every 24 months. The supplier shall maintain records of current inspections which include the extent to which equipment and shielding are in compliance with the safety standards outlined in section 5.44(5).

5.45 Requirements for Certification of Dialysis Facilities. Dialysis facilities are required to meet the requirements enumerated in Wis. Adm. Code sections H 52.05 and 52.06, and shall have a certificate of participation in Medicare.

5.46 Requirements for Certification of Blood Banks. Blood banks are requied to be licensed or registered with the U.S. Food and Drug Administration and shall be approved pursuant to section 143.15, Wis. Stats., and Wis. Adm. Code section H 38.05.

5.47 Requirements for Certification of Health Care Project Grant Centers, Health Maintenance Organizations and Prepaid Health Plans. Health care project grant centers, health maintenance organizations and prepaid health plans shall enter into a written contract with the department for providing services to enrolled recipients.

5.48 Requirements for Certification of Out-Of-State Providers.

(1) Border Status Providers. Providers enumerated in section 5.48(1)(a), (b),(c), whose normal practice includes providing service to Wisconsin recipients may be certified as Wisconsin border status providers if they meet the requirements for certification outlined in this rule. Certified border status providers shall be subject to the same regulations and contractual agreements as Wisconsin providers.

(a) Providers other than nursing homes and hospitals located in the following communities shall be eligible for certification as Wisconsin providers:

IOWA	ILLINOIS	MINNESOTA	MICHIGAN
Dubuque	Antioch	Duluth	Bessemer
Guttenberg	Durland	Hastings	Crystal Falls
Lansing	E. Dubuque	Kingsdale	Iron Mountain
McGregor	Freeport	La Crescent	Iron River
	Galena	Lake City	Ironwood
	Harvard	Markville	Kingsford
	Hebron	Minneapolis	Marenisco
	Richmond	Red Wing	Menominee
	Rockford	Rochester	Norway
	S. Beloit	Rush City	Wakefield
	Stockton	St. Paul	Watersmeet
	Warren	Stillwater	
	Woodstock	Taylor Falls	
		Wabesha	
		Winona	
		Wrenshall	

(b) Hospitals in Ironwood, Michigan, Iron Mountain, Michigan, Winona, Minnesota, and Red Wing, Minessota are eligible for certification as Wisconsin border status providers of inpatient and outpatient services. Hospitals in other communities listed in subsection 5.48(1)(a) are eligible for border status certification only as hospital outpatient services providers.

(c) Out-of-state diagnostic laboratories, regardless of location, are eligible for certification as Wisconsin border status providers.

(d) Other out-of-state providers may apply to the department for border status, except that out-of-state nursing homes are never eligible for border status. Such requests for border status shall be considered by the department on a case-by-case basis.

(2) Limitation on certification of out-of-state providers.

(a) Providers certified in another state whose services are not covered in Wisconsin (e.g., music therapists, art therapists, etc.) shall be denied border status certification in the Wisconsin program.

(b) Providers denied certification in another state shall be denied certification in Wisconsin.

(c) Providers denied certification in another state because their services are not a Medicaid covered benefit in that state, may be eligible for Wisconsin border status certification if their services are covered benefits in Wisconsin. For example, Michigan Medicaid does not cover private duty nursing but Wisconsin Medicaid does. A private duty nurse in Bessemer, Michigan may wish to become a certified Wisconsin border status provider, and may be eligible if the nurse meets the Wisconsin program requirements for certification.

6.01 Introduction. In addition to other provisions of this rule relating to individual provider types, or the manner by which specified services are to be provided and paid for under the program, the participation of all providers certified under section 5.01 to provide or claim reimbursement for services under the program shall be subject to the conditions set forth under this chapter.

6.02 General requirements for the provision of health care services to recipients by providers.

(1) Reimbursability of Services.

(a) An individual or entity may claim reimbursement for covered services as defined in Chapter 7 when the individual or entity providing such service is properly licensed or is otherwise qualified, and is certified under section 5.01 to participate as a provider in the program. Services defined under Chapter 7 as covered shall be reimbursable only if:

1. The recipient of the service was eligible to receive medical assistance benefits on the date such service was provided;

2. The provider complied with applicable state and federal procedural requirements relating to the delivery of the service and;

3. The service provided was appropriate and medically necessary for the condition of the recipient.

(b) If a provider determines that, to assure quality health care to a recipient, it is necessary to provide a non-covered service, nothing in this rule shall preclude the provider from furnishing such service, if before rendering the service, the provider advises the recipient that it is not covered under the program, and that the recipient, and not the program, shall be responsible for payment for the non-covered service.

(2) Refusal to provide program services to recipients. Provider shall not be required to provide services to a recipient if the recipient refuses or fails to present a currently valid medical assistance identification card. If a recipient fails, refuses, or is unable to produce a currently valid identification card, the provider may contact the fiscal agent to confirm the eligibility of the recipient. The department shall require its fiscal agent to install and maintain adequate toll free telephone service to enable providers to verify the eligibility of recipients to receive benefits under the program.

(3) Provider's responsibility to prepare, maintain, and provide access to records.

(a) A provider shall prepare and maintain all records specified under subsection 5.02(4) and the relevant paragraphs of subsection 5.02(5) for purposes of maintaining the provider's certification and to fully disclose the nature and scope of services provided under the program. All such records shall be retained by the provider for a period of not less than five (5) years, or six years in the case of rural health clinics. The five year period, or six years in the case of rural health clinics, shall commence on the date on which the provider received payment from the program for the service to which the records relate.

(b) Termination of a provider's participation in the program shall not terminate the provider's responsibility to retain the subject records unless an alternative arrangement for retention and maintenance has been established by the provider and approved by the department.

(c) The secretary of the department shall designate persons authorized to request access, inspect, audit or review the required records. Persons so authorized shall be issued credentials, including photographic identification, verifying the person's authorization.

(d) Upon the request of an authorized person and upon presentation of the authorized person's credentials, providers shall permit such persons at all reasonable times access to the records requested. Access for purposes of this section shall include the opportunity to inspect, review, audit and/or reproduce the subject records. All costs of reproduction of records shall be borne by the department. The department shall not use or disclose data or information relating to recipients and contained in a provider's records, except for purposes directly related to the administration of the program.

(4) Nondiscrimination. Providers shall, in providing health care services to recipients, comply with the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), regulations promulgated thereunder and section 504 of the Federal Rehabilitation Act of 1973. Accordingly, providers may not exclude, deny or refuse to provide health care services to recipients on the grounds of race, color, national origin or handicap.

6.03 Manner of preparation and submission of claims for reimbursement.

(1) Format. A provider shall utilize claim forms prescribed and furnished by the department. In lieu of using such claim forms, a provider may utilize magnetic tape billing if the format and content of such magnetic tape meets department specification, and the provider receives the department's prior written approval. The department shall, upon request, provide a provider with written format and content specifications required for magnetic tape billings and shall advise the provider of procedures required to obtain departmental approval of magnetic tape billing.

(2) Content. A provider shall make all reasonable attempts to insure that the information contained on the provider's claim forms is complete and accurate. Providers preparing claims shall utilize, where applicable, procedure codes specified by the department for identifying the services that are the subject of the claim. The department shall inform affected providers of the name and source of the designated procedure code. Every claim submitted shall be signed by the provider, or the provider's authorized agent.

(3) Timeliness. A claim may not be submitted until the recipient has received the service which is the subject of the claim. A claim shall be submitted to the fiscal agent within one year of the date such service was provided. Payment shall not be made for any claim submitted after the one (1) year period, except where the provider demonstrates to the satisfaction of the department that unusual circumstances or circumstances beyond the provider's control prevented timely submission of the claim.

(4) Health care services requiring prior authorization. Claims for service requiring prior authorization shall be denied where prior authorization was not obtained before the date of service delivery. Claims rejected due to lack of the provider's timely receipt of prior authorization may be paid under the following circumstances:

(a) Where the provider's initial request for prior authorization was denied and the denial was either rescinded in writing by the department or overruled by administrative order rendered pursuant to the recipient's petition for administrative review of the department's denial of prior authorization.

(b) Where the service requiring prior authorization was provided within a period of retroactive eligibility, i.e., before the recipient became eligible, and the provider applies to and receives from the department retroactive authorization for the service.

(5) Persons or entities eligible to receive payment on claims.

(a) Payment for a service shall be made directly to the provider furnishing the service or to the provider organization which provides or arranges for the availability of such service on a prepayment basis, except that payment may be made:

1. To the employer of an individual provider if such provider is required as a condition of employment to turn over fees derived from such service to the employer, or to a facility;

2. To a facility if a service was provided in such hospital, clinic or other facility, and there exists a contractual agreement between the individual provider and such facility under which the facility prepares and submits the claim for reimbursement for the service provided by the individual provider.

(b) An employer or facility submitting claims for services provided by a provider in its employ or under contract as provided for in paragraph (a) above must apply for and receive certification from the department to submit claims and receive payment on behalf of the performing provider. Any claim submitted by an employer or facility so authorized must identify the provider number of the individual provider who actually provided the service or item that is the subject of such claim.

(c) No payment which under paragraph (a) must be made directly to an individual provider or provider organization providing the service, may be made to anyone else under a reassignment or power of attorney [except to an employer or facility as defined in subparagraphs 1 and 2 of paragraph (a)], but nothing in this paragraph shall be construed:

1. To prevent the making of such a payment in accordance with an assignment from the person or institution providing the service involved if such service is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or;

2. To preclude an agent of such provider from receiving any payment if, and only if, such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for services in connection with the billing or collection of payments due such person or institution under the program is unrelated, directly or indirectly, to the amount of such payments or the claims therefore, and is not dependent upon the actual collection of any such payment.

(6) Assignment of Medicare Part B Benefits. A provider providing a covered service to a recipient eligible to receive Part B Benefits under Medicare (Title XVIII) shall accept assignment of the recipient's Part B Medicare benefits, if the service provided is, in whole or in part, reimbursable under Medicare Part B coverage.

(7) Third party liability for cost of services.

(a) The department shall make reasonable efforts to identify third party resources legally liable to contribute in whole or in part to the cost of services provided a recipient under the program. For purposes of this section, "third party" means an individual, institution, corporation, public or private agency that is liable to pay all or part of the cost of injury, disease or disability of an applicant for a recipient of medical assistance.

(b) If the department identifies a third party insurer (either public or private) that provides health or accident coverage for a recipient, such insurance coverage shall be identified on the recipient's medical assistance card. The department shall prepare and distribute to a provider, code conversion information which indicates whether other insurance coverage is available.

(c) If the existence of a third party source of insurance is identified, the provider shall, before submitting a claim, seek to obtain from that third party, payment for the service. If third party coverage appears unlikely or uncertain, or if the third party denies coverage for all or a portion of the cost of the service, the provider may then submit a claim to the extent payment for the service remains unpaid.

6.04 Payment on claims for reimbursement.

(1) Amount and timeliness. The department shall reimburse a provider for a properly provided covered service, according to provider payment schedule entitled "Terms of Provider Reimbursement". Payment shall issue on a claim for a covered service, properly completed and submitted by the provider, within thirty (30) days of receipt of such claim.

(2) Non-liability of recipients. A provider shall accept payments made by the department in accordance with subsection (1) above as payment in full for services provided a recipient. A provider shall not attempt to impose an additional charge or receive payment from a recipient, relative or other person for services provided, or to impose direct charges upon a recipient in lieu of obtaining payment under the program, except under the following conditions:

(a) A service desired, needed, or requested by a recipient is not covered under the program and the recipient is advised of this fact before receiving such services.

(b) If an applicant is determined to be eligible retroactively under section 49.46(1)(b), Wis. Stats., and a provider bills the applicant directly for services rendered during the retroactive period, the provider shall, upon notification of the recipient's retroactive eligibility, submit claims under this section for covered services provided during the retroactive period. Upon receipt of payment from the program for such services, the provider shall reimburse in full the recipient or other person who has made prior payment to the provider. A provider shall not be required to reimburse the recipient or other person in excess of the amount reimbursed by the program.

(c) A nursing home resident recipient chooses a private room in the nursing home and the provisions of HSS 107.09(3)(i) are met.

(3) Return of overpayment. If a provider receives a payment under the program to which the provider was not entitled or in an amount greater than that to which the provider was entitled, the provider shall promptly return to the department the amount of such erroneous or excess payment.

In lieu of returning such overpayment, a provider may notify the department in writing of the nature, source and amount of the overpayment and request that the excess payment be deducted from future amounts owing the provider under the program. The department shall honor such a request if the provider is actively participating in the program and is claiming and receiving reimbursement in amounts sufficient to allow recovery of the overpayment within a reasonable period of time, as agreed to by the department and the provider.

(4) Request for claim payment adjustment. If a provider contests the propriety of the amount of payment received from the department for services claimed, the provider shall notify the fiscal agent of its concerns, requesting reconsideration and payment adjustment. The fiscal agent shall within thirty (30) days of receipt of such request respond in writing, and advise what, if any, payment adjustment will be made. The fiscal agent's response shall identify the basis for approval or denial of the payment adjustment requested by the provider. This action shall constitute final departmental action with respect to payment of the claim(s) in question.

(5) Departmental recoupment of excess payments.

(a) If the department finds a provider has received payment under the program to which the provider was not entitled or in an amount greater than that to which the provider was entitled, the department may recover the amount of such improper or excess payment by any of the following methods:

1. By offset or appropriate adjustment against other amounts owing the provider for covered services;

2. If the amount owing the provider at the time of the department's finding is insufficient to recover in whole the amount of the improper or excessive payment, by offset or credit against amounts determined to be owing the provider for subsequent services provided under the program.

3. By requiring the provider to pay directly to the department the amount of the excess or erroneous payment.

(b) No recovery by offset, adjustment, or demand for payments shall be made by the department under subsection (a) unless the department gives the provider prior written notice of its intent to recover the amount determined to have been erroneously or improperly paid. The notice shall set forth the amount of the intended recovery, shall identify the claim or claims in question, and shall summarize the basis for the department's finding that the provider has received amounts to which the provider was not entitled or in excess of that to which the provider was entitled.

(c) The department shall not be required to provide prior written notice under subsection (b) above where the payment was made as a result of a computer processing or clerical error, or where the provider has requested or authorized the recovery to be made. In such case the department or its fiscal agent shall provide written notice of any payment adjustments made on the next remittance advice issued the provider. Such notice shall specify the amount of the adjustment made and the claim or claims which were the subject of the adjustments.

(d) If the provider chooses to contest the propriety of a proposed recovery, the provider shall within twenty (20) days after receipt of the department's notice of intent to recover, request a hearing on the matter.

Such a request shall be in writing and shall briefly identify the basis for contesting the proposed recovery. Receipt of a timely request for hearing shall preclude the department from making the recovery proposed while the hearing proceeding is pending. The department shall schedule a hearing on the contested recovery within twenty (20) days of receipt of provider's request for hearing. If a timely request for hearing is not received, the department may recover from current or future obligations of the program to the provider that amount specified in the notice of intent to recover. All hearings on contested recoveries shall be held in accordance with the provisions of Chapter 227, Wis. Stats. All notices under this section shall be in writing and shall be conclusively presumed to have been received within five (5) days after evidence of mailing.

(e) If the provider contests the propriety of adjustments made under subsection (c) above, the provider shall within thirty (30) days of receipt of the remittance advice, request in writing a hearing on the matter. Such written request shall be accompanied by a copy of the remittance advice reflecting the adjustment and by a brief summary statement of the basis for contesting the adjustment. The department shall schedule a hearing on the contested adjustment within twenty (20) days of receipt of the provider's request for hearing. All hearings on contested adjustments shall be held in accordance with the provisions of Chapter 227, Wis. Stats.

(6) Supporting documentation. The department may refuse to make payment and may recover previous payments made, on claims where the provider has failed or refused to prepare, maintain or provide authorized department personnel access to records required under subsection 5.02(4) or subsection 5.02(5) for purposes of disclosing and substantiating the nature, scope and necessity of services which are the subject of the claims.

(7) Good faith payment. A claim denied for recipient eligibility reasons may qualify for a good faith payment if the service provided was provided in good faith to a recipient with a medical assistance identification card which the provider saw on the date of service and which was apparently valid for the date of service.

6.05 Voluntary Termination of Program Participation.

(1) Providers other than nursing homes.

(a) Any provider, other than a skilled nursing or intermediate care facility, may at any time terminate participation in the program. A provider electing to terminate program participation shall within thirty (30) days notify the department in writing of such election and of the effective date of termination from the program.

(b) A provider may not claim reimbursement for services provided recipients on or after the effective date specified in the termination notice. If the provider's notice of termination fails to specify an effective date, the provider's certification to provide and claim reimbursement for services under the program shall be terminated on the date on which notice of termination is received by the department.

(2) Skilled Nursing and Intermediate Care Facilities.

(a) A provider certified under section 5.01 of this rule as a skilled nursing or intermediate care facility may terminate participation in the program upon advance written notice of not less than thirty (30) days, to the department and to the facility's resident recipients or their legal guardians. Such notice shall specify the effective date of the facility's termination of program participation.

(b) A skilled nursing or intermediate care facility electing to terminate program participation may claim and receive reimbursement for services for a period of not more than thirty (30) days after and including the effective termination date. Services furnished during the thirty (30) day period shall be reimbursable provided that:

1. The recipient was not admitted to the facility after the date on which written notice of program termination was given the department.

2. The facility can demonstrate to the satisfaction of the department that it has made reasonable efforts to facilitate the orderly transfer of affected resident recipients to another appropriate facility.

(3) Voluntary termination of a provider's program participation under this section shall not serve to terminate the provider's responsibility to retain and provide access to records as required under subsection 6.02.3 unless an alternative arrangement for retention, maintenance and access has been established by the provider and approved by the department.

6.06 Involuntary termination, suspension or denial of eligibility for program participation. The department may suspend or terminate the certification of any person, partnership, corporation, association, agency, institution or other entity participating as a health care provider under the program, if after reasonable notice and opportunity for a hearing the department finds:

(1) The provider has repeatedly and knowingly failed or refused to comply with federal or state statute, rule or regulation applicable to the delivery of, or billing for, services under the program.

(2) The provider has repeatedly and knowingly failed or refused to comply with the terms and conditions of its provider agreement.

(3) The provider has prescribed, provided, or claimed reimbursement for services under the program which were either:

(a) Inappropriate;
(b) Unnecessary or in excess of the recipient needs;
(c) Detrimental to the health or safety of the recipient; or
(d) Of grossly inferior quality.

Findings precipitating departmental action under this section shall be based upon the written findings of a peer review committee established by the department for the purpose of review and evaluation of health care services provided under the program.

(4) The licensure, certification, authorization, or other official entitlement required under state or federal law as a prerequisite to the provider's certification to participate in the program has been suspended, terminated, expired or revoked.

(5) Provider has provided a service to a recipient during a period in which provider's licensure, certification, authorization or other entitlement to provide the service was terminated, suspended, expired, or revoked.

(6) Provider has been convicted of a criminal offense related to the provision of or claiming reimbursement for services under Medicare (Title XVIII, Social Security Act), or under this or any other state's medical assistance program. For purposes of this section, "convicted" means that a judgment of conviction has been entered by a federal, state, or local court, irrespective of whether an appeal from that judgment is pending.

(7) Provider knowingly made or caused to be made a false statement or misrepresentation of material fact in connection with provider's application for certification or recertification.

(8) Provider has concealed, failed or refused to disclose any material change in licensure, certification, authorization, or ownership which if known to the department would have precluded the provider from certification.

(9) Provider at the time of application for certification under section 5.01 or after receiving such certification, knowingly misrepresented, concealed or failed to disclose to the department full and complete information as to the identity of each person holding an ownership or control interest.

(10) Provider at the time of application for certification under section 5.01 or after receiving such certification knowingly misrepresented, concealed or failed to disclose to the department an ownership or control interest the provider held in corporation, partnership, sole proprietorship, or other entity certified under the program.

(11) The provider has made or caused to be made false statements or misrepresentation of material facts in records required under section 5.02(3)(4)(5) and maintained by provider for purposes of identifying the nature and scope of services provided under the program.

(12) The provider has knowingly made or caused to be made false statements or misrepresentation of material facts in cost reports relating to the provider's costs, expenditures, or usual and customary charges submitted to the department for the purpose of establishing reimbursement rates under the program.

(13) The provider has failed or refused to prepare, maintain or make available for inspection, audit or copy by persons authorized by the department, records necessary to fully disclose the nature and scope of services provided recipients.

(14) The provider has knowingly made or caused to be made a false statement or misrepresentation of a material fact in a claim.

(15) The provider has intentionally by act of omission or commisssion obstructed an investigation or audit being conducted by authorized departmental personnel pursuant to subsection 49.45(3)(9), Wis. Stats.

(16) The provider has offered or paid to another person, solicited or received from another person, any renumeration in cash or in kind in consideration for a referral of a recipient for the purpose of procuring the opportunity to provide covered services to the recipient, payment for which may be made in whole or in part under the program.

(17) The provider has in addition to claiming reimbursement for services provided a recipient, imposed a charge on the recipient for such services or has attempted to procure payment from the recipient in lieu of claiming reimbursement through the program contrary to provisions of subection 6.04(2).

(18) Provider has refused to provide, or has denied services to recipients on the basis of the recipient's race, color or national origin in violation of the Civil Rights Act of 1964.

(19) Provider has refused to provide, or has denied services to a handicapped recipient, solely on the basis of handicap in violation of Section 504 of the Federal Rehabilitation Act of 1973.

(20) A provider providing skilled nursing or intermediate care services has failed or refused to establish and maintain an accounting system which insures full and complete accounting of its resident recipients' personal funds; or has engaged in, caused, or condoned serious mismanagement or misappropriation of such funds.

(21) The provider has failed or refused to repay amounts that have been determined to be owed the department either under subsection 6.04(5) or pursuant to a judgment of a court of competent jurisdiction, as a result of erroneous or improper payments made to the provider under the program.

(22) The provider failed or refused to purge a contempt order issued under section 885.12, Wis. Stats. as a result of the provider's refusal to obey a subpoena under subsection 49.45(3)(h)1, Wis. Stats.

(23) The provider, or a person with management responsibility for the provider, or an officer or person owning directly or indirectly 5% or more of the shares or other evidences of ownership of a corporate provider, or a partner in a partnership which is a provider, or the owner of a sole proprietorship which is a provider, was either:

(a) Terminated from participation in the program within the preceeding five (5) years.

(b) A person with management responsibility for a provider previously terminated under this section, or a person who was employed by a previously terminated provider at the time during which the act(s) occurred which served as the basis for the termination of the provider's program participation and knowingly caused, concealed, performed or condoned those acts.

(c) An officer of, or person owning, either directly or indirectly, 5% of the stock or other evidences of ownership in, a corporate provider previously terminated at the time during which the act(s) occurred which served as the basis for the termination.

(d) An owner of a sole proprietorship, or a partner in a partnership, that was terminated as a provider under this section, and the person was the owner or a partner at the time during which the act or acts occurred which served as the basis for such termination.

6.07 Effects of termination under section 6.06.

(1) Upon the termination of a provider under section 6.06, a person with direct management responsibility for said provider at the time of the occurrence which served as the basis for such termination shall be barred from future participation as a provider for a period not to exceed five (5) years.

(2) Upon termination of a corporate provider under section 6.06, officers and persons owning directly or indirectly 5% or more of the stock or other evidences of ownership in the corporation at the time of the occurrence which served as the basis for such termination, shall be barred from future participation as a provider for a period of not to exceed five (5) years.

(3) Upon the termination of a sole proprietorship or partnership provider under section 6.06 an owner or partner in partnership at the time of the occurrence which served as the basis for the termination, shall be barred from participation as a provider for a period not to exceed five (5) years.

(4) The secretary shall notify the appropriate state licensing agency of the suspension or termination of any provider licensed by the agency, and of the act or acts which served as the basis for the provider's suspension or termination.

6.08 Payment on Claims During Pendency of Proceedings under Section 6.06.

(1) Where termination action is initiated against a provider by the department under subsection (7), (11), (12), (13), (14), or (21) of section 6.06, the department may withhold issuance of payments on the provider's claims while proceedings are pending on such action, except that if a final administrative decision has not been issued within 90 days of the initiation of such action and the delay has not been caused by the subject provider, payment may no longer be withheld and shall be issued to the provider.

6.09 Pre-Payment Review of and Prior Authorization for Claims.

(1) The department shall establish committees of qualified professional health personnel to review the appropriateness and quality of services furnished recipients. Such committees shall perform health care services evaluation and review within the meaning of section 146.37, Wis. Stats.

(2) If the department has cause to suspect that a provider is prescribing or providing services which are not necessary for or which are in excess of the medical needs of recipients, or which are not in conformity with applicable professional practice standards, the department may before issuing payment for the claims, refer such claims to the appropriate health care review committee. The committee shall review and evaluate the medical necessity, appropriateness and propriety of the services of the claims. Denial or issuance of payment for the claims shall take into consideration the findings and recommendation of the committee.

(3) No individual member of a health care review committee established under subparagraph (1) may participate in a review and evaluation contemplated in subparagraph (2) if the individual has been directly involved in the treatment of recipients who are the subject of the claims under review, or if the individual is financially or contractually related to the provider under review, or if the individual is employed by the provider under review.

(4) A provider shall be notified by the department of the institution of the pre-payment review process under subparagraph (2). Claims which undergo pre-payment review shall be evaluated by the committee, and payment shall be issued or denied within sixty (60) days of the date on which the claims were submitted to the fiscal agent by the provider.

(5) If a health care review committee established under subparagraph (1) finds that a provider has engaged in the delivery of services which are inappropriate or not medically necessary, the department may require the provider to request and receive from the department authorization for the delivery of services under the program.

6.10 Procedure, Pleadings and Practice.

(1) Scope. The provisions of this section shall govern procedure and practice relating to administrative actions by the department to enforce program participation requirements, or to effect involuntary termination under section 6.06 for non-compliance with program requirements. They shall be construed to comply with the provisions of Chapter 227, Wis. Stats. and to secure the just, prompt, and inexpensive determination of every action.

(2) Commencement of Action. The department shall commence actions under this rule by serving upon the provider and filing with the Office of Administrative Hearings and Rules, written notice of the intended action. Such notice shall include the following:

(a) A brief and plain statement specifying the nature of and identifying the statute, regulation, or rule according the department the authority to commence the action.

(b) A short and plain statement identifying the nature of the transactions, occurrences or events which served as the basis for commencement of the action.

(c) A statement advising the provider of the right to a hearing and the manner by which a hearing may be requested and effected.

(3) Request for hearing. A provider desiring to contest a departmental action may request a hearing on any matter contested. The request shall be in writing and shall:

(a) Be served upon the department and the Office of Administrative Hearings and Rules within twenty (20) days of the date of service of the department's notice of intended action.

(b) Contain a short and plain statement identifying every matter or issue contested.

(c) Contain a brief and plain statement of any new matter which the provider believes constitutes a defense or mitigating factor with respect to non-compliance alleged in the notice of action.

(4) Contested actions; notice of hearing. Upon receipt of a timely request for hearing, the Office of Adminstrative Hearings and Rules shall schedule and mail notice of hearing to the department and to the provider. Such notice shall be mailed to the parties at least ten (10) working days before the scheduled hearing and shall include:

(a) A statement of the time, place, and nature of the hearing, including whether the matter constitutes a class 1, 2, or 3 proceeding within the meaning of Chapter 227, Wis. Stats.

(b) A statement of the legal authority and jurisdiction under which the hearing is to be held, and in the case of a class 2 proceeding, reference to the particular statutes and rules involved.

(c) A short and plain statement of the nature of the action and a statement of the contested issues.

(5) Effect of failure to request a hearing. The failure of the provider to submit a timely request for hearing shall constitute a default. Accordingly, the findings of the department which served as the basis for the action shall be construed as being admitted by the provider, and the administrative remedy or relief sought by the department via the action may be effected.

(6) Effect of failure to appear at hearing.

(a) If the department fails to appear on the date set for hearing, the hearing examiner may enter an order dismissing the department's action, pursuant to the motion of the provider or on its own motion.

(b) If the provider fails to appear on the date set for hearing, the hearing examiner may enter an order upon due proof of facts which show the department's entitlement to the remedy or relief sought in the action.

(c) The Office of Administrative Hearing and Rules may by order reopen a default arising from a failure of either party to appear on the date set for hearing. Such an order may be issued upon motion or petition duly made and good cause shown. The motion shall be made within twenty (20) days after the date of the hearing examiner's default order.

(7) Prior hearing requirement; exception.

(a) Departmental action may be taken against a provider without a prior hearing where such action is initiated on the basis of the department's finding that:

1. The health or safety of a recipient is in imminent danger as a result of the provider's failure to comply with applicable state or federal law relating to the provision of health care services.

2. The licensure, certification, authorization or other official entitlement required under state or federal law as a prerequisite to the provider's certification has been suspended, terminated, or revoked.

(b) If departmental action is taken under any of the grounds specified under paragraph (a), the department shall immediately provide the provider with notice of the action. The notice shall satisfy the requirements of section 6.10(2). The provider shall be entitled to and may demand and receive a hearing on the actions within ten (10) days (excluding weekends) of the date of such notice.

(8) Motions.

(a) Unless made during the course of a hearing or prehearing conference, all motions shall be made in writing, shall state with particularity the grounds therefore, and shall set forth the relief or order sought. A notice of motion is not required, since notice is satisfied by service of a copy of the motion.

(b) Briefs, affidavits, or other documentation in support of a motion shall be served and filed with the motion.

(9) Service. Unless otherwise provided by law, all orders, notices, and other papers may be served personally, or by first class, certified or registered mail. All papers filed by a party with the Office of Administrative Hearings and Rules shall be served by that party on all parties appearing in a proceeding. The filing of any paper required to be served constitutes a certification by the party or attorney effecting the filing, that a copy of such paper has been timely served on all parties required to be served, except as the person effecting the filing may otherwise state in writing, and no affidavits, certification, or admission of service need be filed with the Office of Administrative Hearings and Rules.

(10) Filing: All pleadings, motions, or other relevant material required to be filed with the Office of Administrative Hearings and Rules shall be submitted to: Office of Administrative Hearings and Rules, state department of health and social services, Madison, Wisconsin 53702.

(11) Hearing Examiners. The Office of Administrative Hearings and Rules shall appoint a hearing examiner to preside over every contested action. An examiner so appointed shall preside at all hearings relating to the action and may:

(a) Administer oaths and affirmations.
(b) Sign and issue subpoenas.
(c) Rule on offers of proof and receive relevant evidence.
(d) Take depositions or have deposition taken when provided by law.
(e) Supervise and regulate the course of hearings.
(f) Dispose of procedural requests or similar matters.
(g) Prepare a written decision which shall include findings of fact, conclusions of law, order and opinion.

(12) Prehearing Conference.

(a) The hearing examiner may direct the parties to appear at a pre-hearing conference to consider:

1. The clarification of issues.
2. The necessity or desirability of amendments to the pleadings.
3. Obtaining admissions of fact and documents which will avoid unnecessary proof.
4. Limitations of the number of witnesses.
5. Such other matters as will aid disposition of the action.

(b) A prehearing conference may be held by telephone.

(13) Mandatory disclosure. At a prehearing conference, parties shall file and exchange lists of their witnesses, and shall identify documentary and other physical evidence which they intend to utilize at the hearing. Following the prehearing conference, the parties remain under a continuing obligation to file and exchange lists of additional witnesses and additional evidentiary matter which they intend to utilize at the hearing. With the exception of rebuttal matter, witnesses or evidence not so submitted prior to three (3) working days before the hearing will not be permitted to testify or be received at the hearing, unless good cause for the failure of submission is shown.

(14) Discovery. Parties shall have available substantially all the means of discovery that are available to parties to judicial proceedings as set forth in Chapter 804, Wis. Stats., to the extent that the same are not

inconsistent with or prohibited by these rules, Wisconsin Statutes or the Wisconsin Administrative Code. Motions to compel discovery shall be directed to the hearing examiner.

(15) Conduct of Hearings.

(a) Open to Public. All hearings shall be open to the public except that the hearing examiner may order a closed hearing where necessary to protect the identity of or the confidentiality of information relating to recipients or providers.

(b) Representation. A provider is entitled to appear in person or by or with counsel or other person authorized by the Wisconsin Supreme Court.

(c) Continuances. The hearing examiner may continue a hearing to another time or place, or order a future hearing on the examiner's own motion or upon the motion of any party and a showing of good cause. If the hearing examiner determines that additional evidence is necessary for proper resolution of the matter, the examiner may:

1. Continue the matter to a later date and order the party to produce additional evidence; or

2. Close the hearing and hold the record open to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to all parties and each party shall have the opportunity for rebuttal.

(d) Evidence. As prescribed by subsection 227.08(1), Wis. Stats., parties to a hearing shall not be bound by common law or statutory rules of evidence. All testimony having reasonable probative value, shall be admitted, but immaterial, irrelevant, or unduly repetitious testimony shall be excluded. All evidence of the parties, including documents and records, may be offered and made a part of the record. Every party shall be afforded the opportunity to inspect and rebut evidence introduced or offer countervailing evidence. Documentary evidence may be offered and received in the form of copies or excerpts if the original is not readily available.

(e) Witnesses. A witness shall be examined first on direct examination by the party calling the witness, unless the witness is an adverse witness, in which case the person may be questioned as if on cross-examination by the party calling the person.

1. Cross-examination shall not be limited to matters to which the witness testified on direct examination, subject to the hearing examiner's discretion.

2. A person examining or cross-examining a witness shall not approach the witness stand except to show the witness an exhibit.

3. Examination and cross-examination shall be confined to questioning the witness and shall not be interspersed with argument or commentary on the testimony, except to the extent that argument relates to evidentiary questions to be resolved by the hearing examiner.

(f) Briefs. The hearing examiner may direct that the parties prepare and submit briefs on any issue related to the proceedings and may impose a briefing schedule.

(g) Stipulation of facts; settlements. The parties may agree upon and file at any time before the conclusion of the submission of testimony at hearing, written stipulation of fact. Any settlement between the parties relating to the disposition of a contested action shall not be effective unless or until approved by the secretary of the department.

(16) Decision. Within thirty (30) days of final hearing or, where applicable, the post-hearing brief deadline, the hearing examiner who presided at the hearing shall prepare a decision including findings of fact, conclusions of law, order and opinion. The hearing examiner's decision shall be the final decision of the department with respect to the action contested.

(17) Service of Decision. Every decision when made, signed, and filed, shall be served by personal delivery or by mailing of a copy to each party to the proceedings or to the party's attorney of record.

(18) Petition for rehearing.

(a) A petition for rehearing shall not be a prerequisite for appeal or review. Any party to a contested action, including the department, which deems itself aggrieved by a final decision may within twenty (20) days after service of the decision, file a written petition for rehearing which shall specify in detail, the grounds for relief and supporting authorities.

(b) The filing of a petition for rehearing shall not suspend or delay the effective date of the decision or order, and the decision or order shall take effect on the date set by the order and shall continue in effect unless the petition is granted or until the order is superceded, modified or set aside as provided by law.

(c) Procedures relating to petition for rehearing shall comply with subsection 227.12, Wis. Stats. A rehearing shall be granted only on the basis of the grounds specified in subsection 227.12(3), Wis. Stats.

(19) Transcripts. Stenographic, electronic or other record of oral proceedings shall be made. A written transcript of the record shall be prepared only as deemed necessary by the Office of Administrative Hearings and Rules and shall not be prepared at the specific request of any persons unless needed by such person for purposes of judicial review or other valid reason. If a transcript has been prepared by the Office of Administrative Hearings and Rules for its own use, copies may be furnished to all interested parties upon payment of a fee of 10 cents per page. If no transcript of the record has been prepared by the Office of Administrative Hearings and Rules and a specific request for a transcript is made, the party making the request shall be responsible for all reasonable costs of transcription of the record and preparation of the transcript. A party seeking judicial review of a decision shall pay the cost of preparing the transcript submitted to the reviewing court. Notwithstanding other provisions of this subsection, any party who on the basis of a verified petition can establish to the satisfaction of the Office of Administrative Hearings and Rules the need for a transcript and the financial inability to pay for a copy, may be furnished a copy free of cost.

(20) Waiver and variance. In order to get a waiver or variance from compliance with a statute or regulation the provider must file a written request with the ~~Bureau of Health Care Financing~~ DIVISION OF HEALTH, detailing the deficiency, the statute or regulation violated, and stating the reasons why the provider cannot comply.

(a) The ~~Bureau~~ DIVISION may grant the waiver or variance, order an investigation, set the matter for a hearing or deny the request if it is without merit.

(b) Hearings shall be held in conformance with the above procedures.

(c) The final decision on waiver or variance shall be made by the DIVISION, ~~Bureau~~. If the request for waiver or variance is denied the provider shall be given a reasonable opportunity to file a plan of correction and remedy the defect before action is taken by the ~~Bureau~~ DIVISION to suspend, revoke or refuse to renew its license or certification.

Chapter 7: Covered Services

7.01 General statement of coverage. Pursuant to section 49.45(1), Wis. Stats., the purpose of the medical assistance program is to make available appropriate health care services to qualified persons whose financial resources are inadequate to provide for their health care needs, so that such persons may attain or retain capability for self care or independence. Therefore, the department shall reimburse providers for medically necessary and appropriate health care services provided to currently eligible recipients. This includes emergency services even if provided by persons or institutions not currently certified.

7.02 General Limitations.

(1) Billing. The department shall reject payment for claims which fail to meet program billing requirements. However, claims rejected for such reasons may be eligible for reimbursement if, upon resubmission, all program requirements are met.

(2) Non-reimbursable services. The department may reject payment for services which ordinarily would be covered, if the service fails to meet program requirements. Example of non-reimbursable services are:

(a) Services which fail to comply with program policies or state and federal laws and regulations (e.g., non-therapeutic sterilizations performed without prior authorization and without following proper informed consent procedures; controlled substances prescribed or dispensed illegally).

(b) Services which the department's professional consultants determine to be not medically necessary, or to be inappropriate, or to be in excess of accepted standards of reasonableness;

(c) Inpatient hospital services or lengths of stay which are not approved by the PSRO review process;

(d) Non-emergency services provided by a person not a certified provider;

(e) Services provided to recipients who were not eligible on the date of service, except as noted in section 7.07(2)(c) 10 and 15.

(3) Prior Authorization.

(a) The department may require prior authorization for covered services so designated under each service category in this section, for the reasons listed below. The department shall act on requests for prior authorization within 10 working days from the receipt of all information necessary to make the determination. The department shall make a reasonable attempt to obtain from the provider the information necessary for 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 department of the reason for the delay.

(b) Reasons for prior authorization.

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) If prior authorization is not requested and obtained before service is provided, reimbursement shall not be made.

(d) A request for prior authorization submitted to the department shall, unless otherwise specified in this rule, identify at a minimum:

1. The name, address and medical assistance number of the recipient for whom the service or item is requested.

2. The name and provider number of the provider who shall perform the service requested.

3. The person or provider requesting prior authorization.

4. The attending physician's or dentist's diagnoses including, where applicable, the degree of impairment.

5. Justification for the provision of the service.

(e) In determining whether to approve or disapprove a request for prior authorization, the department shall consider the following criteria:

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 of pertinent federal or state laws, regulations, or interpretations;

10. The necessity of assuring 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;

12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

(f) The department may use the service of qualified professional consultants in determining whether requests for prior authorization are limited by these criteria.

(g) Prior authorization, once granted, is not transferable to other recipients or to other providers.

(h) 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 the negligence, wrongful act or tort of any other person; and

2. Services for such injuries are covered under the medical assistance program; and

3. The recipient, or the recipient's representative has or will initiate a claim or tort action against the negligent third party, joining the department in the action as provided under section 49.65, Wis. Stats.; and

4. The recipient, or 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) Medicaid coverage is not available for inmates of public institutions.

(5) When inmate status in interrupted.

(a) For inmates who are between the ages of 22 and 65 in an institution for mental diseases, inmate status may be interrupted if the person becomes an inpatient in a medical facility.

(b) For adult inmates of penal institutions, inmate status is not terminated or interrupted until the person is released from the institution on parole or otherwise.

(c) For children in a detention facility as a form of protection from physical danger (i.e, not placed due to a delinquent act), inmate status is interrupted if the child becomes an inpatient in a medical facility.

7.03 Services not covered. The following services are not covered services under the program:

(1) Charges for telephone calls.

(2) Charges for missed appointments.

(3) Sales tax on items for resale.

(4) Procedures considered experimental in nature.

(5) Personal comfort items, such as radios, television sets and telephones, which do not contribute meaningfully to the treatment of an illness.

(6) Alcoholic beverages, even if prescribed for remedial or therapeutic reasons.

(7) Autopsies.

(8) Any service requiring prior authorization for which prior authorization is denied.

(9)(a) Services subject to review and approval pursuant to section]50.02, Wis. Stats., but which have not yet received such approved certificate of need, except where the cost of the proposed service already has been disallowed in the rate set by the Wisconsin Hospital Rate Review Committee.

(b) Services which have been decertified pursuant to section 150.45, Wis. Stats., effective at the time specified in the final determination of the department, or one year from the issuance of the final determination, whichever occurs first, except where the cost of the service in question has been disallowed in the rate set by the Wisconsin Hospital Rate Review Committee.

(10) Medical examinations ordered by the court pursuant to section 51.20(10), Wis. Stats., except that this provision shall not prevent a recipient from using medical assistance benefits as a means of exercising rights under section 51.20(10), Wis. Stats., to secure additional medical or psychological examinations for purposes of contesting the commitment.

(11) Psychiatric examinations and evaluations ordered by the court following conviction of a crime, pursuant to section 972.15, Wis. Stats.

(12) Physical or psychiatric examinations ordered by a juvenile court for purposes of disposition of a case, pursuant to section 48.24, Wis. Stats.

(13) Consultations between or among providers, except as specified in HSS 107.06(3).

7.04 Coverage of out-of-state services. All non-emergency out-of-state services require prior authorization, except where the provider has been granted border status pursuant to the provisions of subsection 5.48 of this rule.

7.05 Coverage of emergency services provided by a person not a certified provider. Emergency services necessary to prevent the death or serious impairment of the health of a recipient are covered services even if provided by a person not a certified provider. Such persons shall submit documentation to the department, to justify provision of emergency services, according to the procedures outlined in section 5.05. The appropriate consultant(s) to the department shall determine whether a service was an emergency service.

7.06 Physicians Services.

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

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] The following physician services require prior authorization in order to be covered under the medical assistance program:

(a) All covered physician services if provided out-of-state under non-emergency circumstances by a provider who does not have border status.

(b) All medical, surgical, or psychiatric services aimed specifically at weight control or reduction, and procedures to reverse such services.

(c) Surgical or other medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability.

(d) Prescriptions for amphetamines, Debrisan (Pharmacia Corp.) and Derifil (Rystan).

(e) Any covered physician service if federal financial participation is not provided. [NOTE: Federal financial participation means the federal funds available to the state to cover a portion of the cost of services provided under the state's Medicaid program. Federal financial participation is available for services which are federally-mandated Medicaid services (e.g., inpatient hospitalization, nursing home services, home health care, physicians services, drugs etc.). FFP is also available for services considered by the federal government to be optional in the Medicaid program (e.g., chiropractic). However, there are services and specific procedures for which FFP is not available, and in such instances, the cost of reimbursing the service must be picked up entirely by state funds.]

(f) Ligation of internal mammary arteries, unilateral or bilateral.

(g) Radical hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area.

(h) Omentopexy for establishing collateral circulation in portal obstruction.

(i) Kidney decapsulation, unilateral and bilateral.

(j) Perirenal insufflation.

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

(l) Circumcision, female.

(m) Hysterotomy, non-obstetrical, vaginal.

(n) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both.

(o) Uterine suspension, with or without presacral sympathectomy.

(p) Ligation of thyroid arteries (independent procedure).

(q) Hypogastric or presacral neurectomy (independent procedure).

(r) Fascia lata by stripper when used as treatment for lower back pain.

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

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

(u) Excision of carotid body tumor without excision of carotid artery, with excision of carotid artery, when used as treatment for asthma.

(v) Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as treatment for hypertension.

(w) Splanchnicectomy, unilateral or bilateral, when used as treatment for hypertension.

(x) Bronchoscopy - with injection of contrast medium for bronchography or - with injection of radioactive substance.

(y) Basal metobolic rate (BMR).

(z) Protein bound iodine (PBI).

(aa) Ballistocardiogram.

(bb) Icterus index.

(cc) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study.

(dd) Angiocardiography, utilizing CO2 method, supervision and interpretation only.

(ee) Angiocardiography - single plane, supervision and interpretation in conjunction with cineradiography or - multi-plan, supervision and interpretation in conjunction with cineradiography.

(ff) Angiography - coronary, unilateral selective injection supervision and interpretation only, single view unless emergency.

(gg) Angiography - extremety, unilateral, supervision and interpretation only, single view unless emergency.

(hh) Fabric wrapping of adbominal aneurysm.

(ii) Extra-intra cranial arterial bypass for stroke.

(jj) Reversal of tubal ligation or vasectomy.

(kk) Sterilizations.

1. Sterilization of a mentally competent individual aged 21 or older. Sterilization is covered only if:

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

b. The individual is not a mentally incompetent individual;

c. The individual has voluntarily given informed consent in accordance with all the requirements prescribed in HSS 107.06(3)(kk) 5. through 6. and

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

2. Mentally incompetent or institutionalized individuals. Sterilization of a mentally incompetent or institutionalized individual is not covered.

3. Sterilization by hysterectomy.

a. A hysterectomy is not covered if:

i. It was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or

ii. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

b. A hysterectomy enumerated in paragraph a. is covered only if:

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

ii. The individual or her representative, if any, has signed a written acknowledgement of receipt of that information.

4. Additional condition for coverage. Before reimbursement will be made for a sterilization or hysterectomy, the department must receive documentation showing that the requirements of this subpart were met. This documentation must include a consent form or an acknowledgement of receipt of hysterectomy information.

5. Informed consent. Informing the individual. For purposes of this subpart, an individual has given informed consent only if:

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

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

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

iii. Advice that the sterilization procedure is considered to be irreversible.

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

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

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

vii. Advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in HSS 107.06(3)(kk)1.d.

b. Suitable arrangements were made to insure that the information specified in HSS 107.06(3)(kk)5.a. was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

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

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

e. The consent form requirements of HSS 107.06(3)(kk)6. were met; and

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

g. When informed consent may not be obtained. Informed consent may not be obtained while the individual to be sterilized is:

i. In labor or childbirth;

ii. Seeking to obtain or obtaining an abortion; or

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

6. Consent form requirements.

a. Content of consent form. The consent form must be the form approved by the department.

b. Required signatures. The consent form must be signed and dated by:

i. The individual to be sterilized;

ii. The interpreter, if one was provided;

iii. The person who obtained the consent; and

iv. The physician who performed the sterilization procedure.

c. Required certifications.

i. The person securing the consent must certify, by signing the consent form, that:

aa. Before the individual to be sterilized signed the consent form, he or she advised the individual to be sterilized that no federal benefits may be withdrawn because of the decision not to be sterilized;

bb. He or she explained orally the requirements for informed consent as set forth on the consent form; and

cc. To the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

ii. The physician performing the sterilization must certify, by signing the consent form, that:

aa. Shortly before the performance of sterilization, he or she advised the individual to be sterilized that no federal benefits may be withdrawn because of the decision not to be sterilized;

bb. He or she explained orally the requirements for informed consent as set forth on the consent form; and

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

iii. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician must certify that the sterilization was performed less than 30 days, but not less than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and:

aa. In the case of premature delivery, must state the expected date of delivery; or

bb. In the case of abdominal surgery, must describe the emergency.

iv. If an interpreter is provided, the interpreter must certify that he or she translated the information and advice presented orally and read the consent form and explained its contents to the individual to be sterilized and that, to the best of the interpreter's knowledge and belief, the individual understood what the interpreter told him or her.

(3) Other Limitations.

(a) The following services require physician's orders or prescription in order to be covered under medical assistance:

1. Skilled nursing facility services, excluding services in an institution for mental diseases;
2. Intermediate care facility services;
3. Home health care services;
4. Physical and occupational therapy services;
5. Psychotherapy services;
6. Speech pathology and audiology services;
7. Medical supplies and equipment, including rental of durable equipment;
8. Drugs;
9. Prosthetic devices;
10. Diagnostic, screening, preventive and rehabilitative services;
11. Inpatient hospital services;
12. Inpatient psychiatric hospital services for individuals under 21 years of age (or for individuals under 22 years of age who were receiving such service immediately before reaching age 21), and for individuals over 65 years of age;
13. Personal care services, as enumerated in section 7.]2 of this rule;
14. Long-term private duty nursing services;
15. Hearing aids;

16. Specialized transportation services for persons not requiring a wheelchair;

17. Hospital private room accommodations.

(b) Except where indicated otherwise in federal or state statute or regulations, prescriptions or orders shall be in writing or given orally and later reduced to writing by the provider filling the prescription, and shall include the date of the order, the name and address of the prescriber, the prescriber's medical assistance provider number, the name and address of the recipient, the recipient's medical assistance eligibility number, an evaluation of the service to be provided and the prescriber's signature. In the case of hospital patients and nursing home patient recipients, orders shall be entered into the medical and nursing charts and shall include the information required by this paragraph.

(c) Prescriptions for specialized transportation services of a recipient not confined to a wheelchair shall include an explanation of the reason the recipient is unable to travel in a private automobile, taxicab, bus or other common carrier. The prescription shall specify the length of time for which the recipient shall require the specialized transportation. One copy of the prescription shall be sent to the fiscal agent where it shall be kept on file; one copy shall be kept on file with the transportation provider.

(d) A maximum of one physician's visit per month to a recipient confined to a nursing home is covered unless the recipient has an acute condition which warrants more frequent care.

(e) The services of a surgical assistant shall not be covered for procedures which normally do not require assistance at surgery, that is, for procedures indicated as minor surgery in the Milwaukee relative value guide.

(f) Laboratory and radiology services performed by a provider other than the physician or the physician's office staff shall be covered services only if billed by the provider performing the laboratory or radiology services.

(g) A maximum of one annual physical examination per year per recipient shall be covered.

(h) Abortions performed which do not comply with section 20.927, Wis. Stats., shall not be covered services.

(i) Consultations by physicians.

1. Certain consultations are covered if they are professional services furnished a recipient by a second physician at the request of the attending physician. Consultations must include the history and examination of the patient, and a written report which becomes a part of the recipient's permanent medical record. The name of the attending physician shall be included on the consultant's claim for reimbursement. These consultations are covered:

a. Consultation requiring limited examination and/or evaluation of a given system.

b. Consultation requiring more extensive examination and/or evaluation.

c. In unique and complicated cases, where adequate documentation to justify the consultation is submitted with the claim, consultation requiring complete diagnostic history and examination and/or evaluation.

2. Services by means of a telephone call between physicians and recipients (including those in which the physician provides advice or instructions to or on behalf of a recipient), or between or among physicians on behalf of the recipient, are not covered services.

(4) Non-covered services. The following are not covered services under medical assistance:

(a) Artificial insemination.

(b) Transsexual surgery.

7.07 Dental Services.

(1) Covered Services. Covered dental services are those services, except where limited by this rule, which are provided by or under the supervision of a dentist or physician, within the scope of practice of dentistry, as defined in section 447.02, Wis. Stats.

(a) Covered diagnostic procedures are those listed as follows:

1. Clinical oral examination and emergency diagnosis;

2. Radiographs:

a. Intraoral - (complete periapical series including bitewings or panoramic including bitewings);

b. Intraoral periapical - single, first film;

c. Intraoral periapical - each additional film - up to nine (9) films;

d. Intraoral - occlusal, single film;

e. Extraoral;

f. Bitewing films;

3. Tests and Laboratory Examinations:

a. Biopsy and examination of oral tissue (hard);

b. Biopsy and examination of oral tissue (soft).

(b) Covered preventive procedures are those listed below:

1. Dental Prophylaxis - scaling and polishing (including prophylaxis treatment paste if used);

2. Fluoride treatments - topical (excluding prophylactic treatment paste);

3. Space Maintainers - Fixed Unilateral, for premature loss of second primary molar only;

4. Recementation of space maintainer.

(c) Covered restorative procedures are those listed below:

1. Amalgam Restorations (includes polishing) - primary and permanent teeth;
2. Silicate Restorations, per restoration;
3. Acrylic, Plastic or Composite restoration;
4. Crowns, Single Restorations Only:
   a. Stainless Steel, Primary Cuspid and Primary Posteriors only;
   b. Stainless Steel - permanent teeth;
5. Other Restorative Services:
   a. Recement inlay:
   b. Recement crowns;
   c. Retention pins per tooth;
   d. Recement facings;
   e. Sedative fillings.

(d) Covered endodontic procedures are those listed below:
1. Pulp Capping - includes bases but not final restoration;
2. Pulpotomy - includes base but not final restoration:
   a. Therapeutic Pulpotomy - primary teeth only;
   b. Vital Pulpotomy;
   c. Pulpectomy in primary teeth;
3. Root Canal Therapy - gutta percha or silver points only:
   a. Anterior (excludes final restoration);
   b. Bicuspids (excludes final restoration);
   c. Apexification or Therapeutic Apical Closure;
4. Periapical Services:
   a. Apicoectomy, with Filling of Root Canal (Anterior and bicuspids only);
   b. Retrograde filling;
   c. Replantation and Splinting of Traumatically Avulsed Tooth.

(e) Covered Removable Prosthodontic procedures are those listed below:
1. Adjustments to Dentures (by other than dentist providing appliances);
2. Repairs to Dentures - (full dentures, partial dentures and reline allowances include adjustments for six-month period following insertion);
3. Other Prosthetic Services - Special tissue conditioning (in addition to relining and rebasing).

(f) Covered Fixed Prosthodontic procedures are those covered below:
1. Repairs:
   a. Replace broken facing where post is intact;
   b. Replace broken facing with acrylic;
   c. Replace broken Tru-pontic;
   d. Replace broken facing where post backing is broken;
2. Other Prosthetic Services - Recement bridge.

(g) Covered oral surgery procedures including anesthetics and routine post operative care are those listed below:
1. Simple extractions including sutures;
2. Surgical extractions:
   a. Extraction of tooth - erupted;
   b. Root recovery (surgical removal of residual roots);
   c. Oral antral fistula closure (and/or antral root recovery);

3. Alveoloplasty (surgical preparation of ridge for dentures) - per sextant or quadrant in conjunction with extractions;

4. Surgical Excision - excision of reactive inflammatory lesions (scar tissue or localized congenital lesions; not hyperplastic tissue);

5. Excision of Tumors (not hyperplastic tissue);

6. Surgical Incision:

a. Incision and drainage of abscess - intraoral/extroral;

b. Sequestrectomy for osteomyelitis;

7. Treatment of Fractures - Simple (maxillae, mandible, malar, alveolus and facial);

8. Treatment of Fractures - Compound or Comminuted (maxillae, mandible, malar, alveolus);

9. Reduction of Dislocation and Management of Other Temporo-mandibular Joint Dysfunctions;

10. Other oral surgery - suture of soft tissue wound or injury apart from other surgical procedure;

11. Other repair procedures:

a. Excision of pericoronal gingiva;

b. Closure of salivary fistula;

c. Emergency tracheotomy.

(h) Orthodontic records (applicable to orthodontic cases only).

(i) Covered adjunctive general services are those listed below:

1. Unclassified Treatment, Palliative (emergency) treatment, per visit;

2. Anesthesia, Local anesthetic, per quadrant (not in conjunction with oral surgery procedure);

3. Professional Visits, out of office:

a. House calls/nursing home calls;

b. Office visit, after regularly scheduled office hours (no operative services performed);

4. Drugs:

a. Pre-operative medication;

b. Post-operative medication.

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).]

(a) The department may require prior authorization for covered dental services, where necessary to meet the program objectives stated in section 7.02(3). A request for prior authorization of dental services submitted to the department by a dentist or physician shall identify at a minimum those items enumerated in section 7.02(3)(d). In addition, the following shall be identified:

1. The age and occupation of the recipient.

2. Service or procedure requested.

3. When the service involves training in preventive dental care or orthodontics, or whenever requested by the department, an estimate of the fee associated with the provision of the service.

4. Diagnostic casts and/or radiographs may be requested by the department.

(b) In determining whether to approve or disapprove a request for prior authorization, the Department shall consider the criteria enumerated in section 7.02(3)(e) and, the cost of the service when necessary;

(c) The following dental services require prior authorization in order to be reimbursed under the medical assistance program:

1. All covered dental services if provided out-of-state under non-emergency circumstances by non-border status providers.

2. Surgical or other dental procedures of questionable dental necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability.

3. Diagnostic Procedures-Temporomandibular Joint Radiographs.

4. Diagnostic Casts (other than requests for orthodontics)

5. Training in preventive dental care

6. Space Management Therapy:
   a. Fixed Bilateral Type;
   b. Removable bilateral type-acrylic.

7. Restorative Procedures:
   a. Inlays, gold;
   b. Crowns:
      i. Plastic (acrylic) anterior teeth only-laboratory processed;
      ii. Plastic with metal;
      iii. Porcelain;
      iv. Porcelain with metal;
      v. Gold (full cast or 3/4 cast);
      vi. Stainless Steel, laterals and centrals, primary teeth;
   c. Metal post (dowel).

8. Endodontics (gutta percha or silver points only):
   a. Molars (excludes final restoration);
   b. Root Resection/Apicoectomy.

9. Periodontics:
   a. Surgical (including post operative services):
      i. Gingivectomy or Gingivoplasty;
      ii. Gingivectomy, osseous or muco-gingival surgery;
      iii. Osseous grafts;
      iv. Osseous surgery;
      v. Pedicle soft tissue graft;
      vi. Vestibuloplasty;
      vii. Gingival curettage and root planning;
   b. Periodontics Adjunctive Services:
      i. Provisional splinting - intracronal/extracronal;
      ii. Occlusal adjustments (equlibration);
      iii. Special periodontal appliances.

10. Prosthodontics (Removable, including six months post delivery care) - Note: If the request is approved, the recipient is required to be eligible on the date the authorized prosthodontic treatment is started. Once started, the service will be reimbursed to completion, regardless of the recipient's eligibility.
   a. Complete dentures;
   b. Partial dentures;
   c. Denture Duplication (jump case) and Relining - (full dentures, partial dentures and reline allowances include adjustments for six-month period following insertion);
   d. Other Prosthetic Services:
      i. Obturator for surgically excised palatal tissue;
      ii. Obturator for deficient velopharyngeal function (cleft palate);

11. Prosthodontics - Fixed;
12. Oral Surgery (including anesthetics and routine post - operative care):
a. Surgical Extractions:
i. Soft tissue impaction;
ii. Partial bony impaction;
iii. Complete bony impaction;
b. Other Surgical Procedures:
i. Surgical exposure of impacted or unerupted tooth for orthodontic reasons - including wire attachment where indicated;
ii. Surgical exposure of impacted or unerupted tooth to aid eruption;
c. Alveoloplasty not in conjunction with extractions;
d. Removal of cysts and neoplasms (odontogenic/nonodontogenic);
e. Surgical Incision:
i. Removal of foreign body from skin, or subcutaneous - areolar tissue;
ii. Removal of foreign body from hard tissues;
f. Excision of Bone Tissue (exostosis and partial ostectomy);
g. Reduction of dislocation and management of other temporomandibular joint dysfunctions:
i. Condylectomy;
ii. Meniscectomy;
iii. Injection of sclerosing agent or cortisone;
h. Other repair procedures:
i. Injection of trigeminal nerve branches for destruction;
ii. Osteoplasty (orthognathic deformities);
iii. Frenulectomy;
iv. Excision of hyperplastic tissue;
v. Excision of salivary gland;
15. Orthodontics - The diagnostic work-up is required to be performed and submitted with the prior authorization request. If the request is approved, the recipient is required to be eligible on the date the authorized orthodontic treatment is started. Once started, the service will be reimbursed to completion, regardless of the recipient's eligibility.
16. Adjunctive general services:
a. General anesthesia;
b. Hospital calls, services in hospitals;
17. Any other service not specified in this rule as a covered, dental service or as a non-covered dental service.

(3) Other limitations

(a) A full-mouth series of radiographs (including either a full-mouth intra-oral series of radiographs including bitewings, or a panographic film including bitewings, but not both) will be reimbursed only once per patient per dentist during a three-year period.

(b) Bitewing films will be reimbursed only once per patient per dentist during a six-month period.

(c) Prophylaxis procedures will be reimbursed only once during a six-month period per patient per dentist, unless prior authorized.

(d) Fluoride treatments-topical shall be reimbursed only once during a six-month period per patient per dentist, unless prior authorized.

(e) Training in preventive dental care shall be reimbursed only once per patient.

(f) Only one house call or nursing home call charge per day per home visited shall be reimbursed, regardless of the number of patients/residents seen at each home.

(g) Initial oral examinations shall be reimbursed only once during a one-year period per patient per dentist.

(h) Periodic oral examinations shall be reimbursed only once during a six-month period per patient per dentist.

(i) Requests for replacement of full or partial dentures shall be judged on an individual case basis according to the necessity and appropriateness of the prosthetic appliance. The department shall consider the following criteria when evaluating the request: medical necessity; appropriateness; extent to which less expensive alternative services are available; misutilization practices of recipients; and adequacy of information in the prior authorization request as presented by the provider.

(4) Non-covered services. Non-covered services are those listed below (in addition to those listed in section 7.03 of this rule):

(a) Dental implants and transplants;
(b) Fluoride mouthrinse;
(c) Services for purely esthetic (cosmetic) purposes;
(d) Overlay dentures;
(e) Cu-sil dentures;

7.08 Hospital services.

(1) Covered Services.

(a) Inpatient hospital services. Covered inpatient hospital services are those medically necessary services ordinarily furnished by the hospital, for the care and treatment of inpatients, which are provided under the direction of a physician or dentist in an institution which is a certified provider.

(b) Outpatient hospital services. Covered hospital outpatient services are those preventive, diagnostic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient in a hospital which is a certified provider.

(2) Services Requiring Prior Authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] The following covered services require prior authorization:

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

(b) Hospitalization for non-emergency dental services.

(c) Hospitalization for any surgical procedure noted in section 7.06 (2) of this rule.

(3) Other Limitations.

(a) Inpatient admission for non-therapeutic sterilization is a covered service only if the procedures specified in section 7.06(2)(kk) of this rule are followed.

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

Abscess
Acute upper respiratory infection
Acute viral infection
Agammaglobulinemia
Anthrax
Aszhemer's Disease
Bronchitis
Burns-third degree
Ceasarian Section
Cellulitis
Cerebral Concussion
Cholera
Conjunctivitis, Inclusive
Diabetic Kioacidosis
Diarrhea Enteropathic (E. coli)
Diptheria
Down's Syndrome
Epigottitis
Gas gangrene (due to Clostridium perfringens)
Gastroenteritis (due to Salmonella, Shigella or E. coli)
Gonococcal Opthalmia Neonatorum
Herpes Simplex & Disseminated neonatal
Herpes Zoster
Infectious Hepatitis
Laryngotracheobronchitis
Lassa Fever, Marburg virus disease
Leukemia
Listerosis
Measles
Melioidosis, extrapulmonary
Meningitis, Aseptic
Menigitis, Meningoccoccal
Mental Retardation listed with any diagnosis
Mononucleosis
Mumps
Narcotic Addiction
Otitis Media Pharyngitis
Overdose
Peritonitis
Pertussis
Plague, Pneumonic or Bubonic
Poliomyelitis
Pneumonia with Staphlococcus or streptococcus
Pregnancy with an infectious diagnosis
Pregnancy, pre-eclampsia
Premature infant with respiratory diagnosis
Psittacosis
Psychoses-Acute
Rabies
Rubella and Congential Rubella Syndrom
Sarcoma
Scarlet Fever
Septicemia
Shigellosis
Sinusitis
Smallpox
Streptococcal Infection
Staphylococcal Infection
Suicidal Tendencies
Terminal Carconoma
Tuberculosis
Typhoid Fever
Uncontrolled Seizures
Vaccinia (cowpox)
Varicella (Chickenpox)

[NOTE: It is the responsibility of the attending physician to determine the necessity of private room accommodations. Any claim for private room accommodations with a diagnosis not listed here will be suspended and submitted to the medical consultant of the department for pre-payment review and will be reimbursed at the semi-private room rate, unless necessity is documented and certified by the attending physician. When a private room is not medically necessary, neither the medical assistance program nor the recipient can be held responsible for the difference between the private room charge and the most prevalent semi-private room charge. If, however, a recipient requests a private room and the provider informs the recipient at the time of admission of the cost differential, and if the recipient understands and agrees to pay the differential, then the recipient may be charged for the differential.]

(c) Day surgery procedures are considered outpatient services in all cases. Emergency room services are outpatient services unless the patient is admitted and counted in the midnight census. Patients who are same day admission/discharge patients who die before the midnight census are considered inpatients.

(4) Non-covered services. The following hospital services are not covered (in addition to those services listed in section 7.03 of this rule):

(a) Unnecessary or inappropriate inpatient admissions;

(b) Hospitalizations or portions of hospitalizations disallowed by the professional standards review organization or the PSRO-approved review process in delegated hospitals.

7.09 Nursing Home Services. (The former Wis. Adm. Code chapter PW-MA 27 is repealed and recreated in this section.)

(1) Covered services. Covered nursing home services include those medically necessary services provided by a certified nursing home and prescribed by a physician in a written plan of care. The costs of all routine, day-to-day health care services and materials provided to recipients by a nursing home shall be reimbursed within the daily rate determined by the medical assistance program in accordance with section 49.45(6m)(a), Wis. Stats. Such services shall include the following:

(a) Routine services and costs.

1. Nursing services.
2. Special care services (including activity therapy, recreation, social services, and religious services).
3. Supportive services (including dietary, housekeeping, maintenance, institutional laundry and personal laundry services, but excluding dry cleaning services).
4. Administrative and other indirect services.
5. Capital (including depreciation, insurance, and interest).
6. Property taxes.

(b) Personal comfort and medicine chest items. Those items reasonably associated with normal and routine nursing home services, provided that, if a recipient specifically requests a brand name which the nursing home does not routinely supply and for which there is no equivalent or close substitute included in the daily rate, the recipient after having been informed in advance that such equivalent or close substitute is not available without charge, will be expected to pay for that brand item out of personal funds, at a rate based on actual cost. The department may modify the list of items covered. The following is a partial list of the items covered by this subparagraph:

1. Body powders.
2. Foot powders.
3. Body lotions & skin creams.
4. Alcohol (for external use).
5. Cotton-tip applicators, tongue depressors.
6. Adhesive tape.
7. Bandages.
8. Antiseptics.
9. Rubber and plastic gloves & finger cots.
10. Denture cups, dentifrices.
11. Tincture of benzoin and tincture of benzoin-based products.
12. Lubricating jellies.

13. Analgesic rubs.
14. Aromatic liquids and ointments/creams.
15. Cotton, cotton balls.
16. Shampoo.
17. Soap.
18. Disposable tissues.
19. Drinking tubes & straws.
20. Sugar substitutes.
21. Salt substitutes.
22. Disposable cleaning tissues.
23. Diet supplements and replacements.
24. Lemon & glycerin swabs.
25. Walkers.
26. Wheelchairs.
27. Name tags.
28. Oral hygiene products.
29. Denture adhesive.
30. Deodorants.
31. Denture cleaning products.

(c) All personal laundry services, except in the case of nursing homes which do not provide laundry services either directly or through outside contractors, in which case the daily nursing home rate shall be adjusted downward.

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

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] The following services require prior authorization of the department:

(a) The level of care and services to be received by the recipient must be documented by the attending physician and approved by the department.

(b) The rental or purchase of a specialized wheelchair for a recipient in a nursing home, regardless of the purchase or rental cost, as enumerated in section 7.24 of this rule.

(3) Other Limitations.

(a) Ancillary Costs. Those treatment costs which are both extraordinary and unique to individual recipients in nursing homes shall be reimbursed separately as ancillary costs, subject to any modifications made pursuant to section 7.09(])(b) of this rule. The following are items not included in calculating the daily nursing home rate and which can be reimbursed separately:

1. The following supplies and materials provided by a nursing home:

a. Intravenous sets and solutions.

b. Catheter set and foley, in "set" form only, excluding component parts except where size requirements necessitate component part purchases.

c. Bladder irrigation sets, in "set" form only, excluding component parts except where size requirements necessitate component part purchases.

d. Oxygen in liters, tanks, or hours.

e. Disposable medical or nursing supplies or both used in nursing care that are a medical necessity and are included in the medical regimen without a specific prescription, including but not limited to the following:

i. Materials used in temporary isolation of a recipient.

ii. Tubing and masks used in respiratory therapy.

iii. Dressings.

iv. Syringes.

v. Underpads, chux, diapers, "blue" pads.

2. Transportation of a recipient to obtain health treatment or care, provided:

a. Such treatment or care is prescribed by a physician as medically necessary, and is performed at a physician's office, clinic, or other recognized medical treatment center; and

b. The transportation service is provided by one of the following modes:

i. By the nursing home, in its controlled equipment and by its staff; or

ii. By a common carrier, such as a bus or taxi.

3. Direct laboratory or radiology services performed by the nursing home in a certified laboratory or radiology unit at the home.

4. Direct services provided by independent providers of service are reimbursable to the nursing home as an ancillary cost only if a nursing home can demonstrate to the department that it is more economical to pay for the service in question through the nursing home's daily rate than it is to reimburse the independent service provider through a separate billing. The nursing home may receive an ancillary add-on adjustment to its daily rate in accordance with section 49.45 (6m)(b), Wis. Stats. The independent service provider shall not be entitled to claim direct reimbursement.

5. An individual nursing home shall claim reimbursement of the costs of services and materials defined in subparagraphs 7.09 (3)(a) 1-4, which are provided to recipients, in the following manner:

a. Claims should be submitted under the nursing home's provider number, and should appear on the same claim form used for claiming reimbursement at the daily nursing home rate.

b. The items identified above shall have been prescribed in writing by the attending physician or, the physician's entry in the medical records or nursing charts must make the need for the items obvious.

c. The amounts billed to the medical assistance program must be reasonable and customary from the standpoint of efficient nursing home operation and may include a 10% add-on for handling charges.

d. It is expected that the amounts billed will reflect the fact that the nursing home has taken advantage of the benefits associated with quantity purchasing and other outside funding sources.

e. The reimbursement of questionable materials and services will be decided by the department.

f. Claims for transportation must show the name and address of any treatment center to which the patient recipient was transported, and the total number of miles to and from the treatment center.

g. The amount charged for transportation cannot include the cost of the facility's staff time, and must be for an actual mileage amount.

h. The nursing home must receive authorization from the department before ancillary billings for laboratory or radiology services may be submitted.

i. Claim forms for these billings must detail the number and type of services performed, including a description of the laboratory or radiology procedure provided.

(b) Independent providers of service. Whenever an ancillary cost is incurred under these rules by an independent provider of service, reimbursement may be claimed only by the independent provider on its provider number. The procedures followed shall be in accordance with program requirements for that provider specialty type.

(c) Services covered in a christian science sanitorium shall be those services ordinarily received by inpatients of a christian science sanitorium, but, only to the extent that such services are the christian science equivalent of services which constitute inpatient services furnished by a hospital or skilled nursing facility.

(d) Wheelchairs shall be provided by skilled nursing and intermediate care facilities in sufficient quantity to meet the health needs of patient recipients. Nursing homes which specialize in providing rehabilitative services and treatment for the developmentally or physically disabled (or both) shall provide the special equipment necessary for the provision of such services. The facility shall also provide replacement wheelchairs for recipients who have changing wheelchair needs.

(e) Determination of services as skilled. In determining whether a service is skilled, the following criteria shall apply:

1. Where the inherent complexity of a service prescribed for a patient is such that it can be safely and effectively performed only by or under the supervision of technical or professional personnel, the service would constitute a skilled service.

2. The restoration potential of a patient is not the deciding factor in determining whether a service is to be considered skilled or nonskilled. Even where full recovery or medical improvement is not possible, skilled care may be needed to prevent, to the extent possible, deterioration of the condition or to sustain current capacities. For example, even though no potential for rehabilitation exists, a terminal cancer patient may require skilled services as defined in the following paragraphs of this section.

3. A service that is generally nonskilled would be considered to be a skilled service where, because of special medical complication, its performance or supervision or the observation of the patient necessitates the use of skilled nursing or skilled rehabilitation personnel. For example, the existence of a plaster cast on an extremity generally does not indicate a need for skilled care, but a patient with a preexisting acute skin problem or with a need for special traction of the injured extremity might need to have technical or professional personnel properly adjust traction or observe the patient for complications. In such cases, the complications and special services involved must be documented by physician's orders and nursing or therapy notes.

(f) Skilled nursing services or skilled rehabilitation services must be required and provided on a "daily basis"--i.e., on essentially a 7-day-a-week basis. However, if skilled rehabilitation services are not available on a 7-day-a-week basis, a patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement where the patient needs and receives such services on at least five days a week. Accordingly, where a facility provides physical therapy on only five days a week and the patient in such a facility requires and receives physical therapy on each of the days on which it is available, the requirement that skilled rehabilitation services be provided on a daily basis would be met.

(g) Determining the appropriateness of services at the skilled level of care.

1. In determining whether the care needed by a recipient can, as a practical matter, only be provided in a skilled nursing facility on an inpatient basis, consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services.

2. If the needed service is not available in the area in which the individual resides, and transporting the person to the closest facility furnishing the services would be an excessive physical hardship, it would be appropriate to conclude that the needed care can, as a practical matter, only be provided in a skilled nursing facility. This would also be true even though the patient's condition might not be adversely affected, if it would be more economical or more efficient to provide the covered services in the institutional setting.

3. In determining the availability of alternative facilities and services, availability of funds to pay for the services furnished by such alternative facilities is not a factor to be considered. For instance, an individual in need of daily physical therapy might be able to receive the needed services from an independent physical therapy practitioner.

(h) Residents' Accounts.

1. Each recipient who is a resident in a public or privately-owned nursing home shall have an account established for the maintenance of earned or unearned money payments received (Social Security payments, SSI payments, etc.). The payee for the account shall be the recipient, a legal representative or other representative designated by the recipient such as the nursing home administrator.

2. If it is determined by the agency making the money payment that the recipient is not competent to handle the payments, and if no other legal representative can be appointed, the administrator may be designated as the representative payee. The need for the representative payee shall be reviewed when the annual periodic review of the recipient's eligibility status is made.

(i) Private rooms are not a covered service within the daily rate reimbursed to a nursing home, except where certified by the department pursuant to Wis. Adm. Code section H 32.06(3). However, if a recipient or legal representative or both chooses a private room with full knowledge and acceptance of the financial liability, the recipient may reimburse the nursing home for a private room if the following conditions are met:

1. At the time of admission the recipient or legal representative or both are informed of the personal financial liability encumbered if the recipient chooses a private room; and

2. Pursuant to Wis. Adm. Code section H 32.055(1)(d), the recipient or legal representative or both document the private room choice in writing; and

3. The recipient or legal representative or both are personally liable for no more than the differential between the nursing home's private-pay rate for a semi-private room and the private room rate; and

4. Pursuant to Wis. Adm. Code section H 32.055(1)(d), at any time the differential rate determined by subparagraph 7.09(3)(i)3 changes, the recipient or legal representative or both must be notified and a new consent agreement reached.

(j) Bed-Hold. Bed-hold payments shall be made to a nursing home for an eligible recipient during the recipient's temporary absence if such absence is due to hospitalization for an acute condition, or for a therapeutic visit, or for attendance at a therapeutic/rehabilitative program, and only for those days during which there is a likelihood that the held bed would otherwise be required for occupancy by some other resident. There is a likelihood that the held bed would be required for occupancy by some other resident when the nursing home meets or exceeds the department-approved occupancy rate in that part of the facility certified for the same level of care that the recipient requires in the month in which such recipient is absent from the facility, or for the facility as a whole if all of the beds in the facility are dually certified.

1. Bed-Hold days for hospitalization.

a. Reimbursement is available for a period not to exceed 15 days per hospital stay. There is no limit on the number of stays per year.

b. The first day that is deemed as being absent shall be the day the recipient leaves the home, regardless of the time of day. The day of return to the home shall not count as a bed-hold day, regardless of the time of day.

c. All hospital leaves of absence not in excess of 15 days are deemed to be covered services until determined to the contrary; therefore, bed-hold charges to the recipient, family or friends are prohibited.

d. Recipients shall not be administratively discharged from the nursing home unless they remain in the hospital longer than 15 days.

e. Claims for bed-hold days during leaves for hospitalization shall not be submitted when it is known in advance that a recipient will not return to the facility following the period of hospitalization. In the case where the recipient dies while hospitalized, or where the facility is notified that the recipient is terminally ill, or that due to changes in the recipient's condition the recipient will not be returning to the facility, payment may be claimed only for those days prior to the recipient's death or prior to the notification of the recipient's terminal condition or need for discharge to another facility.

f. A staff member designated by the administrator (e.g., director of nursing service or social service director) shall document the recipient's absence in the recipient's chart and shall sign off each leave.

2. Bed-Hold days for therapeutic visits.

a. Reimbursement is available for therapeutic visit bed-hold days if the recipient requests leave days for visits, and if the recipient's physician records approval of the leave in the physician's

plan of care. This statement shall include the rationale for, and the anticipated goals of, such leave as well as any limitations regarding the frequency or duration of such leave. A new statement shall be written into the physician's plan of care any time there is a change in the recipient's condition.

b. The first day that is deemed as being absent shall be the day the recipient leaves the home, regardless of the time of day. The day of return to the home shall not count as a bed-hold day, regardless of the time of day.

c. All therapeutic leaves of absence for visits are deemed to be covered services until determined to the contrary; therefore, bed-hold charges to the recipient, family or friends are prohibited.

d. Claims for bed-hold days for therapeutic visit leave shall not be submitted when it is known in advance that a recipient does not plan to return to the facility following the therapeutic visit.

e. A staff member designated by the administrator, (e.g., social service or nursing service director) shall document the recipient's absence in the recipient's chart, and shall sign off each leave.

3. Bed-Hold days for Therapeutic/Rehabilitative Programs. Reimbursement is available for therapeutic/rehabilitative program bed-hold days if the following criteria are met:

a. The program meets the definition of therapeutic/rehabilitative program in this section, and shall in the opinion of the recipient's physician, contribute to the recipient's mental, physical or social development in accordance with the recipient's plan of care.

b. Upon request from the department, the nursing home shall submit, in writing, the following information regarding the program:

i. Dates of the program's operation.

ii. Number of participants.

iii. Identification of the sponsorship of the program.

iv. The anticipated goals of the program and how these goals will be accomplished (treatment modalities), and

v. The leadership or faculty of the program and the credentials of the individuals.

c. Each time the recipient attends a therapeutic/rehabilitative program, the recipient's physician shall enter a written statement into the plan of care indicating approval for the recipient to participate in the program, the goals of the program which apply to the recipient, and the duration or frequency of the recipient's participation.

d. The first day that is deemed as being absent shall be the day the recipient leaves the home, regardless of the time of day. The day of return to the home shall not count as a bed-hold day, regardless of the time of day.

e. Leaves of absence to attend programs which meet the above definition are deemed to be covered services until determined to the contrary, therefore, bed-hold charges to the recipient, family or friends are prohibited.

f. A staff member designated by the administrator (e.g. director of nursing service or social service director) shall document the recipient's absence in the recipient's chart.

(k) Physician certification and recertification of need for inpatient care--SNF and ICF.

1. A physician must certify and recertify for each applicant or recipient that nursing home services are or were needed.

2. The certification must be made at the time of admission, or if an individual applies for assistance while in a nursing home, before the medicaid agency authorizes payment.

3. Recertification must be made at least every 60 days after certification.

(l) Medical, psychiatric, and social evaluations - SNF

1. Before admission to an SNF or before authorization for payment, the attending physician must make:

a. A medical evaluation of each applicant's or recipient's need for care in the SNF; and

b. A plan of rehabilitation, where applicable.

2. In a SNF that cares primarily for mental patients, appropriate professional personnel must make a psychiatric and a social evaluation of need for care.

3. Each medical evaluation must include: diagnoses; summary of present medical findings; medical history; mental and physical functional capacity; prognoses; and a recommendation by a physician concerning admission to the SNF or continued care in the SNF, for individuals who apply for medicaid while in the facility.

(m) Medical, psychological, and social evaluations--ICF.

1. Before admission to an ICF or before authorization for payment, an interdisciplinary team of health professionals must make a comprehensive medical and social evaluation and where appropriate, a psychological evaluation of each applicant's or recipient's need for care in the ICF.

2. In an institution for the mentally retarded or persons with related conditions, the team must also make a psychological evaluation of need for care. The psychological evaluation must be made before admission or authorization of payment, but not more than three months before admission.

3. Each evaluation must include: diagnoses; summary of present medical, social, and where appropriate, developmental findings; medical and social family history; mental and physical functional capacity; prognoses; kinds of services needed; evaluation by an agency worker of the resources available in the home, family and community; and a recommendation concerning: admission to the ICF; or continued care in the ICF for individuals who apply for medicaid while in the ICF.

4. If the comprehensive evaluation recommends ICF services for an applicant or recipient whose needs could be met by alternative services that are currently unavailable, the facility must enter this fact in the recipient's record and begin to look for alternative services.

(n) Medicaid agency review of need for admission - SNF and ICF. Medical and other professional personnel of the medicaid agency or its designees must evalute each applicant's or recipient's need for admission by reviewing and assessing the evaluations required.

(o) Individual written plan of care - SNF.

1. Before admission to a SNF or before authorization for payment, the attending physician must establish a written plan of care for each applicant or recipient in a SNF.

2. The plan of care must include diagnoses, symptoms, complaints and complications indicating the need for admission; a description of the functional level of the individual; objectives; any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient; plans for continuing care, including review and modification to the plan of care; and plans for discharge.

3. The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 60 days.

(p) Individual written plan of care - ICF.

1. Before admission to an ICF or before authorization for payment, a physician must establish a written plan of care for each applicant or recipient.

2. The plan of care must include: diagnoses, symptoms, complaints, and complications indicating the need for admission; a description of the functional level of the individual; objectives; any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures designed to meet the objectives of the plan of care; plans for continuing care, including review and modification of the plan of care; and plans for discharge.

3. The team must review each plan of care at least every 90 days.

(q) Reports of evaluations and plans of care - ICF and SNF. A written report of each evaluation and plan of care must be entered in the applicant's or recipient's record:

1. At the time of admission; or

2. If the individual is already in the facility, immediately upon completion of the evaluation or plan.

(4) Non-covered services. The following services are not covered (in addition to those listed in section 7.03 of this rule):

(a) Services of private duty nurses when provided in a nursing home.

(b) For Christian Science sanitoria, custodial care and rest and study.

7.10 Drugs

(1) Covered services. Drugs and drug products covered by the medical assistance program include legend and certain non-legend drugs and supplies prescribed by a physician licensed pursuant to section 448.04, Wis. Stats., by a dentist licensed pursuant to section 447.05, Wis. Stats., or by a podiatrist licensed pursuant to section 448.04, Wis. Stats. The department may determine whether or not drugs judged by the Food and Drug Administration to be "possibly effective" shall be reimbursable under the program.

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] The following drugs/supplies require prior authorization:

(a) All CS II stimulant drugs.

(b) Stimulant drugs in CS III and CS IV with the exception of Ritalin, Sanorex, Deaner and including salts and/or derivatives of Phentermine, Chlorphentermine, Fenfluramine, Phendimetrazine, Diethylpropion, Pipradrol Benzphetamine (alone or combination).

(c) Methaqualone.

(d) All high nitrogen food supplement/replacement products; Lytren, Ensure, Polycose, etc.

(e) Debrisan.

(f) Derifil.

(3) Other Limitations.

(a) Dispensing of schedule III, IV and V drugs shall be limited to the original dispensing plus five refills, or six months, whichever comes first.

(b) Dispensing of non-scheduled legend drugs shall be limited to the original dispensing plus eleven refills, or 12 months, whichever comes first.

(c) Generically-written prescriptions are required to be filled with a generic drug included in the Wisconsin drug formulary.

(d) Legend drugs, except drugs dispensed by unit-dose methods, shall be dispensed in amounts not to exceed a 34-day supply.

(e) Provision of drugs and supplies to nursing home recipients shall comply with the department's policy on ancillary costs as specified in section 7.09(3).

(f) To be included as a covered service, an over-the-counter drug shall be:

1. Used in the treatment of a diagnosable condition;
2. A rational part of an accepted medical treatment plan;
3. Listed in the Physicians' Desk Reference.

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

(a) Claims for underpads or chux for nursing home recipients when billed by a pharmacy provider.

(b) Refills of schedule II drugs.

(c) Refills beyond the limitations of subsection 7.]0(3).

(d) Personal care items (e.g. non-therapeutic bath oils).

(e) Cosmetics (e.g. non-therapeutic skin lotions, sun screens).

(f) Common medicine chest items (e.g. antiseptics, band aids).

(g) Personal hygiene items (e.g. tooth paste, cotton balls).

(h) "Patent" medicines.

(i) Uneconomically small package sizes.

(j) Items which are in the inventory of a home regardless of the health of the persons residing in the home.

7.11 Nursing and Home Health Care Services

(1) Covered Services.

(a) Services provided by a certified home health agency. Services provided by a certified home health agency which are covered by the medical assistance program are part-time or intermittent nursing and home health aide services, medical supplies, equipment and appliances suitable for use in the home, and therapeutic services which the agency is certified to provide, when provided upon prescription of a licensed physician to a recipient confined to a place of residence. Such residence does not include a hospital, skilled nursing facility or intermediate care facility, except that these services and items may be furnished as home health services to a recipient in an intermediate care facility if they are not required to be furnished by the facility as intermediate care services.

(b) Services provided by a nurse.

1. Services provided by a registered nurse in independent practice which are covered by the MA program are part-time or intermittent nursing services, as defined in section 441.11 Wis. Stats., when there is no certified home health agency in the area to provide such services and when such services are prescribed; and

2. Private duty nursing when prescribed by a physician. Licensed practical nurses may provide private duty nursing services if the physician's prescription calls for a level of care which the licensed practical nurse is licensed to provide.

3. Services provided by a Christian Science nurse which are covered by the MA program are part-time or intermittent Christian Science nursing services when prescribed by a Christian Science practitioner and provided by or under the supervision of a Christian Science visiting nurse organization, and private duty nursing services prescribed for the recipient and provided in a Christian Science sanitorium or in the patient's home.

(2) Services Requiring Prior Authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] Long-term private duty nursing services provided in a recipient's place of residence require prior authorization of the department. This includes Christian Science private duty nursing.

(3) Other Limitations.

(a) All services provided by a certified home health agency or by a nurse shall be provided upon a physician's orders as part of a written plan of care which is reviewed by the physician at least every 60 days. The plan of care shall include diagnosis, specific medical orders, specific types of services required, rehabilitation potential of the recipient and any other appropriate items. Christian Science nursing services do not require a physician's prescription or orders.

(b) Registered nurses providing part-time or intermittent nursing service shall receive written orders from the recipient's physician to provide the level of care needed. The registered nurse shall contact the district public health nursing consultant in the area to receive orientation

to acceptable clinical and administrative record-keeping before any service is provided. The registered nurse shall document the care and services provided and shall make such documentation available to the department upon request.

(c) Private duty nursing services may only be provided when the recipient requires individual and continuous care beyond that available on a part-time or intermittent basis, and when the recipient's physician has prescribed private duty nursing.

(4) Non-covered services. Private duty nursing services provided in a nursing home are not covered by the medical assistance program.

7.12 Personal Care Services

(1) Covered Services. Covered personal care services are the services listed in this section when provided in a recipient's home, and when prescribed by a physician, supervised by a registered nurse, provided in accordance with a written plan of treatment and performed by a person trained to perform personal care. Reimbursement for personal care services shall only be made to certified providers of the service: home health agencies certified as meeting the requirements of HSS 105.16 and social service agencies certified as meeting the requirements of HSS 105.17.

(a) Activities of daily living (e.g., helping the recipient to bathe, to get in and out of bed, to care for hair and teeth, to exercise and to take medications specifically ordered by a physician which are ordinarily self-administered, and to retrain the recipient in necessary self-help skills);

(b) Household services related to keeping a safe environment in the areas of the home used by the recipient (e.g., changing the bed, light cleaning, rearrangements to assure that the recipient can safely reach necessary supplies or medication, laundering essential to the comfort and cleanliness of the recipient); and

(c) Seeing to the nutritional needs of the recipient (e.g., purchase of food, assistance in meal preparation, washing utensils).

(2) Services Requiring Prior Authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] Personal care services provided in excess of 60 hours require prior authorization. In cases in which the department, in reviewing a request for prior authorization, determines that personal care services are necessary for an extended period of time, the department may authorize up to 12 months of personal care services.

(3) Other Limitations.

(a) Before personal care services are initiated, the registered nurse shall perform an on-site assessment of the recipient's condition and of the need for personal care services. If another level of care is needed, the registered nurse shall refer the recipient to an appropriate other source of care (e.g., nursing home, home health agency).

(b) The plan of treatment shall specify what services are to be provided, and the frequency and duration of services. The plan shall be prepared by the registered nurse and based on the physician's evaluation of the recipient's need for care. It shall be signed by the physician and the nurse.

(c) The registered nurse shall reevaluate the recipient's condition not less frequently than every 60 days. The reevaluation shall include at least one visit to the recipient's home, a review of the personal care worker's daily written record, a review of the plan of care and contact with the physician as necessary. If a change in level of care is necessary, appropriate referrals shall be made.

(d) Persons providing and supervising personal care services shall be adequately trained and oriented to the provision of care in the home. In the case of the personal care worker, this means a minimum of 40 hours of training. In the case of the registered nurse supervisor, this means an orientation session with the public health nurse, except if the registered nurse is a public health nurse or has had experience providing nursing services in a patient's home.

7.13 Mental Health Services

(1) Covered Services

(a) Inpatient psychiatric services. Inpatient psychiatric care is a covered service when prescribed by a physician, and when provided within a psychiatric unit of a general hospital which meets the requirements of section 5.09, or when provided by a psychiatric facility within the limitations enumerated in HSS 107.13(1).

(b) Requirements for coverage of inpatient psychiatric facility services for recipients under 21 years of age.

1. Inpatient psychiatric services for recipients under age 21 must be provided under the direction of a physician; and by a psychiatric facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Hospitals; and before the recipient reaches age 21 or, if the recipient was receiving the services immediately before reaching age 21, before the earlier of the following:

a. The date the recipient no longer requires the services; or

b. The date the recipient reaches age 22.

2. Certification of need for services. A team specified in HSS 107.13(1)(b)3 must certify that:

a. Ambulatory care resources available in the community do not meet the treatment needs of the recipient; and

b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

d. The certification specified in this section and in HSS 107.13(1)(b)3 satisfies the utilization control requirement for physician certification in HSS 107.13(1)(b)7.

3. Team certifying need for services. Certification under HSS 107.13(1)(b)2 must be made by teams specified as follows:

a. For an individual who is recipient when admitted to a facility or program, certification must be made by an independent team that includes a physician; has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and has knowledge of the individual's situation.

b. For an individual who applies for medicaid while in the facility or program, the certification must be made by the team responsible for the plan of care and specified in HSS 107.13(1)(b)6; and cover any period before application for which claims are made.

c. For emergency admissions, the certification must be made by the team responsible for the plan of care within 14 days after admission.

4. Active treatment. Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care, described in HSS 107.13(1)(b)5 that is:

a. Developed and implemented no later than 14 days after admission; and

b. Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

5. Individual plan of care.

a. "Individual plan of care" means a written plan developed for each recipient in accordance with HSS 107.13(1)(b)9 and 10, to improve his condition to the extent that inpatient care is no longer necessary. The plan of care must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;

2. Be developed by a team of professionals specified under HSS 107.13 (1)(b)6 in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge;

3. Specify treatment objectives;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and

5. Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

b. The plan must be reviewed every 30 days by the team specified in HSS 107.13(1)(b)6 to:

1. Determine that services being provided are or were required on an inpatient basis, and

2. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

c. The development and review of the plan of care as specified in this section satisfies the utilization control requirements for:

1. Physician recertification; and

2. Establishment and periodic review of the plan of care.

6. Team developing individual plan of care.

a. The individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

b. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:

1. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

2. Assessing the potential resources of the recipient's family;

3. Setting treatment objectives; and

4. Prescribing therapeutic modalities to achieve the plan's objectives.

c. The team must include, as a minimum, either:

1. A Board-eligible or Board-certified psychiatrist;

2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

d. The team must also include one of the following:

1. A psychiatric social worker.

2. A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

3. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals.

4. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

7. Physician certification and recertification of need for inpatient care.

a. A physician must certify and recertify for each applicant or recipient that inpatient services in a mental hospital are or were needed.

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

c. Recertifications must be made at least every 60 days after certification.

8. Medical, psychiatric, and social evaluations.

a. Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each applicant's or recipient's need for care in the hospital; and appropriate professional personnel must make a psychiatric and social evaluation.

b. Each medical evaluation must include diagnoses; summary of present medical findings; medical history; mental and physical functional capacity; prognoses; and a recommendation by a physician concerning admission to the mental hospital; or continued care in the mental hospital for individuals who apply for medicaid while in the mental hospital.

9. Individual written plan of care.

a. Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the individual;
3. Objectives;
4. Any orders for medications; treatments; restorative and rehabilitative services; activities; therapies; social services; diet; and special procedures recommended for the health and safety of the patient;
5. Plans for continuing care, including review and modification to the plan of care; and
6. Plans for discharge.
7. The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.

b. Before admission to a SNF or before authorization for payment, the attending physician must establish a written plan of care for each applicant or recipient in a SNF. The plan of care must include:
1. Diagnoses, symptoms, complaints and complications indicating the need for admission;
2. A description of the functional level of the individual;
3. Objectives;
4. Any orders for medications; treatments; restorative and rehabilitative services; activities; therapies; social services; diet; and special procedures recommended for the health and safety of the patient;
5. Plans for continuing care, including review and modification to the plan of care; and
6. Plans for discharge.
7. The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 60 days.

10. Reports of evaluations and plans of care. A written report of each evaluation and plan of care must be entered in the applicant's or recipient's record:
a. At the time of admission; or
b. If the individual is already in the facility, immediately upon completion of the evaluation or plan.

11. Recipients under age 22 residing in JCAH-accredited inpatient psychiatric facilities, and recipients over age 65 residing in an institution for mental diseases are eligible for medicaid benefits for services not provided through that institution and not reimbursed as part of the cost of care of that individual in the institution.

12. Patient's accounts. Each recipient who is a patient in a state, county, or private mental hospital shall have an account established for the maintenance of earned or unearned money payments received (Social Security payments, SSI payments, etc.). The account for patients in state mental health institutes shall be kept in accord with section 46.07, Wis. Stats. The payee for the account may be the recipient, if competent, or a legal representative.
a. Legal representatives who are employees of county departments of social services or the department of health and social services shall not receive payments.
b. If the payee of the resident's account is a relative, friend or other legal representative, the payee shall submit an annual report on the account to the Social Security Administration.

(c) Outpatient psychotherapy services. Outpatient psychotherapy services are covered services when prescribed by a physician and when provided by a provider who meets the requirements of section 5.22, and when the following conditions are met:

1. The psychotherapy furnished is in accordance with the definition of psychotherapy in chapter one of this rule.

2. A differential diagnostic examination is performed by a certified psychotherapy provider. A physician's prescription is not necessary to perform the examination.

3. Before the actual provision of psychotherapy services, a physician shall prescribe therapy in writing.

4. Psychotherapy is furnished by a:

a. Provider who is a licensed physician or a licensed psychologist defined under subsection 5.22(1)(a) or (b), and who is:

i. Working in an outpatient facility defined under subsection 5.22(1)(c)(d) or (e) which is certified to participate in the medical assistance program, or

ii. Working in private practice; or

b. Provider defined under subsection 5.22(2)(a)(1),(2) or (3) who is:

i. Working in an outpatient facility defined in 5.22 (1)(c)(d) or (e) which is certified to participate in the medical assistance program.

5. Psychotherapy is performed only in the following locations:

a. Office of the provider.
b. Hospital.
c. Outpatient facility.
d. Nursing home.
e. School.
f. Client's home or foster home.

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

7. Outpatient psychotherapy services for up to 15 hours in a 12-month period may be reimbursed without prior authorization. The 12-month period begins on the first date of the actual provision of psychotherapy services. If reimbursement is also made to any provider for alcoholism or other drug abuse treatment services outlined in section 7.13(1)(d) during the same 12-month period for the same recipient, the hours reimbursed for such services will be considered a concurrent part of the amount available for psychotherapy. If reimbursement is also made to any non-institutional provider for psychotherapy services during the same 12-month period for the same recipient while that recipient is an inpatient in an acute care general hospital with a diagnosis of, or for a procedure associated with, a psychiatric condition, reimbursement for such services will not be considered a concurrent part of the amount available for psychotherapy.

8. Reimbursement for psychotherapy services provided to a recipient who is an inpatient in an acute care general hospital or psychiatric facility with a diagnosis of, or for a procedure associated with, a psychiatric condition such service shall be covered as an additional item. The differential diagnostic examination for psychotherapy and the medical evaluation for alcoholism or other drug abuse treatment services shall also be covered as additional items.

(d) Alcohol and other drug abuse services. Outpatient alcohol and drug abuse treatment services are covered when prescribed by a physician and when provided by a provider who meets the requirements of 5.22 or 5.23, and when the following conditions are met:

1. The treatment services furnished are in accordance with the definition in chapter one of this rule.

2. Before the enrollment in an alcohol or drug abuse treatment program, the recipient shall receive a complete medical evaluation. The evaluation shall include diagnosis, summary of present medical findings, medical history, and explicit recommendations by the physician for participation in the alcohol or other drug abuse treatment program. A medical evaluation performed for such purpose within 60 days prior to enrollment shall be valid for reenrollment.

3. The supervising physician or psychologist shall be responsible for development of a treatment plan, which shall relate to behavior and personality changes being sought, and to the expected outcome of treatment.

4. Outpatient alcohol or other drug abuse treatment services for up to 15 hours in a 12-month period may be reimbursed without prior authorization. If reimbursement is also made to any provider for outpatient psychotherapy services outlined in section 7.13(1)(c) during the same 12 month period for the same recipient, the hours reimbursed for such services will be considered a concurrent part of the amount available for outpatient alcohol or other drug abuse treatment services. The medical evaluation defined in subsection 7.13(d)(2) and the differential diagnostic examination for psychotherapy shall be covered as additional items.

(e) Day treatment or day hospital service. Day treatment or day hospital services are covered services when prescribed by a physician and when provided by a provider who meets the requirements of section 5.245, and when the following conditions are met:

1. The day treatment services furnished are in accordance with the definition of day treatment in chapter one of this rule.

2. Before the involvement in a day treatment program, the recipient shall receive a medical evaluation which shall include diagnosis, summary of present medical findings, medical history, and explicit recommendations for involvement in a medically-oriented day treatment or day hospital program.

3. The supervising psychiatrist shall approve a written treatment plan for each recipient and shall review such plan no less frequently than once every 90 days. The treatment plan shall be based on the initial medical evaluation and shall include individual goals and the treatment modalities to be used to achieve these goals, and the expected outcome of treatment.

4. Reimbursement may be made without prior authorization from the department for up to 120 dates of service in a twelve-month period which begins on the first date day services are provided. Day services provided concurrently with psychotherapy services or occupational therapy services will be calculated as hours included in the limitation for psychotherapy, or occupational therapy service, and may be subject to departmental review for reasonableness.

5. Day treatment or day hospital services provided to recipients with inpatient status in a hospital shall be limited to 40 hours per inpatient admission.

(2) Services Requiring Prior Authorization.

(a) Outpatient psychotherapy services and outpatient alcohol or other drug abuse treatment services.

1. Reimbursement beyond 15 hours of service may be claimed for services furnished after receipt of authorization by the department. Services reimbursed by any third party payer shall be included when calculating the 15 hours of service.

2. The department may authorize reimbursement for a specified number of hours of outpatient services to be provided to a recipient within the 12 month period.

3. The Department shall set limits on the number of hours for which prior authorization is approved. The Department shall require periodic progress reports and subsequent prior authorization requests in instances where additional services are requested.

4. Persons who review prior authorization requests for the department shall have the same minimum training required of providers.

5. The prior authorization request shall include the following information:

a. The name, address and medical assistance provider or identifier numbers of the providers conducting the diagnostic examination or medical evaluation and performing psychotherapy or performing AODA services.

b. The physician's original prescription for treatment.

c. When authorization is being requested for psychotherapy services a detailed summary of the differential diagnostic examination, setting forth the severity of the mental illness or medically significant emotional or social dysfunction and the medical necessity for psychotherapy, and the expected outcome of treatment.

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

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

6. The provider requesting prior authorization shall be notified in writing of the department's decision. In cases of a denial of the request, the recipient will also be notified in writing of the department's decision.

(b) Day treatment or day hospital services.

1. Reimbursement beyond 120 dates of service may be claimed for day treatment or day hospital services furnished, after receipt of authorization by the department.

2. All day treatment or day hospital services provided to recipients with inpatient status in a nursing home shall require prior authorization by the department. No more than 10 dates of service will be authorized in a 12 month period of time.

3. The department may authorize reimbursement for a specified number of additional days of day treatment or day hospital services to be provided to a recipient within the 12 month period which begins with the first date of day treatment or day hospital.

a. The prior authorization request shall be requested by the provider and shall include:

i. The name, address, and medical assistance number of the recipient.

ii. The name, address, and provider number of the provider of the service and of the billing provider.

iii. The physician's original prescription for treatment.

iv. A copy of the treatment plan and the expected outcome of treatment.

v. A statement of the estimated additional dates of service necessary and total cost.

b. The provider requesting prior authorization and the recipient shall be notified in writing of the department's decision.

(3) Other Limitations.

(a) Inpatient psychiatric services. Diagnostic interviews with immediate family members of the recipient are covered services. Immediate family members means parents, spouse or children, or for a child in a foster home, foster parents. A maximum of five hours of such interviews shall be covered.

(b) Outpatient psychotherapy services.

1. Collateral interviews are limited to members of the recipient's immediate family; parents, spouse or children, or for children in foster care, foster parents.

2. Group sessions. A psychotherapy group session means a session at which there are more than one but not more than ten recipients receiving psychotherapy services together from one or two providers.

3. Emergency psychotherapy. Emergency psychotherapy may be performed by a provider for a recipient without a prescription for treatment or prior authorization when the provider has reason to believe that the recipient may immediately injure himself or herself or any other person. A prescription for the emergency treatment must be obtained within 48 hours of the time the emergency treatment was provided excluding weekends and holidays. Reimbursement for emergency psychotherapy may be made in accordance with section 5.22(3). Subsequent treatment may be provided if section 7.13(1)(c) is followed.

4. Not more than one provider shall be reimbursed for the same treatment session, unless the session involves a couple, a family group or is a group session as described in subsection 7.13(3)(b)(2). Under no circumstances shall more than two providers be reimbursed for the same session.

(c) Day treatment or day hospital services.

1. Frequency of treatment. Reimbursement shall not be made for day treatment services provided in excess of 30 hours of treatment in any week.

(4) Non-Covered Services.

(a) Inpatient psychiatric services.

1. Activities which are primarily diversional in nature such as services which act as a social or recreational outlet for the recipient are not covered services.

2. Mild tranquilizers or sedatives provided solely for the purpose of relieving anxiety or insomnia are not covered services for inpatients in a psychiatric facility.

3. Consultation with other providers about the recipient's care is not a covered service.

4. Inpatient psychiatric hospital services are not covered for recipients who are between the ages of 22 and 65.

(b) Outpatient psychotherapy services.

1. Collateral interviews with persons not stipulated in 7.12(3)(b)(1) and consultations are not covered services.

2. Court appearances or evaluations, except as noted in subsection 7.03(10) are not covered services.

3. Psychotherapy is not an appropriate treatment for the diagnosis of mental retardation are not covered services.

(c) Day treatment or day hospital services.

1. Day treatment services which are primarily recreation-oriented and which are provided in a non-medically supervised setting such as 24-hour day camps, or other social service programs are not covered services.

2. Consultation with other providers or service agency staff regarding the care or progress of a recipient are not covered services.

3. Preventive or education programs provided as an outreach service; and/or casefinding are not covered services.

4. Aftercare programs, provided independently or operated by or under contract to community mental health agencies under 51.42 or 51.437 are not covered services.

5. Court appearances or evaluations, except as noted in subsection 7.03(10), are not covered services.

7.14 Podiatry Services.

(1) Covered Services. Podiatry services covered by medical assistance include those medically necessary services for the diagnosis and treatment of the feet, within the limitations described below, when provided by a certified podiatrist.

(2) Other Limitations.

(a) Podiatric services pertaining to the cleaning, trimming, and cutting of toenails (often referred to as palliative or maintenance care, or debridement) will be reimbursed on a once per 31 day period if the recipient is under the active care of a physician, and when the recipient's condition is one of the following:

1. Diabetes mellitus;
2. Chronic thrombophlebitis;
3. Peripheral neuropathies involving the feet, which are associated with:
   a. Carcinoma;
   b. Diabetes mellitus;
   c. Drugs and toxins;
   d. Multiple sclerosis;
   e. Uremia;
   f. Malnutrition or vitamin deficiency;
   g. Rheumatoid, Psoriatic, Osteo, and Gouti Arthritis;
   h. Cardiovascular disease (when inhibiting physical movement), as follows:
      i. Congestive heart failure;
      ii. Arteriosclerosis;

i. Respiratory disease (when inhibiting physical movement), as follows:

i. Emphysema;
ii. Asthma.

4. Other systemic conditions may be appropriate as covered services under this section and claims may be submitted for reimbursement. If the services are questionable, the claims will be submitted to peer review for assessment and potential reimbursement.

(b) Foot care is a covered service when performed by a podiatrist, if the recipient's condition is such that the performance of foot care by a non-professional person (i.e., nurse's aide) may pose a hazard to the recipient's health; or if the foot care is performed by a podiatrist as a necessary and integral part of other covered services such as, but not limited to, diagnosis and treatment of diabetic ulcers, wounds, and infections. Claims for foot care not supported by one of the conditions listed in subsection 7.14(2)(a), shall be accompanied by a copy of the podiatrist or physician's prescription or orders and a description of the underlying conditions and diagnosis.

(c) Cleaning and trimming of toenails once per 90 day period, regardless of the involvement of systemic conditions, is a covered service for patients who present no acute foot problems. Medical conditions which warrant such service include but are not limited to:

1. Obesity;
2. Physical movement and articulating disabilities caused by old age.

(d) Physical therapy performed by a podiatrist is a covered service only when performed as part of one of the following medical procedures:

1. Pre-operative procedure for the purpose of softening tissue.
2. Post-operative improvement of ankle and foot joint articulation.
3. Relieving edema.
4. Improving movement in ankle and foot joints which have been fractured or are afflicted with tendonitis, myositis, fibrocytis.

(e) Office visits for the purpose of diagnosing and evaluating need for medical service are covered services for the following medical conditions:

1. Foot pain inhibiting ambulation due to physical structure or size of the foot causing difficulty in acquiring the proper shoes.
2. Foot pain caused by flat feet, high arches, tendonitis, or skin disorders.

(f) The following types of claims for reimbursement may be suspended and submitted for peer review:

1. Claims submitted more frequently than allowed by the above limitations.
2. Claims for palliative or maintenance care or debridement, when the diagnosis is a condition not listed in subsection 7.14(2)(a).
3. Claims for cleaning and trimming of toenails when the diagnosis is a condition not listed in subsection 7.14(2)(c).
4. Claims for physical therapy modalities or procedures that appear to be inappropriate to achieve the purposes listed in subsection 7.14(2)(d).
5. Claims for office visits for the purpose of diagnosing and evaluating the need for medical service for a condition not listed in subsection 7.14(2)(e).

(g) On a podiatrist's claim for a nursing home visit (for the cutting, cleaning, trimming of toenails, corns, callouses, and bunions), the program will reimburse at the nursing home visit procedure code rate for only one of the patients seen on that day of service. All other claims for patients seen at the nursing home on the same day of service will be reimbursed up to the multiple nursing home visit rate. The podiatrist shall identify on the claim form the single patient for whom the nursing home single patient rate may be allowed, and the patient(s) for whom the multiple nursing home visit rate is applicable.

(h) For surgical treatment service for multiple deformities (hammertoe, metatarsol deformities, bunions, etc.) the podiatrist will be reimbursed at 100 percent for the primary (first) procedure and 50 percent for the following same procedures.

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

(3) Non-covered Services. The following are non-covered services (in addition to section 7.03):

(a) Claims will be denied which submit a diagnosis merely explained in Latin terminology (i.e.: Hallux Elevatus, Pes Planus, etc.) or with terminology such as "flat feet", painful arches", "intoeing", etc. and which have a description of service similar to "maintenance care" or "office visit".

(b) Procedures which do not relate to the diagnosis or treatment of the ankle and foot are not covered services.

7.15 Chiropractic Services.

(1) Covered Services. Chiropractic services which are covered by the medical assistance program are manual manipulations of the spine used to treat a subluxation, and certain specific diagnostic services. Such services shall be performed by a chiropractor certified pursuant to section 5.26 of this rule.

(2) Services requiring prior authorization. [NOTE: For more information on prior authoriziation, see subsection 7.02(3).]

(a) Prior authorization is required for services beyond the initial visit and 28 manipulations during a 12 month period per recipient per episode of illness as defined in subsection 7.15(3)(a). The prior authorization request must include a justification of why the condition is chronic and why it warrants the scope of service being requested.

(b) Spinal supports which have been prescribed by a physician or chiropractor are a covered service. If the purchase or rental price of the support is over $75.00, prior authorization is required. Rental costs under $75.00 will be paid for one month without prior approval.

(3) Other Limitations.

(a) An x-ray or set of x-rays (such as anterior-posterior and lateral) is a covered service once per episode of illness if the x-ray(s) 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. (Episode of illness is defined as either the acute onset of a new condition or re-occurrence of a preexisting condition which limits the functional ability of the recipient and requires a sequence of chiropractic adjustments to rectify).

(b) A diagnostic laboratory test is a covered service for an initial office visit only; or when related to the diagnosis of a spinal subluxation; or when verifying a symptomatic condition beyond the scope of chiropractic. The only test covered is urinalysis, when used solely for assessing the possible existance of underlying medical conditions (i.e. diabetes, infections).

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

(4) Non-covered services. Consultations (second opinions) between providers regarding a diagnosis of treatment are not a covered service.

7.16 Physical therapy

(1) Covered services. Covered physical therapy services are those medically necessary modalities, procedures and evaluations enumerated in this section, when performed by or under the supervision of a qualified physical therapist and when prescribed by a physician. Reimbursement for covered physical therapy services shall be based on the treatment unit(s) performed.

(a) Evaluation. Covered evaluations are those enumerated in the list below: (A written report of the results of the evaluation performed shall accompany the test chart or form in the recipient's medical record.)

1. Stress test;
2. Orthotic check-out;
3. Prosthetic check-out;
4. Functional evaluation;
5. Manual muscle test;
6. Isokenitic 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);
   e. "H" test;
   f. Electro-myography;
10. Respiratory assessment (spirometer, CO2 exchange, chest expansion);
11. Sensory evaluation;
12. Cortical integration (evaluation);
13. Reflex testing;
14. Coordination evaluation;
15. Posture analysis;
16. Gait analysis;
17. Crutch fitting;
18. Cane fitting;
19. Walker fitting;
20. Splint fitting;
21. Corrective shoe fitting (Orthopedic shoe fitting);
22. Brace fitting (assessment);
23. Chronic-obstructive pulmonary disease evaluation;
24. Hand evaluation;
25. Skin temperature measurement;

26. Oscillometric test;
27. Doppler peripheral-vascular evaluation;
28. Developmental evaluation:
    a. Millani-Comparetti evaluation;
    b. Denver Developmental;
    c. Ayres;
    d. Gessell;
    e. Kephart and Roach;
    f. Bazelton scale;
    g. Bailey scale;
    h. Lincoln osteretsky motion development scale;
29. Neuro-muscular evaluation;
30. Wheelchair fitting (evaluation, prescription, modification, adaptation);
31. Jobst measurement;
32. Jobst fitting (stockings);
33. Perceptual evaluation;
34. Pulse volume recording;
35. Physical capacities testing;
36. Home evaluation;
37. Garment fitting.

(b) Modalities. Covered modalities are those enumerated in the list below:

1. Hydro therapy:
    a. Hubbard tank (unsupervised);
    b. Needle-spray;
    c. Sitz bath;
    d. Whirlpool;
2. Electro therapy:
    a. Biofeedback;
    b. Electrical stimulation (transcutaneous nerve stimulation; medcolator);
3. Exercise therapy:
    a. Finger ladder;
    b. Overhead pulley;
    c. Restorator;
    d. Shoulder wheel;
    e. Stationary bicycle;
    f. Wall weights;
    g. Wand exercises;
    h. Static stretch;
    i. Elgin table;
    j. N-k table;
    k. Resisted exercise;
    l. PRE;
    m. Weighted exercise;
    n. Orthotron;
    o. Kinetron;
    p. Cybex;
    q. Skate (powder) board;
    r. Sling suspension modalities;
    s. Standing table;
4. Mechanical apparatus:
    a. Cervical and lumbar traction;
    b. Vasoneumatic pressure treatment;

5. Thermal therapy:
   a. Baker;
   b. Cryotherapy (ice immersion--cold packs);
   c. Diathermy;
   d. Hot pack--Hydrocollator pack;
   e. Infra-red;
   f. Microwave;
   g. Moist air heat;
   h. Paraffin bath;
   i. Sauna;

(c) Procedures. Covered procedures are those enumerated in the list below:

1. Hydro therapy:
   a. Contrast bath;
   b. Hubbard tank (supervised);
   c. Whirlpool (supervised);
   d. Walking tank;
2. Electro therapy:
   a. Biofeedback;
   b. Electrical stimulation (supervised);
   c. Iontophoresis (ion transfer);
   d. Transcutaneous nerve stimulation (T.N.S.) (supervised);
3. Exercise:
   a. Peripheral vascular exercise (Beurger-Allen);
   b. Breathing exercises;
   c. Cardiac rehabilitation:
      i. Immediate post-discharge from hospital;
      ii. Conditioning Rehabilitation Program;
   d. Codman's exercise;
   e. Coordination exercises;
   f. Exercise therapeutic (active, passive, active assistive, resistive);
   g. Frenkel's exercise;
   h. In-water exercises;
   i. Mat exercises;
   j. Neurodevelopmental exercise;
   k. Neuromuscular exercise;
   l. Post-natal exercise;
   m. Postural exercises;
   n. Pre-natal exercises;
   o. Range of motion exercises;
   p. Relaxation exercises;
   q. Relaxation techniques;
   r. Thoracic outlet exercises;
   s. Williams flexion exercise;
   t. Stretching exercise;
   u. Pre-ambulation exercises;
   v. Pulmonary rehabilitation program;
   w. Stall bar exercise;
4. Mechanical apparatus:
   a. Intermittent positive pressure breathing;
   b. Tilt table (standing table);
   c. Ultra-sonic nebulizer;
   d. Ultra-violet;

5. Thermal:
   a. Cryo therapy (ice massage) (supervised);
   b. Medcosonulator;
   c. Ultra-sound.
6. Manual application:
   a. Accupressure (shiatsu);
   b. Adjustment of traction apparatus;
   c. Application of traction apparatus;
   d. Manual traction;
   e. Massage;
   f. Mobilization;
   g. Perceptual facilitation;
   h. Percussion (tapotement), vibration;
   i. Strapping (tapping, bandaging);
   j. Stretching;
7. Neuromuscular techniques:
   a. Balance training;
   b. Muscle reeducation;
   c. Neurodevelopmental techniques (PNF, Rood, Temple-Fay, Doman-Delacato, Cabot, Bobath);
   d. Perceptual training;
   e. Sensori-stimulation;
   f. Facilitation techniques;
8. Ambulation training:
   a. Gait training (crutch, cane, walker);
   b. Gait training (level, incline, stair climbing);
   c. Gait training (parallel bars);
9. Miscellaneous:
   a. Aseptic procedures (sterile);
   b. Functional training (activities of daily living):
      i. Self-care training;
      ii. Transfers;
      iii. Wheelchair independence;
   c. Orthotic training;
   d. Positioning;
   e. Posture training;
   f. Preprosthetic training:
      i. Desensitization;
      ii. Strengthening;
      iii. Wrapping;
   g. Prosthetic training;
   h. Postural drainage;
   i. Home program.

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] Prior authorization is required for physical therapy services provided to a nursing home recipient in excess of 60 treatment days per recipient per spell of illness. Prior authorization may also be required for services provided to recipients who are not nursing home residents.

(a) "Spell of illness" means a period of time beginning with the first day of physical therapy treatment following:

1. Initial admission to a nursing home where it is documented in the plan of care that physical therapy is necessary. This does not apply to readmission;

2. An acute onset of a new disease or injury or condition such as

a. Neuromuscular dysfunction:
i. Stroke-hemiparesis;
ii. Multiple sclerosis;
iii. Parkinsons;
iv. Diabetic neuropathy;
b. Musculoskeletal dysfunction:
i. Fracture;
ii. Amputation;
iii. Strains, sprains;
iv. Complication associated with surgical procedure;
c. Problems and complications associated with physiologic dysfunction:
i. Ulcerations of skin;
ii. Pain;
iii. Vascular condition;
iv. Cardio-pulmonary condition.

3. An exacerbation of a pre-existing condition, including but not limited to the following, which requires physical therapy intervention on an intensive basis:
a. Multiple sclerosis;
b. Rheumatoid arthritis;
c. Parkinsons.

4. A regression in the recipient's condition due to lack of physical therapy, (e.g. a decrease of functional ability, strength, mobility, motion).

(b) The spell of illness shall end when the recipient's condition improves so that the services of a qualified physical therapist are no longer required, or when 60 treatment days have been exhausted, whichever comes first.

(c) A spell of illness must be documented in the plan of care.

(d) Unused treatment days from one spell of illness shall not be carried over into a new spell of illness.

(e) With proper documentation, the department may approve prior authorization requests for up to a year of preventive/maintenance physical therapy.

(f) Treatment days covered by Medicare or other third-party insurance shall be included in computing the 60-day total.

(g) To the extent that the legislature appropriates sufficient funds and position authority, the department will have on its staff qualified physical therapist(s) to review prior authorization requests and perform other consultative activities.

(h) A peer review committee will serve to assist in review of claims and prior authorization requests, to advise the department and to act as first level of an appeal mechanism.

(3) Other limitations. [NOTE: Subsection 7.16(3) applies to physical therapy, occupational therapy, speech pathology and audiology services.]

(a) Plan of care for therapy services. Services shall be furnished under the plan of care established and periodically reviewed by a physician. The plan shall be established (that is, reduced to writing either by the physician who makes the plan available to the provider or by the provider of therapy when the provider makes a written record of the physician's oral orders) before treatment is begun. The plan shall be promptly signed by the ordering physician and incorporated into the provider's permanent record for the recipient.

1. The plan shall state the type, amount, frequency, and duration of the therapy services that are to be furnished the recipient and shall indicate the diagnosis and anticipated goals. Any changes shall be made in writing and signed by the physician or by the provider of therapy services, registered professional nurse, or physician on the staff of the provider pursuant to the attending physician's oral orders.

2. The plan shall be reviewed by the attending physician, in consultation with the therapist providing services, at such intervals as the severity of the recipient's condition requires, but at least every 30 days. Each review of the plan shall contain the initials of the physician and the date performed. The recipient's plan shall be retained in the provider's file. The provider shall certify on the claim form that the plan is on file.

(b) Restorative therapy services are covered services without further requirements.

(c) Preventive/maintenance therapy services are covered services only when one of the following conditions are met:

1. The skills and training of a therapist are required to execute the entire preventive/maintenance program; or

2. The specialized knowledge and judgment of a physical therapist are required to establish and monitor the therapy program, including the initial evaluation, the design of the program appropriate to the individual recipient, the instruction of nursing personnel, family or recipient, and the reevaluations required; or

3. When the treatment program requires the use of therapy equipment; or

4. When, due to the severity or complexity of the recipient's condition, nursing personnel cannot handle the recipient safely and effectively.

(d) Evaluations are covered services. The need for an evaluation/reevaluation shall be documented in the plan of care.

(4) Non-covered services. The following services are not covered, (in addition to section 7.03):

(a) Services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation.

(b) Pursuant to Wis. Adm. Code subsection H 32.11(d)(1-5), those services that can be performed by restorative nursing shall not be covered physical therapy services.

7.17 Occupational therapy.

(1) Covered services. Covered occupational therapy services are those medically necessary services listed below, when prescribed or ordered by a physician and when performed by or under the direct, immediate, on-premises supervision of a certified occupational therapist:

(a) Motor Skills:
1. Range of Motion;
2. Gross/Fine Coordination;
3. Strengthening;
4. Endurance/Tolerance;
5. Balance;

(b) Sensory Integrative Skills:

1. Reflex/Sensory Status;
2. Body Concept;
3. Visual-Spatial Relationships;
4. Posture and Body Integration;
5. Sensorimotor Integration;

(c) Cognitive Skills:
1. Orientation;
2. Attention Span;
3. Problem Solving;
4. Conceptualization;
5. Integration of Learning;

(d) Activities of Daily Living Skills:
1. Self Care;
2. Work Skills;
3. Avocational Skills;

(e) Social Interpersonal Skills:
1. Dyadic Interaction Skills;
2. Group Interaction Skills;

(f) Psychological Intrapersonal Skills:
1. Self Identity and Self Concept;
2. Coping Skills;
3. Independent Living Skills;

(g) Preventive Skills:
1. Energy Conservation;
2. Joint Protection;
3. Edema Control;
4. Positioning;

(h) Therapeutic Adaptions:
1. Orthotics/Splinting;
2. Prosthetics;
3. Assistive/Adaptive Equipment;
4. Environmental Adaptations;

(i) Environmental Planning;

(j) Evaluation/Reevaluation. Covered evaluations are those enumerated in the list below (A written report of the results of the evaluation performed shall accompany the test chart or form in the recipient's medical record.):

1. Motor Skills
   Range of Motion
   Gross muscle test
   Manual muscle test
   Coordination evaluation
   Nine hole peg test
   Purdue Pegboard test
   Strenth evaluation
   Head trunk balance evaluation
   Standing balance-endurance
   Sitting balance-endurance
   Prosthetic check out
   Hemiplegic evaluation
   Arthritis evaluation
   Hand evaluation-strength and R.O.M.

2. Sensory Integrative Skills
Beery Test of Visual Motor Integration
Southern California Kinesthesia and Tactile Perception Tests
A. Milloni-Comparetti Developmental Scale
Gesell Developmental Scale
Southern California Perceptual Motor Test Battery
Marianne Frostig Developmental Test of Visual Perception
Reflex testing
Ayres Space Test
Sensory evaluation
Denver Developmental Test
Perceptual Motor evaluation
Visual Field Evaluation

3. Cognitive Skills
Reality Orientation Assessment
Level of Cognition evaluation

4. Activities of Daily Living Skills

Bennet Hand Tool Evaluation
Crawford Small Parts Dexterity Test
Avocational Interest/Skill Battery
Minnesota Rate of Manipulation
ADL evaluation - men/women

5. Social Interpersonal Skills

Evaluation of response in group

6. Psychological Intrapersonal Skills

Subjective Assessment of current emotional status
Azima Diagnostic Battery
Goodenough Draw-A-Man Test

7. Therapeutic Adaptions

8. Environmental Planning

Environmental evaluation

(2) Services Requiring Prior Authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] Prior authorization is required for occupational therapy services provided to nursing home recipients in excess of 60 treatment days per recipient per spell of illness. Prior authorization may be required for services to recipients who are not nursing home residents.

(a) "Spell of illness" means a period of time beginning with the first day of occupational therapy treatment following the occurrence of one of the following events:

1. Initial admission to a nursing home where it is documented in the plan of care that occupational therapy is necessary. This does not apply to readmission.

2. An acute onset of a new disease or injury or condition such as:

a. Neuromuscular dysfunction:
i. Stroke - hemiparesis;
ii. Multiple sclerosis;
iii. Parkinsons;
iv. Diabetic neuropathy;

b. Musculoskeletal dysfunction:
i. Fracture;
ii. Amputation;
iii. Strains, sprains;
iv. Complication associated with surgical procedure;

c. Problems and complications associated with physiologic dysfunction:
i. Ulcerations of skin;
ii. Pain;
iii. Vascular condition;
iv. Cardio - pulmonary condition;

d. Psychological dysfunction, including thought disorders, organic conditions, retardation, and affective disorders.

3. An exacerbation of a pre-existing condition including but not limited to the following, which requires occupational therapy intervention on an intensive basis:

a. Multiple sclerosis;
b. Rheumatoid arthritis;
c. Parkinsons;
d. Schizophrenia;

4. A regression in the recipient's condition due to lack of occupational therapy, (e.g. a decrease of functional ability, strength, mobility, motion).

(b) The spell of illness ends when the recipient's condition improves so that the services of a qualified occupational therapist are no longer required, or when 60 treatment days have been exhausted, whichever comes first.

(c) A spell of illness shall be documented in the plan of care.

(d) Unused treatment days from one spell of illness shall not be carried over into a new spell of illness.

(e) With proper documentation, the department may approve prior authorization requests for up to a year of preventive/maintenance occupational therapy.

(f) Treatment days covered by other third-party insurance shall be included in computing the 60-day total.

(g) To the extent that the legislature appropriates sufficient funds and position authority, the department will maintain qualified occupational therapist(s) to review prior authorization requests and perform other consultative activities.

(h) A peer review committee will serve to assist in review of claims and prior authorization, to advise the department, and to act as first level of an appeal mechanism.

(i) Services listed under subsection 7.17(1)(e) and (f), provided beyond the evaluation and 15 treatment days (from the first date of service after evaluation) require prior authorization.

(3) Other limitations. The limitations of subsection 7.16(3) apply to occupational therapy services.

(4) Non-covered services. The following services are not covered (in addition to section 7.03):

(a) Services related to activities for the general good and welfare of recipients, such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation.

(b) Pursuant to Wis. Adm. Code, section H 32.11(d)15, those services that can be performed by restorative nursing shall not be covered occupational therapy services.

(c) Crafts and other supplies used in occupational therapy services for inpatients in an institutional program are not billable by the therapist.

7.18 Speech pathology.

(1) Covered services. Covered speech pathology services are those medically necessary diagnostic, screening, preventive or corrective speech pathology services prescribed by a physician and provided by or under the supervision of a certified speech pathologist.

(a) Evaluation/reevaluation procedures. (To be performed by certified speech pathologist.) The types of tests and measurements that speech pathologists may perform include, but are not limited to, the following:

1. Expressive Language (examples of formal tests have been included):
   a. Aphasia evaluation (Eisenson, PICA, Schuell);
   b. Articulation evaluation (Arizona Articulation, Proficiency Scale, Goldman-Fristoe Test of Articulation, Templin-Darley Screening and Diagnostic Tests of Articulation);
   c. Cognitive Assessment (tests of classification, conservation, Piagetian concepts);
   d. Language Concept evaluation (tests of temporal, spatial, quantity concepts, environmental concepts, and the language of directions);
   e. Morphological evaluation (the Miller-Yoder Test, Michigan Inventory);
   f. Question evaluation (yes-no, is-are, what, where, who, why, how, and when);
   g. Stuttering evaluation;
   h. Syntax evaluation;
   i. Vocabulary evaluation;
   j. Voice evaluation;
   k. Zimmerman Pre-School Language Scale;
   l. Illinois Test of Psycholinguistic Abilities;
2. Receptive Language (examples of formal tests have been included):
   a. ACLC (Assessment of Children's Language Comprehension);
   b. Aphasia evaluation (Eisenson, PICA, Schuell);
   c. Auditory discrimination evaluation (Goldman-Fristoe-Woodcock test of Auditory, Discrimination and Wepman test of Auditory, Discrimination);
   d. Auditory Memory (Spencer-MacGrady Memory for Sentences);
   e. Auditory Processing evaluation;

f. Cognitive assessment (One-to-one correspondence, seriation classification conservation);
g. Language Concept evaluation (Boehm Test of Basic Concepts);
h. Morphological evaluation (Bellugi-Klima Grammatical Comprehension Tests, Michigan Inventory, Miller-Yoder Test);
i. Question evaluation;
j. Syntax evaluation;
k. Visual Discrimination evaluation;
l. Visual Memory evaluation;
m. Visual Sequencing evaluation;
n. Visual Processing evaluation;
o. Vocabulary evaluation (Peabody Picture Vocabulary Test);
p. Zimmerman Pre-School Language Scale;
q. Illinois Test of Psycholinguistic Abilities;

3. Pre-Speech Skills:
a. Diadochokinetic Rate evaluation;
b. Oral Peripheral evaluation;

4. Hearing-Auditory Training:
a. Auditory Screening;
b. Informal Hearing evaluation;
c. Lip-reading evaluation;
d. Auditory Training evaluation;
e. Hearing-aid orientation evaluation;
f. Non-verbal evaluation.

(b) Speech procedure treatment which requires the continuous supervision of a certified speech pathologist.

1. Expressive Language:
a. Articulation;
b. Fluency;
c. Voice;
d. Language:
i. Language structure, including phonology, morphology, and syntax;
ii. Language content, including range of abstraction in meanings and cognitive skills;
iii. Language functions, including verbal, non-verbal and written communication;

2. Receptive Language:
a. Auditory processing:
i. Attention span;
ii. Acuity (perception);
iii. Recognition;
iv. Discrimination;
v. Memory;
vi. Sequencing;
vii. Comprehension;
b. Visual processing:
i. Attention span;
ii. Acuity (perception);
iii. Recognition;
iv. Discrimination;
v. Memory;
vi. Sequencing;

vii. Comprehension;

3. Pre-speech skills:
   a. Oral and peri-oral structure;
   b. Vegetative function of the oral motor skills;
   c. Volitional oral motor skills;
4. Hearing/Auditory training:
   a. Hearing screening and referral;
   b. Auditory training;
   c. Lip reading;
   d. Hearing aid orientation;
   e. Non-verbal communication;

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] Prior authorization is required for speech therapy services provided to a nursing home recipient in excess of 60 treatment days per recipient per spell of illness. Prior authorization may also be required for services provided to recipients who are not nursing home residents.

(a) "Spell of illness" means a period of time beginning with the first day of speech therapy treatment following:

1. Initial admission to a nursing home where it is documented in the plan of care that speech therapy is necessary. This does not apply to readmission;
2. An acute onset of a new disease or injury or condition such as
   a. Neuromuscular dysfunction:
      i. Stroke-hemiparesis;
      ii. Multiple sclerosis;
      iii. Parkinsons;
      iv. Diabetic neuropathy;
   b. Musculoskeletal dysfunction:
      i. Fracture;
      ii. Amputation;
      iii. Strains, sprains;
      iv. Complication associated with surgical procedure;
   c. Problems and complications associated with physiologic dysfunction:
      i. Ulcerations of skin;
      ii. Pain;
      iii. Vascular condition;
      iv. Cardio-pulmonary condition.
3. An exacerbation of a pre-existing condition, including but not limited to the following, which requires speech therapy intervention on an intensive basis:
   a. Multiple sclerosis;
   b. Rheumatoid arthritis;
   c. Parkinsons.
4. A regression in the recipient's condition due to lack of speech therapy, (e.g. a decrease of functional ability, strength, mobility, motion).

(b) The spell of illness shall end when the recipient's condition improves so that the services of a qualified speech therapist are no longer required, or when 60 treatment days have been exhausted, whichever comes first.

(c) A spell of illness must be documented in the plan of care.

(d) Unused treatment days from one spell of illness shall not be carried over into a new spell of illness.

(e) With proper documentation, the department may approve prior authorization requests for up to a year of preventive/maintenance speech therapy.

(f) Treatment days covered by Medicare or other third-party insurance shall be included in computing the 60-day total.

(g) To the extent that the legislature appropriates sufficient funds and position authority, the department will have on its staff qualified speech therapist(s) to review prior authorization requests and perform other consultative activities.

(h) A peer review committee will serve to assist in review of claims and prior authorization requests, to advise the department and to act as first level of an appeal mechanism.

(3) Other limitations. The limitations of subsection 7.16(3) apply to speech pathology services.

(4) Non-covered services.

(a) Services which are of questionable therapeutic value in a program of speech pathology shall not be covered. For example, charges by speech pathology providers for "language development--facial physical," "voice therapy--facial physical" or "appropriate outlets for reducing stress" shall not be covered.

(b) Activities not associated with the treatment of a recipient, such as the end of day clean up of the treatment area, shall not be reimbursable services.

7.19 Audiology.

(1) Covered services. Covered audiology services are those medically necessary diagnostic, screening, preventive or corrective audiology services prescribed by a physician and provided by or under the supervision of an audiologist certified pursuant to section 5.31. Such services include:

(a) Audiological evaluation;
(b) Hearing aid evaluation;
(c) Hearing aid performance check;
(d) Audiological tests;
(e) Audiometric techniques;
(f) Impedance audiometry;
(g) Aural rehabilitation;
(h) Speech and audio therapy.

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] The following services require prior authorization from the department:
(a) Speech and audio therapy;
(b) Aural rehabilitation, including:
1. Use of residual hearing;
2. Speech reading or lip reading;
3. Compensation techniques;
4. Gestural communication techniques;
(c) Dispensing of hearing aids;
(d) Requests for prior authorization of audiological services shall be reviewed only if such requests contain the following information:
1. The number of treatment days requested;
2. The name, address and medical assistance number of the recipient;
3. The name of the provider of the requested service;
4. The name of the person or agency making the request;
5. The attending physician's diagnosis, indication of degree of impairment, and justification for the requested service;
6. An accurate cost estimate if the request is for the rental, purchase or repair of an item; and
7. If out-of-state non-emergency service is requested, a justification for obtaining service outside of Wisconsin, including an explanation of why service cannot be obtained in the state.

(3) Other limitations. The limitations of subsection 7.16(3) apply for audiology services.

(4) Non-covered services. See Sec. HSS 107.03 for services which are not covered services.

7.20 Vision care services.

(1) Covered services. Covered vision care services are eyeglasses and those medically necessary services provided by licensed and certified optometrists within the scope of practice of the profession as defined in section 449.01, Wis. Stats., and by physicians.

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] The following services require prior authorization by the department:
(a) Visual training, orthoptics, and pleoptics;
(b) Aniseikonic services;
(c) Tinted eyeglass lenses except for tints number 1 or 2 of the rose type;
(d) Eyeglass frames with a cost which exceeds the department's maximum allowable cost;

(e) All contact lenses;

(f) All contact lenses, including related materials and services, except where the recipient's diagnosis is aphakia or keratoconus;

(g) Ptosis crutch services and materials;

(h) Prosthetic eye services and materials;

(i) Eyeglass frames or lenses beyond the original and one unchanged prescription replacement pair from the same provider in a 12-month period.

(3) Other limitations.

(a) Eyeglass frames, lenses and related materials shall be provided at wholesale laboratory cost.

(b) Lenses and frames shall comply with ANSI standards (Z-80).

(4) Non-covered services. The following shall be non-covered services and materials:

(a) Anti-glare coating.

(b) Spare eyeglasses or sunglasses.

(c) Services provided principally for cosmetic reasons.

7.21 Family Planning Services.

(1) Covered services. Covered family planning services are those services enumerated below when prescribed by a physician and provided to a recipient, including initial physical exam and health history, annual visits and follow-up visits, laboratory services, prescribing and supplying of contraceptive supplies and devices, counseling services, and the prescribing of medication for specific treatments. All family planning services performed in family planning clinics must be prescribed by a physician, and furnished, directed, or supervised by a physician, registered nurse, nurse practitioner or licensed practical nurse.

(a) Initial physical examination with health history is a covered services and may include the following:

1. Complete obstetrical history including menarche, menstrual, gravidity, parity, pregnancy outcomes and complication of pregnancy/ delivery, and abortion history;

2. History of significant illness - morbidity, hospitalization and previous medical care (particularly about thromboembolic disease), breast and genital neoplasm, diabetic and prediabetic condition, cephalelgia and migraine, pelvic inflamatory disease, gynecologic and venereal disease;

3. History of previous contraceptive use;

4. Family, social, physical health, and mental health history, e.g., chronic illnesses, genetic aberrations, mental depression.

5. Physical examination - recommended procedures for examination should include, but are not limited to:

a. Thyroid palpation;
b. Examination of breasts and axillary glands;
c. Auscultation of heart and lungs;
d. Blood pressure;
e. Height and weight;
f. Abdominal examination;
g. Pelvic examination;
h. Extremities;

(b) Laboratory services may be performed in conjunction with an initial examination with health history.

1. Laboratory service routinely performed:

a. CBC, or Hematocrit and/or Hemoglobin;

b. Urinalysis;
c. Papanicolaou Smear (for females between the ages of 12 and 65);
d. Bacterial Smear or culture (gonorrhea, trichomonas, yeast, etc.) including VDRL - Syphilis serology with positive gonorrhea cultures;
e. Serology;

2. Covered if indicated from history:
a. Skin test for TB;
b. Vaginal smears and wet mounts for suspected vaginal infection;
c. Pregnancy test;
d. Rubella titer;
e. Sickle-cell screening;
f. Post-Prandial blood glucose;
g. Colposcopy;
h. Blood test for cholesterol, triglycerides when related to oral contraceptive prescriptions;

3. Covered procedures relating to infertility:
a. Semen analysis (includes pelvic exam as necessary);
b. Endometrial biopsy (when performed after hormone blood test);
c. Hysterosalpingogram;
d. Laparoscopy;
e. Basal body temperature monitoring;
f. Cervical mucus exam;
g. Vasectomies;
h. Culdoscopy;

4. Covered procedures relating to genetics, such as:
a. Ultrasound;
b. Amniocentesis;
c. Tay-Sachs;
d. Hemophilia screening;
e. Muscular Dystrophy screening;
f. Sickle-cell screening;

5. Colposcopy, culdoscopy, and laparoscopy procedures may be used either as diagnostic or treatment procedures.

(c) Counseling services in the clinic are covered and may be performed or supervised by a physician, registered nurse, or licensed practical nurse. Counseling services may be provided as a result of request by a recipient or upon indications from exam procedures and history. These services are limited to the following areas of concern:

1. Instruction on reproductive anatomy and physiology;
2. Overview of available methods of contraception, including natural family planning (An explanation of the medical ramifications and effectiveness of each must be provided.);
3. Venereal Disease;
4. Sterility and full explanation of sterilization procedures (including associated discomfort and risks, benefits, and irreversibility);
5. Genetics and a full explanation of procedures utilized in genetic assessment, including information regarding the medical ramifications for unborn children and planning of care for unborn children with either diagnosed or possible genetic abnormalities;
6. Information regarding teratologic evaluations;

7. Information and education regarding pregnancies requested by the recipient, including pre-natal counseling and referral.

(d) The prescribing of contraceptive methods is a covered service. The method selected should be the choice of the recipient, based on full information, except when in conflict with sound medical practice.

1. I.U.D.:
   a. Furnishing and fitting of the device;
   b. Localization procedures are limited to sonography, and up to two x-rays with interpretation;
   c. Follow-up office visit once within the first 90 days after insertion;
   d. Extraction;
2. Diaphragm:
   a. Furnishing and fitting of the device;
   b. Follow-up office visit once within 90 days after furnishing and fitting;
3. Contraceptive Pills:
   a. Furnishing and instruction for the taking of such pills;
   b. Follow-up office visit once during the first 90 days after the initial prescription to assess physiological changes; this visit must include blood pressure and weight, interim history, and laboratory examination(s) as necessary.

(e) Follow-up office visits performed by either a nurse or physician, and annual physicals and health histories, are covered services.

(f) The following supplies are covered when prescribed:
1. Oral contraceptives;
2. Diaphragms;
3. Jellies, cream, foam;
4. Condoms;
5. Natural family planning supplies (e.g., charts, etc.);
6. Medication for vaginal infections.

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).] All non-therapeutic sterilization procedures require prior authorization by the medical consultant to the department, as well as the informed consent of the recipient. The informed consent requests shall be in accordance with section 7.06(2)(kk) of this rule.

(3) Non-covered services. Sterilizations of recipients under the age of 21, or of recipients declared legally incapable of consenting to such a procedure shall not be covered services.

7.22 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

(1) Covered services. Early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of conditions discovered shall be covered services for all recipients under 21 years of age, when provided by a certified EPSDT screening clinic, by a certified physician, or by a certified private clinic or hospital.

(a) The EPSDT screening package shall include the following services, as indicated by the person's age:

1. Health history, including nutritional and developmental assessment;

2. Vision screening;
3. Hearing screening;
4. Unclothed physical assessment;
5. Immunization status assessment and administration of needed immunizations;
6. Oral health assessment;
7. Anemia screening;
8. Developmental testing;
9. Blood lead screening, when indicated by a person's history;
10. Height, weight and head circumference;
11. Blood pressure.

(b) Selection of additional screening tests to supplement the screening package shall be based on the health needs of the target population.

1. Specific racial or ethnic characteristics of the population shall be considered in selection of screening test for specific conditions associated with these factors.

2. Available prevalence rates for specific conditions shall be considered in the selection of disease-specific tests.

3. Consideration shall be given to the existence of treatment programs for each condition for which screening is provided.

(2) Outreach and follow-up services in support of screening, diagnosis and treatment shall be covered when provided by a provider certified according to section 5.37(1) and when performed and documented pursuant to section 5.37. Such services shall include:

(a) Outreach which does not result in screening;

(b) Outreach that does result in screening;

(c) Follow-up that does not result in the diagnostic and treatment services indicated by screening results;

(d) Follow-up that does result in the indicated diagnostic and treatment services;

(e) Arrangement for, or provision of, transportation for screening, diagnosis, or treatment services when requested by the recipient and when documented by the provider;

(3) All medically necessary services and items, provided in connection with diagnosis and treatment of conditions uncovered through the EPSDT program shall be covered services, subject to the conditions of Sec. 5.37(3).

7.23 Transportation.

(1) Covered Services.

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

1. From the recipient's residence (or other, e.g., site of an accident) to a hospital or nursing home; or

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

3. From a nursing home to a hospital or from a hospital to a nursing home; or

4. From a hospital to another hospital or from a nursing home to another nursing home; or

5. From a recipient's residence (or nursing home) to a physician's or dentist's office, if other means of transportation are contraindicated and if the transportation is to obtain a physician's or dentist's services which require special equipment for diagnoses or treatment that cannot be obtained in the nursing home or recipient's residence.

(b) Specialized medical vehicle transportation shall be a covered service if the recipient is confined to a wheelchair, or if the recipient's condition contraindicates transportation by common carrier and the recipient's physician has prescribed specialized medical vehicle transportation. This type of transportation service is covered only if the transportation is to a facility at which the recipient receives medical services.

(c) Transportation, and related travel expenses, by common carrier (e.g., bus, taxi, train, airplane) or private automobile to receive covered medical services is a covered service. Such transporation costs may include the cost of the common carrier or mileage expenses; the cost of meals and commercial lodging enroute to medical care, while receiving the care, and returning from the medical services; and the cost of an attendant to accompany the recipient, if medically or otherwise necessary. The cost of an attendant may include transportation, meals, lodging and salary of the attendant, except that no salary may be paid to a member of the recipient's family. This transportation service is reimbursed directly to the recipient by the county social services department.

(d) A provider of transportation service may carry more than one recipient at a time.

(2) Services requiring prior authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3).]

(a) All non-emergency transportation by air and water ambulances to receive medical services requires prior authorization.

(b) Non-emergency transportation of a recipient to a provider in another state requires prior authorization by the department unless the non-emergency transportation is for the purpose of receiving services from a provider which is a certified Wisconsin border-status provider.

(c) Non-emergency transportation provided under section 7.23(1)(c) of a recipient to an out-of-state provider must be approved by the county social service department, before departure.

(3) Other Limitations.

(a) In instances of hospital to hospital or nursing home to nursing home transfers by ambulance, the ambulance provider shall obtain a certification from the recipient's physician that the discharging institution was not an appropriate facility for the patient's condition, and that the admitting institution was the nearest one appropriate for that condition. Such certification shall contain the reason(s) for which the discharging institution was considered inappropriate and the reasons for which the admitting institution was considered appropriate. The certification shall be signed by the recipient's physician and shall also contain details pertinent to the recipient's condition. A check-off form is not acceptable.

(b) A claim for ambulance transport to a physician's or dentist's office or clinic shall be accompanied by a separate statement, attached to the claim, which lists 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, and an explanation of why the service could not be performed in the nursing home or recipient's residence; and the dated signature of the physician or dentist performing the service. The services obtained shall be performed by a physician or dentist (or under their direct supervision). Trips to obtain physical therapy, occupational therapy, speech therapy, audiology, chiropractic or psychotherapy shall not be covered.

(c) If specialized medical vehicle transportation is provided to a facility whose function is not primarily medical (e.g. medical supply house, Goodwill Industries) the transportation provider shall obtain from the provider of services at the destination a written statement of the medical services provided. This statement shall accompany the claim for transportation services.

(d) If ambulance or specialized medical vehicle transportation is to a nursing home for the provision of outpatient services, a statement of services received shall be obtained from the nursing home. This statement shall accompany the claim for transportation service.

(e) Charges for waiting time are covered charges. For non-emergency services, waiting time is allowable only when a continuous trip is being billed.

(f) When the recipient is not confined to a wheelchair, a physician's prescription, stating the specific medical problem preventing the use of a common-carrier transportation and the specific period of time the service should be provided, must be obtained. (A check-off form will not be acceptable.) This prescription would be valid for a maximum of one year from the physician's signature date, and the provider must indicate on the claim form that a prescription is on file with the provider, and the name and provider number of the prescribing physician.

(g) Services of an additional specialized medical vehicle transportation attendant are covered only if the recipient's condition requires the physical presence of another for purposes of restraint or lifting.

(h) Services of an additional ambulance attendant are covered only if the recipient's condition requires the physical presence of another for purposes of restraint or lifting. Medical personnel who care for the recipient in transit shall bill the program separately.

(i) If a recipient is pronounced dead by a legally authorized person after an ambulance is called but before the ambulance's arrival, service to the point of pick-up is covered.

(j) If ambulance service is provided to a recipient who is pronounced dead enroute or dead on arrival by a legally authorized person, the entire amublance service is covered.

(k) Specialized medical vehicle transportation may be reimbursed for unloaded miles, only when the distance from the dispatch point to the pickup point is 20 miles or greater. Such unloaded mileage may only be claimed once when multiple recipients are being carried on one trip.

(4) Non-Covered Services. The following transportation services are not covered:

(a) Charges for reusable devices and equipment.

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

(c) Transportation of a lab specimen only.

(d) Charges for sterilization of a vehicle after carrying a recipient with a contagious disease.

(e) Additional charges for services provided at night or on weekends.

(f) If a recipient is pronounced dead by a legally authorized person before an ambulance is called, emergency transportation service is not covered.

(g) Excessive mileage charges resulting from the use of indirect routes to and from medical destinations.

7.24 Medical Supplies and Equipment.

(1) Covered services. Medical supplies and devices, corrective shoes, hearing aids, durable medical equipment, and prosthetic and orthotic devices which have been prescribed by a physician or other person eligible to prescribe such services are covered services within the limitations enumerated in this section. Corrective shoes are a covered service at the following frequency rates:

(a) Three pair per/year (from original date of service) for children up to 15 years of age; and

(b) Two pair per/year for recipients over 15 years of age. These frequencies apply to shoes which are or are not attached to an orthotic brace.

(2) Services Requiring Prior Authorization. [NOTE: For more information on prior authorization, see subsection 7.02(3.)] The following services require prior authorization:

(a) Purchase of wheelchairs and prosthetic and orthotic appliances which are not included on the department-approved price tables. Rental of such items requires prior authorization for the second and succeeding months of rental use, except that if rental cost exceeds a dollar amount established by the department and communicated to providers, prior authorization is required before the first month's use. Needed repairs and modifications exceeding the dollar amount established by the department require prior authorization. Replacements of the total appliance unit require prior authorization.

(b) Purchase or rental of all power driven or semi and full reclining wheelchairs and purchase or rental of a wheelchair for a nursing home resident recipient.

(c) Purchase of hearing aids regardless of cost.

1. Once authorized, the hearing aid is under guarantee for the first year of usage. Any repairs to that aid after the guarantee period must have prior authorization when the dollar amount exceeds an upper limit set by the department and communicated to all hearing aid providers.

2. Hearing aid batteries and accessories do not require prior authorization.

3. Requests for prior authorization of hearing aids shall be reviewed only if such requests consist of the following reports on forms designated by the department, containing information requested by the department:

a. A medical report from the recipient's physician; and

b. An audiological report from an audiologist.

c. After a new or replacement hearing aid has been worn for a 30-day trial period, a performance check shall be obtained from a certified audiologist or certified speech and hearing center. The department shall provide reimbursement for the cost of the hearing aid only after the performance check has shown the hearing aid to be satisfactory, or the lapse of 45 days has occurred with no response from the recipient.

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(d) Prior authorization shall be requested and obtained before service is provided. Requests for prior authorization of medical equipment shall be reviewed only if such requests contain the following information:

1. The name, address and medical assistance number of the recipient.

2. The name of the provider and provider number.

3. The name of the person or agency making the request.

4. The attending physician's diagnosis, indication of degree of impairment, and justification for the requested service.

5. An accurate cost estimate if the request is for the rental, purchase, or repair of an item.

6. If out-of-state non-emergency service is requested, a justification for obtaining service outside of Wisconsin, including an explanation of why service cannot be obtained in the state.

7. If the request is for a wheelchair required pursuant to section 7.24 (3)(b)1.b. below, the following additional information shall be included:

a. A physician's order for the wheelchair.

b. A statement by the attending physician that the purchase of a wheelchair will contribute to the rehabilitation of the resident toward self-sufficiency.

(3) Other Limitations.

(a) A visit to a recipient's place of residence by a provider or member of the provider's staff for the purpose of fitting a prosthetic or orthotic device or a corrective shoe is a covered service only if the service is provided by the provider to all customers as part of the provider's normal practice.

(b) The services covered under this section are not covered for recipients who are nursing home residents, with the following exceptions:

1. Purchase of a wheelchair prescribed by a physician is covered for a nursing home recipient if the wheelchair will contribute towards the rehabilitation of the recipient through maximizing the recipient's potential for independence, and if:

a. The recipient has a long-term or permanent disability and the wheelchair requested constitutes basic and necessary health care for the recipient consistent with a plan of health care; or

b. The recipient is about to transfer from a nursing home to an alternative and more independent setting.

2. Corrective shoes, and prosthetic and orthotic devices.

3. Billing for such services for nursing home recipients shall be in accordance with section 7.09 of this rule.

(c) Hearing aid accessories, batteries and repairs do not require a physician's prescription.

(d) Repair of rented durable medical equipment is covered only when the rented equipment shall continue to be used by the same recipient.

(4) Non-covered services. Temporary breast prostheses are not covered services.

7.25 Diagnostic testing services.

(1) Covered services. Professional and technical diagnostic services covered by the medical assistance program are laboratory services provided by a certified physician or under the physician's supervision, or prescribed by a physician and provided by an independent certified laboratory and X-ray service prescribed by a physician and provided by or under the general supervision of a certified physician.

(2) Other limitations.

(a) All diagnostic services shall be prescribed or ordered by a physician, dentist or podiatrist. A chiropractor may perform urinalysis testing within the scope of the practice, in accordance with section 7.15 of this rule.

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

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

7.26 Dialysis services.

(1) Covered services. Dialysis services are covered services when provided by facilities certified pursuant to section 5.45 of this rule.

7.27 Blood.

(1) Covered services. The provision of blood is a covered service when provided by a physician certified pursuant to section 5.07; a blood bank certified pursuant to section 5.46; or a hospital certified pursuant to section 5.09 of this rule.

7.28 Health Care Project Grant Center, Health Maintenance Organization and Prepaid Health Plan Services.

(1) Covered services. Covered services include all services agreed upon in the contract between the department and the provider, when such services are furnished to an enrolled recipient. Services provided by a health care project grant center, health maintenance organization or prepaid health plan are not subject to the limitations listed elsewhere in this rule, but shall be provided in accordance with the contract between the department and the provider.

7.29 Rural Health Clinic Services. Covered rural health clinic services are the following:

(1) Services furnished by a physician within the scope of practice of the profession under state law, if the physician performs the services in the clinic or the services are furnished away from the clinic and the physician has an agreement with the clinic providing that the physician will be paid by it for such services.

(2) Services furnished by a physician assistant or nurse practitioner if the services are furnished in accordance with the requirements specified in HSS 105.35.

(3) Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant or nurse practitioner.

(4) Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

(a) The clinic is located in an area in which there is a shortage of home health agencies;

(b) The services are furnished by a registered nurse or licensed practical nurse employed by, or otherwise compensated for the services by, the clinic;

(c) The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic, or that is established by a physician, physician assistant or nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

(d) The services are furnished to a homebound recipient. For purposes of visiting nurse care, a "homebound" recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition. The person may be considered homebound if the person leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or a skilled nursing facility.

(5) Other ambulatory services furnished by a rural health clinic. Other ambulatory services means ambulatory services other than rural health clinic services, as defined in HSS 107.29(1),(2) and (3) that are otherwise included in the plan and meet specific state plan requirements for furnishing those services. Other ambulatory services furnished by a rural health clinic are not subject to the physician supervision requirements specified in HSS 105.35.

Chapter 8: General Administration

8.01 Safeguarded Information

(1) Except for purposes directly related to program administration, the Department shall not use or disclose any information concerning past or present applicants and recipients of medical assistance.

(2) Direct administration of the medical assistance program shall include but not be limited to:

(a) Determining initial or continuing applicant/recipient eligibility.
(b) Determining appropriate services to be covered.
(c) Providing services for recipients.
(d) Processing provider claims for reimbursement.
(e) Auditing provider claims for reimbursement.
(f) Investigating or prosecuting criminal or civil proceedings conducted in connection with program administration.
(g) Activity determined by the department to be necessary for proper and efficient administration of the medical assistance program.

(3) The Department shall request the attorney general to institute appropriate action when necessary to enforce provisions of this section.

(4) Safeguarded information concerning an individual applicant or recipient shall include but not be limited to:

(a) Name and address
(b) Social data including but not limited to:
    1. Marital status
    2. Age
    3. Race
    4. Names and numbers of family members
    5. Paternity status of children
    6. Unique identifying characteristics
(c) Economic data, including but not limited to:
    1. Assets
    2. Amount of assistance received
    3. Amount of medical expenses incurred
    4. Sources of payment or support.
    5. Past or present employment
    6. Income, regardless of source
    7. Social security number
    8. Income expense deductions
(d) Agency evaluation information, including but not limited to:
    1. Verification of client information
    2. Identity of verification sources
(e) Medical data including but not limited to:
    1. Past history and medical record content
    2. Diagnosis
    3. Drugs prescribed
    4. Course of treatment prescribed
    5. Name of provider

(5) For purposes of direct program administration, the department may permit disclosure to, or use of safeguarded information by qualified persons or agency representatives outside the department. Governmental authorities, the courts, and law enforcement officers are persons outside the department who must comply with subsection (6) of this rule.

(6) Persons or agency representatives outside the department to whom the department may disclose or permit use of safeguarded information must meet the following qualifications:

(a) The purpose for use or disclosure must involve direct program administration.

(b) The person or their agency must be bound by law or other legally enforceable obligation to observe confidientiality standards comparable to the department's.

(7) Unless related to direct program administration, the department shall respond to a subpoena for a case record or for agency representative testimony regarding an applicant or recipient as follows:

(a) The department shall provide the court and all parties to the proceeding with a copy of the department's rule on safeguarded information.

(b) The department shall request that the attorney general intervene in the proceeding in a manner which will give effect to the department's rule on safeguarded information.

(c) The department shall notify in writing applicants or recipients affected by a subpoena for safeguarded information concerning them.

(8) The department shall publicize its safeguarded information rule as follows:

(a) Publication in the administrative register.

(b) Incorporation by reference in certification procedures for all providers.

(c) Incorporation in information provided to recipients regarding their rights and responsibilities.

(9) The department shall mail or distribute materials to applicants, recipients or medical providers, as follows:

(a) All materials shall be limited to purposes directly related to program administration.

(b) Materials prohibited from mailing or distribution shall include:

1. "Holiday" greetings
2. General public announcements
3. Voting information
4. Alien registration notices
5. Names of individuals, unless:

a. The named individual is connected with direct program administration.

b. The named individual is identified only in an official agency capacity.

6. Any material with political implications

(c) Materials permitted for mailing or distribution shall include:

1. Information of immediate interest to applicants' or recipients' health and welfare.
2. Information regarding the deletion or reduction of covered services.
3. Consumer protection information.

(10) The Secretary or a designee shall determine the appropriate application of this section to circumstances not covered expressly herein. Use or disclosure not expressly provided herein shall not occur prior to such a determination.

8.02 County responsibilities. (1) Pursuant to section 49.45(2)(a)3, Wis. Stats., county agencies shall be responsible for determination of eligibility for medical assistance. These determinations shall be in conformity with standards for eligibility found in sections 49.19(11) and 49.47(4), Wis. Stats., and these regulations.

(2) County agencies shall inform recipients of the recipients' rights and duties under the program, including those rights enumerated in HSS 106.04(2).