CR 87-85

CERTIFICATE

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

I, Timothy F. Cullen, Secretary of the Department of Health and Social Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to the Medical Assistance Program were duly approved and adopted by this Department on December 30, 1987.

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

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 30th day of December, 1987.

Tim Cullen

Timothy F. Cullen, Secretary
Department of Health and Social Services

SEAL:

3-1-88

12-18-87

Proposed Order of the
Department of Health and Social Services
Repealing, Renumbering, Amending and Creating Rules

To repeal HSS 104.01(12)(a)1j and k, 105.01(2)(b) and (c) and (5)(a)6, 105.09(3)(c) and (d), 106.04(2)(b)10 and 11, 106.08(1) and 106.10(5)(c); to renumber HSS 103.01(1), 105.01(2)(d) and (5)(a)7 to 12, 105.09(1), (2) and (3)(a) and (b), 106.03(3), 106.08(2) and 107.09(1) to (4); to amend HSS 101.03(88), 103.03(1)(b)1, 104.01(4)(b), 105.09(2), as renumbered, and (4)(b), as renumbered, 105.34, 105.49, 106.07(2), 106.10(1)(c) and (4)(b), 107.01(1), 107.02(4)(c)12 and 13, 107.06(4)(a)3, 107.07(1)(i)10, and (2)(c)9e and f, 107.08(4)(e) and f, 107.09(4)(g)2, as renumbered, and (5)(b) and (c), as renumbered, 107.10(3)(h), 107.13(1)(f)8, 107.18(1)(a), (b)(intro.) and (c)(intro.), (2)(b), (d), (e) and (h) and (4)(a), and 107.23(1)(c) and (4)(f); to repeal and recreate HSS 106.075, 106.10(5)(a) and (b), 107.02(1) and 107.07(4)(q); and to create HSS 101.03(9m), (22m), (75m), (85m), (114m), (122m), (129m) and (149m), 103.01(1)(b), 103.11, 104.01 (4)(f) and (g), 105.09(1) and (4)(c) and (d), 105.50 and 105.51, 106.03(3)(b), 106.04(7)(f), 106.10(8), 107.06(2)(cm), 107.06(4)(h) and (5)(y), 107.07(2)(c)9g and (3)(q), 107.08(4)(g), 107.09(1), (4)(u) and (5)(d) and (e), 107.31, 107.32 and 107.33, relating to the Medical Assistance Program.

Analysis Prepared by the
Department of Health and Social Services

These are substantive revisions to 6 of the 8 chapters of the Department's rules for the Medical Assistance (MA) Program under ss. 49.45 to 49.47 and 49.49 to 49.497, Stats., as amended by 1987 Wisconsin Act 27. The Department's authority to repeal, renumber, amend and create these rules is found in s. 49.45(10), Stats.

Medical Assistance, also known as Medicaid, is a program that reimburses providers for the cost of health care services provided to eligible persons whose financial resources are not adequate to pay for their health care needs.

This order clarifies policies to ensure compliance with federal statutes and regulations and implements provisions of the 1987-89 state budget pertaining to case management, hospice care services and services for presumptively eligible pregnant women. Specifically, Chapter 101 is amended to add definitions for case management, hospice, ambulatory pre-natal care, presumptive eligibility and institutions for mental disease (IMDs), and to amend the definition for institutional provider. In Chapter HSS 103 there is a new section on the presumptive eligibility of low income pregnant women. Chapters 104 and 106 are amended to define the right to freedom of choice of providers for recipients of case management services and for presumptively eligible pregnant women, delete two exemptions from the copayment requirement, establish billing deadlines in retroactive eligibility cases, and clarify dates of service of notice and effective dates in hearings. In Chapter HSS 105, certification criteria for new provider types for hospice and case management are established, the requirement for Medicare certification of an adequate number of nursing home

beds is strengthened effective July 1, 1988, and certification criteria for rehabilitation agencies and ambulatory surgery centers are clarified. Covered services added under Chapter HSS 107 are case management, hospice care for recipients in nursing homes who are eligible for both Medical Assistance and Medicare, ambulatory pre-natal care, and cough preparations and opthalmic lubricants as over-the-counter drugs. Temporomandibular joint surgery will be provided, within limitations and prior authorization requirements, under covered services for physicians and dental care. Inpatient services provided by institutions for mental disease to persons age 21 to 64 are no longer covered nor, as of September 15, 1986, are services for developmentally disabled persons in ICF facilities that are not ICF/MRs.

SECTION 1. HSS 101.03(9m) and (22m) are created to read:

HSS 101.03(9m) "Ambulatory prenatal care" means care and treatment for a pregnant woman and her fetus to protect and promote the woman's health and the healthy development of the fetus.

(22m) "Case management" means activities which help MA recipients and, when appropriate, their families, identify their needs and manage and gain access to necessary medical, social, rehabilitation, vocational, educational and other services. Case management includes assessment, case plan development, and ongoing monitoring and service coordination under s. HSS 107.32.

SECTION 2. HSS 101.03(75m) and (85m) are created to read:

HSS 101.03(75m) "Hospice" means a public agency or private organization or a subdivision of either which primarily provides palliative care to persons experiencing the last stages of terminal illness and which provides supportive care for the family and other individuals caring for the terminally ill persons. This care is provided in a homelike environment, and includes short-term inpatient care as necessary to meet the individual's needs. Services provided by a hospital, long term care facility, outpatient surgical center or home health agency do not constitute a hospice program of care unless that entity establishes a free-standing or distinct hospice unit, or has a distinct hospice program including staff, facility and services certified under s. HSS 105.50 to provide hospice care.

(85m) "Institution for mental disease" or "IMD" means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services,

as determined by the department or the federal health care financing administration. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

SECTION 3. HSS 101.03(88) is amended to read:

HSS 101.03(88) "Institutional provider" means a hospital, ~~nursing home, health maintenance organization,~~ home health agency, ~~51.42 board~~ county department operated facility, rehabilitation agency ~~or other facility meeting the requirements of HSS 105.01(2)(a).~~ , portable x-ray provider, independent clinical laboratory, rural health clinic, skilled nursing facility, intermediate care facility, case management agency provider, personal care provider, ambulatory surgical center or hospice which is:

(a) Composed of more than one individual providing services;

(b) Eligible to receive payment only as a certified group or organization, rather than as individuals providing services within a facility or agency; and

(c) Required by the department to establish that its personnel who provide services meet the applicable certification criteria contained in ch. HSS 105, although they need not be separately certified by the department.

SECTION 4. HSS 101.03(114m) is created to read:

HSS 101.03(114m) "Palliative care" means treatment provided to persons experiencing the last stages of terminal illness for the reduction and management of pain and other physical and psychosocial symptoms of terminal illness, rather than treatment aimed at investigation and intervention for the purpose of cure. "Palliative care" will normally include physician services, skilled nursing care, medical social services and counseling.

SECTION 5. HSS 101.03(122m), (129m) and (149m) are created to read:

HSS 101.03(122m) "Physically or sensory disabled" means a condition which affects a person's physical or sensory functioning by limiting his or her mobility or ability to see or hear, is the result of injury, disease or congenital deficiency, and significantly interferes with or limits one or more major life activities and the performance of major personal or social roles.

(129m) "Presumptive eligibility" means eligibility of a pregnant woman for MA coverage of ambulatory prenatal care and other services, as determined under s. 49.465(2), Stats., prior to application and determination of MA eligibility under ss. 49.46(1), and 49.47(4), Stats., and ch. HSS 103.

(149m) "Qualified provider" means a provider who is qualified to determine presumptive eligibility of pregnant women, as ascertained by the department in accordance with 42 USC 1396a(a)(10).

SECTION 6. HSS 103.01(1) is renumbered HSS 103.01(1)(a).

SECTION 7. HSS 103.01(1)(b) is created to read:

HSS 103.01(1)(b) Presumptive eligibility for pregnant women shall be determined under s. 46.465, Stats., and this chapter.

SECTION 8. HSS 103.03(1)(b)1 is amended to read:

HSS 103.03(1)(b)1. The person is pregnant and meets the conditions specified in ss. 46.46(1)(a)1m, 49.465 ~~and~~ or 49.47(4)(a)2, Stats.;

SECTION 9. HSS 103.11 is created to read:

HSS 103.11 PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN. (1) REQUIREMENTS. Pregnant women may be determined presumptively eligible for MA on the basis of

verification of pregnancy and preliminary information about family income. That determination shall be made by providers designated by the department who are qualified in accordance with this section. A provider qualified to make determinations of presumptive eligibility shall meet the following requirements:

(a) Be certified as an MA provider under ch. HSS 105; and

(b) Provide one or more of the following services:

1. Outpatient hospital services;

2. Rural health clinic services; or

3. Clinic services furnished by or under the direction of a physician; and

(c) Receive funding or participate in a program under:

1. The migrant health center or community health center programs under s. 329 or 330 of the public health service act;

2. The maternal and child health services block grant programs;

3. The special supplemental food program for women, infants and children under s. 17 of the child nutrition act of 1966;

4. The commodity supplemental food program under D.4(a) of the agriculture and consumer protection act of 1973; or

5. A state prenatal program; and

(d) Have been determined by the department to be qualified providers under this section.

(2) DUTIES AND RESPONSIBILITIES. (a) A qualified provider shall ascertain presumptive MA eligibility for a pregnant woman by:

1. Verifying or obtaining verification of the woman's pregnancy; and

2. Determining on the basis of preliminary information that the woman's family income meets the applicable income limits.

(b) The provider shall inform the woman, in writing, of the determination of presumptive eligibility and that she has 14 calendar days from the date of the determination to file an application for MA eligibility with the county department of social services.

(c) Within 5 working days following the date on which the determination was made, the provider shall in writing notify the department and the agency where the woman will apply for MA eligibility of the woman's presumptive eligibility.

(d) In the event that the provider determines that a woman is not presumptively eligible, the provider shall inform her that she may file an application for MA eligibility at the county department of social services.

SECTION 10. HSS 104.01(4)(b) is amended to read:

HSS 104.01(4)(b) Limitations. A recipient may request service from any certified provider, subject to ss. HSS 104.02(1), 104.03, and 104.05, except as provided in ~~par.~~ pars. (d), (f) and (g).

SECTION 11. HSS 104.01(4)(f) and (g) are created to read:

HSS 104.01(4)(f) Case management services. Only recipients in the target populations designated by the department in s. HSS 107.32(1)(a)2 may choose case management services. Receipt of case management services does not restrict a recipient's right to receive other MA services from any certified provider.

(g) A recipient who requests a determination of presumptive eligibility to receive MA services shall file an application only with a qualified provider designated by the department and certified under s. HSS 105.52.

SECTION 12. HSS 104.01(12)(a)1j and k are repealed.

SECTION 13. HSS 105.01(2)(b) and (c) are repealed.

SECTION 14. HSS 105.01(2)(d) is renumbered HSS 105.01(2)(b).

SECTION 15. HSS 105.01(5)(a)6 is repealed.

SECTION 16. HSS 105.01(5)(a)7 to 12 are renumbered HSS105.01(5)(a)6 to 11.

SECTION 17. HSS 105.09(1), (2) and (3)(a) and (b) are renumbered HSS 105.09(2), (3) and (4)(a) and (b).

SECTION 18. HSS 105.09(1) is created to read:

HSS 105.09 MEDICARE BED REQUIREMENT. (1) DEFINITION. In this section, "sufficient number of medicare-certified beds" means a supply of beds that accommodates the demand for medicare beds from both the home county and contiguous counties so that no dual eligible recipient is denied access to medicare SNF benefits because of a lack of available beds. In this subsection, "dual eligible recipient" means a person who qualifies for both medical assistance and medicare.

SECTION 19. HSS 105.09(2), as renumbered, is amended to read:

HSS 105.09(2) MEDICARE BED OBLIGATION. Each county shall have a sufficient number of skilled nursing beds certified by the medicare program pursuant to ss. 49.45(6m)(g) and 50.02(2), Stats. The number of medicare-certified beds required in each county shall be ~~determined by the department, based on factors including but not limited to the number of persons over 65 in the county and the~~

~~number-of-medical-eligible-persons-transferred-from-hospitals-to-skilled-nursing facilities-in-the-county-for-convalescent-stays~~ at least 3 beds per 1000 persons 65 years of age and older in the county.

SECTION 20. HSS 105.09(3)(c) and (d) are repealed.

SECTION 21. HSS 105.09(4)(b), as renumbered, is amended to read:

HSS 105.09(4)(b) ~~Homes~~ A home or portion of a home ~~which are~~ certified as an ICF/MR ~~are~~ is exempt from this section.

SECTION 22. HSS 105.09(4)(c) and (d) are created to read:

HSS 105.09(4)(c) The department may grant an exemption based on but not limited to:

1. Availability of a swing-bed hospital operating within a 30 mile radius of the nursing home; or

2. Availability of an adequate number of medicare-certified beds in a facility within a 30 mile radius of the nursing home.

(d) A skilled nursing facility located within a county determined to have an inadequate number of medicare-certified beds and which has less than 100 beds may apply to the department for partial exemption from the requirements of this section. An SNF which applies for partial exemption shall recommend to the department the number of medicare-certified beds that the SNF should have to meet the requirements of this section based on the facility's analysis of the demand for medicare-certified beds in the community. The department shall review all recommendations and issue a determination to each SNF requesting a partial exemption.

SECTION 23. HSS 105.34 is amended to read:

HSS 105.34 CERTIFICATION OF REHABILITATION AGENCIES. For MA certification on or after January 1, 1988, ~~rehabilitation agencies~~ a rehabilitation agency providing outpatient physical therapy, ~~or~~ speech and language pathology, or occupational therapy shall be certified to participate in medicare as an outpatient rehabilitation agency ~~and shall meet the requirements of~~ under 42 CFR 405.1702 to 405.1726.

SECTION 24. HSS 105.49 is amended to read:

HSS 105.49 CERTIFICATION OF AMBULATORY SURGICAL CENTERS. For MA certification, an ambulatory surgical ~~centers~~ center shall ~~meet the requirements for participation~~ be certified to participate in Medicare as an ambulatory surgical center ~~as stated in~~ under 42 CFR 416.39.

Note: For covered ambulatory surgical center services, see s. HSS 107.30.

SECTION 25. HSS 105.50 and 105.51 are created to read:

HSS 105.50 CERTIFICATION OF HOSPICES. For MA certification, a hospice shall be certified to participate in medicare as a hospice under 42 CFR 418.50 to 418.100.

HSS 105.51 CERTIFICATION OF CASE MANAGEMENT AGENCY PROVIDERS. (1) AGENCY. For MA certification, a provider of case management services shall be an agency with state statutory authority to operate one or more community human service programs. A case management agency may be a county or Indian tribal department of community programs, a department of developmental disability services, a department of social services, a department of human services, or a county or tribal aging unit. Each applicant agency shall specify each population eligible

for case management under s. HSS 107.32(1)(a)2 for which it will provide case management services. Each certified agency shall offer all 3 case management components described under s. HSS 107.32(1) so that a recipient can receive the component or components that meet his or her needs.

(2) EMPLOYED PERSONNEL. (a) To provide case assessment or case planning services reimbursable under MA, persons employed by or under contract to the case management agency under sub. (1) shall:

1. Possess a degree in a human services-related field, possess knowledge regarding the service delivery system, the needs of the recipient group or groups served, the need for integrated services and the resources available or needing to be developed, and have acquired at least one year of supervised experience with the type of recipients with whom he or she will work; or

2. Possess 2 years of supervised experience or an equivalent combination of training and experience.

Note: The knowledge required in subd. 1 is typically gained through supervised experience working with persons in the target population.

(b) To provide ongoing monitoring and service coordination reimbursable under MA, personnel employed by a case management agency under sub. (1) shall possess knowledge regarding the service delivery system, the needs of the recipient group or groups served, the need for integrated services and the resources available or needing to be developed.

(3) SUFFICIENCY OF AGENCY CERTIFICATION FOR EMPLOYED PERSONNEL. Individuals employed by or under contract to an agency certified to provide case management services under this section may provide case management services upon the department's issuance of certification to the agency. The agency shall maintain a list of the names of individuals employed by or under contract to the agency who are performing case management services for which reimbursement may be

claimed under MA. This list shall certify the credentials possessed by the named individuals which qualify them under the standards specified in sub. (2). Upon request, an agency shall promptly advise the department in writing of the employment of persons who will be providing case management services under MA and the termination of employes who have been providing case management services under MA.

(4) CONTRACTED PERSONNEL. Persons under contract with a certified case management agency to provide assessments or case plans shall meet the requirements of sub. (2)(a), and to provide ongoing monitoring and service coordination, shall meet the requirements of sub. (2)(b).

(5) RECORDKEEPING. The case manager under s. HSS 107.32(1)(d) shall maintain a file for each recipient receiving case management services which includes the following:

(a) The assessment document;

(b) The case plan;

(c) Service contracts;

(d) Financial forms;

(e) Release of information forms;

(f) Case reviews;

(g) A written record of all monitoring and quality assurance activities; and

(h) All pertinent correspondence relating to the recipient's case management.

(6) REIMBURSEMENT. (a) Case management services shall be reimbursed when the services are provided by certified providers or their subcontractors to recipients eligible for case management.

(b) Payment shall be made to certified providers of case management services according to terms of reimbursement established by the department.

(7) COUNTY ELECTION TO PARTICIPATE. (a) The department may not certify a case management agency for a target population unless the county board or tribal government of the area in which the agency will operate has elected to participate in providing benefits under s. HSS 107.32 through providers operating in the county or tribal area. The county board or tribal government may terminate or modify its participation by giving a 30 day written notice to the department. This election is binding on any case management agencies providing services within the affected county or tribal area.

(b) Any case management agency provider requesting certification under this section shall provide written proof of the election of the county or tribal government to participate under this subsection.

SECTION 26. HSS 106.03(3) is renumbered HSS 106.03(3)(a).

SECTION 27. HSS 106.03(3)(b) is created to read:

HSS 106.03(3)(b). If a provider is notified by an agency or recipient that a recipient has been determined to be eligible retroactively under s. 49.46(1)(b), Stats., a claim shall be submitted to the fiscal agent within 12 months after the certifying agency notifies the fiscal agent of the effective date of eligibility.

SECTION 28. HSS 106.04(2)(b)10 and 11 are repealed.

SECTION 29. HSS 106.04(7)(f) is created to read:

HSS 106.04(7)(f) Date of service of notice. 1. The date of service of the written notice required under par. (b) or the date of a remittance issued by the

department under par. (c) shall be the date on which the provider receives the notice. The notice shall be conclusively presumed to have been received within 5 days after evidence of mailing.

2. The date of service of a provider's request for a hearing under par. (d) or (e) shall be the date on which the department's office of administrative hearings receives the request.

Note: Hearing requests should be sent to the Office of Administrative Hearings, P.O. Box 7875, Madison, Wisconsin 53707.

SECTION 30. HSS 106.07(2) is amended to read:

HSS 106.07(2) MEDICARE OR OTHER STATE MEDICAL ASSISTANCE SANCTIONS. Notwithstanding any other provision in this chapter, a party identified in this chapter who is suspended, excluded or terminated under the medicare program or under the medical assistance program of another state shall be barred from participation as a provider during the term of the suspension, exclusion or termination. If the suspension is based solely on action taken by the medicare program, the department shall automatically reinstate the provider, effective on the date of reinstatement in the medicare program, whenever the department is notified by the U.S. office of the inspector general that the provider has been reinstated in the medicare program.

SECTION 31. HSS 106.075 is repealed and recreated to read:

HSS 106.075 DEPARTMENT DISCRETION TO PURSUE MONETARY RECOVERY.

(1) Nothing in this chapter shall preclude the department from pursuing monetary recovery from a provider at the same time action is initiated to impose sanctions provided for under this chapter.

(2) The department may pursue monetary recovery from a provider of case management services when an audit adjustment or disallowance has been attributed to the provider by the federal health care financing administration or the department. The provider shall be liable for the entire amount. However, no fiscal sanction under this subsection shall be taken against a provider unless it is based on a specific policy which was:

(a) In effect during the time period being audited; and

(b) Communicated to the provider in writing by the department or the federal health care financing administration prior to the time period audited.

SECTION 32. HSS 106.08(1) is repealed.

SECTION 33. HSS 106.08(2) is renumbered HSS 106.08.

SECTION 34. HSS 106.10(1)(c) and (4)(b) are amended to read:

HSS 106.10(1)(c) Any action or inaction for which due process is otherwise required ~~by law~~ under s. 227.42, Stats.

(4)(b) For requests for hearings on actions or intended actions by the department, be served within ~~20~~ 15 days of the date of service of the department's notice of intended action or notice of action;

SECTION 35. HSS 106.10(5)(a) and (b) are repealed and recreated to read:

HSS 106.10(5) PRIOR HEARING REQUIREMENT: EXCEPTION (a) Except as provided under par. (b), if no request for a hearing is timely filed, no action described in sub. (1)(a) or (b) may be taken by the department until 15 days after the notice of intended action has been served. Except as provided under par. (b),

if a request for a hearing has been timely filed, no action described in sub. (1)(a) or (b) may be taken by the department until the hearing examiner issues a final decision.

(b) Actions described under sub. (1)(a) or (b) may be taken against a provider 15 days after service of the notice of intended action and without a prior hearing when the action is initiated by the department under s. HSS 106.06(4), (5), (6), (8) or (28). If the provider prevails at the hearing, the provider shall be reinstated retroactive to the date of decertification or suspension.

SECTION 36. HSS 106.10(5)(c) is repealed.

SECTION 37. HSS 106.10(8) is created to read:

HSS 106.10(8) DATES OF SERVICE. The date of service of a written notice required under sub. (3) shall be the date on which the provider receives the notice. The notice shall be conclusively presumed to have been received within 5 days after evidence of mailing. The date of service of a request for hearing under sub. (4) shall be the date on which the office of administrative hearings receives the request.

SECTION 38. HSS 107.01(1) is amended to read:

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

provide case management services as defined in s. HSS 107.32 to eligible recipients.

SECTION 39. HSS 107.02(1)is repealed and recreated to read:

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

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

SECTION 40. HSS 107.02(4)(c)12 and 13 are amended to read:

HSS 107.02(4)(c)12. Outpatient psychotherapy services received over 15 hours or $500 in equivalent care, whichever comes first, during one calendar year; ~~or~~

13. Occupational, physical or speech therapy services received over 30 hours or $1,500 ~~for any one therapy~~ in equivalent care for any one therapy, whichever comes first, during one calendar year; or

SECTION 41. HSS 107.06(2)(cm) is created to read:

HSS 107.06(2)(cm) Temporomandibular joint surgery when performed by a physician who meets the specific qualifications established by the department in a provider bulletin for this type of surgery. The prior authorization request

shall include documentation of all prior treatment of the recipient for the condition and evidence of necessity for the surgery.

SECTION 42. HSS 107.06(4)(h) and (5)y is created to read:

(4)(h) Temporomandibular joint surgery is a covered service only when performed after all necessary non-surgical medical or dental treatment has been provided by a multidisciplinary temporomandibular joint evaluation program or clinic approved by the department, and that treatment has been determined unsuccessful.

(5)(y) All non-surgical medical or dental treatment for a temporomandibular joint condition.

SECTION 43. HSS 107.06(4)(a)3 is amended to read:

HSS 107.06(4)(a)3 Prescriptions for specialized transportation services for a recipient not ~~confined to a wheelchair~~ declared legally blind or not determined to be permanently disabled shall include an explanation of the reason the recipient is unable to travel in a private automobile, or a taxicab, bus or other common carrier. The prescription shall specify the length of time for which the recipient shall require the specialized transportation, but shall not exceed 90 days.

SECTION 44. HSS 107.07(1)(i)10 and (2)(c)9e and f are amended to read:

HSS 107.07(1)(i)10 Reduction of dislocation and management of ~~other~~ temporomandibular joint dysfunctions; and

(2)(c)9e Osteoplasty for orthognathic deformity if the case is an EPSDT referral; ~~and~~

f. Frenulectomy if the case is an EPSDT referral; and

SECTION 45. HSS 107.07(2)(c)9g and (3)(q) are created to read:

HSS 107.07(2)(c)9g Temporomandibular joint surgery when performed by a dentist who meets the specific qualifications established by the department in a provider bulletin for this type of surgery. The prior authorization request shall include documentation of all prior treatment of the recipient for the condition and evidence of necessity for the surgery.

(3)(q) Temporomandibular joint surgery is a covered service only when performed after all necessary non-surgical medical or dental treatment has been provided by a multidisciplinary temporomandibular joint evaluation program or clinic approved by the department, and that treatment has been determined unsuccessful.

SECTION 46. HSS 107.07(4)(q) is repealed and recreated to read:

HSS 107.07(4)(q) All non-surgical medical or dental treatment for a temporomandibular joint condition.

SECTION 47. HSS 107.08(4)(e) and (f) are amended to read:

HSS 107.08(4)(e) Hospital admissions on Friday or Saturday, except for emergencies, accident care and obstetrical cases, unless the hospital can demonstrate to the satisfaction of the department that the hospital provides all of its services 7 days a week; ~~and~~

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

SECTION 48. HSS 107.08(4)(g) is created to read:

HSS 107.08(4)(g) Inpatient services for recipients between the ages of 21 and 64 when provided by a psychiatric hospital or an institution for mental disease, except that services may be provided to a 21 year old resident of a psychiatric hospital or an IMD if the person was a resident of one of those institutions immediately prior to turning 21, and continuously thereafter.

SECTION 49. HSS 107.09(1) to (4) are renumbered HSS 107.09(2) to (5).

SECTION 50. HSS 107.09(1) is created to read:

HSS 107.09(1) DEFINITION. In this section, "active treatment" means an ongoing, organized effort to help each resident attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

SECTION 51. HSS 107.09(4)(g)2, as renumbered, is amended to read:

HSS 107.09(4)(g)2. Intermediate care services may include services provided in an institution for ~~mentally retarded~~ developmentally disabled persons ~~or persons with related conditions~~ if:

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

b. The institution meets the standards in s. HSS 105.12; and

c. The ~~mentally retarded~~ developmentally disabled recipient for whom payment is requested is receiving active treatment ~~defined as an ongoing, organized effort to fulfill each resident's developmental capacity through regular participation, in accordance with an individual plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable~~ and meeting the requirements of 42 CFR 442.445 and 442.464, s. HSS 132.695 and ch. HSS 134.

SECTION 52. HSS 107.09(4)(u) is created to read:

HSS 107.09(4)(u) All developmentally disabled residents of SNF or ICF certified facilities who require active treatment shall receive active treatment subject to the requirements of s. HSS 132.695.

SECTION 53. HSS 107.09(5)(b) and (c), as renumbered, are amended to read:

HSS 107.09(5)(b) For Christian Science sanatoria, custodial care and rest and study; ~~and~~

(c) Inpatient nursing care for ICF personal care and ICF residential care to residents who entered a nursing home after September 30, 1981~~.~~; and

SECTION 54. HSS 107.09(5)(d) and (e) are created to read:

HSS 107.09(5)(d) ICF-level services provided to a developmentally disabled person admitted after September 15, 1986, to an ICF facility other than to a facility certified under s. HSS 105.12 as an intermediate care facility for the mentally retarded unless the provisions of s. HSS 132.51(2)(d)1 have been waived for that person; and

(e) Inpatient services for residents between the ages of 21 and 64 when provided by an institution for mental disease, except that services may be provided to a 21 year old resident of an IMD if the person was a resident of the IMD immediately prior to turning 21 and continues to be a resident after turning 21.

SECTION 55. HSS 107.10(3)(h) is amended to read:

HSS 107.10(3)(h) To be included as a covered service, an over-the-counter drug shall be used in the treatment of a diagnosable condition and be a rational part of an accepted medical treatment plan. Only the following general categories of over-the-counter drugs are covered:

1. Antacids;
2. Analgesics;
3. Insulins; ~~and~~
4. Contraceptives~~.~~;
5. Cough preparations; and
6. Opthalmic lubricants.

SECTION 56. HSS 107.13(1)(f)8 is amended to read:

HSS 107.13(1)(f)8 Inpatient ~~psychiatric~~ services for recipients between the ages of 21 and 64 when provided by a psychiatric hospital or an institution for mental disease, except that services may be provided to a 21 year old resident of a psychiatric hospital or IMD if the person was a resident of one of those institutions immediately prior to turning 21 and continues to be a resident after turning 21.

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

SECTION 57. HSS 107.18(1)(a), (b)(intro.) and (c)(intro.), (2)(b), (d), (e), and (h) and (4)(a) are amended to read:

HSS 107.18 SPEECH AND LANGUAGE PATHOLOGY SERVICES. (1) COVERED SERVICES. (a) General. Covered speech and language pathology services are those medically necessary diagnostic, screening, preventive or corrective speech and language pathology services prescribed by a physician and provided by a certified speech and language pathologist or under the direct, immediate on-premises supervision of a certified speech and language pathologist.

(b) Evaluation procedures. Evaluation or reevaluation procedures shall be performed by certified speech and language pathologists. Tests and measurements that speech and language pathologists may perform include the following:

(c) Speech procedure treatments. The following speech procedure treatments shall be performed by a certified speech and language pathologist or under the direct, immediate, on-premises supervision of a certified speech and language pathologist:

(2)(b) Requirement. Prior authorization is required under this subsection for speech and language pathology services provided to an MA recipient in excess of 45 treatment days per spell of illness, except that speech and language pathology services provided to an MA recipient who is a hospital inpatient or who is receiving speech therapy services provided by a home health agency are not subject to prior authorization under this subsection.

(d) Onset and termination of spell of illness. The spell of illness begins with the first day of treatment or evaluation following the onset of the new

disease, injury or medical condition or increased severity of a pre-existing medical condition and ends when the recipient improves so that treatment by a speech and language pathologist for the condition causing the spell of illness is no longer required, or after 45 treatment days, whichever comes first.

(e) Documentation. The speech and language pathologist shall document the spell of illness in the patient plan of care, including measurable evidence that the recipient has incurred a demonstrated functional loss of ability to perform daily living skills.

(h) Department expertise. The department may have on its staff qualified speech and language pathologists to develop prior authorization criteria and perform other consultative activities.

(4)(a) Services which are of questionable therapeutic value in a program of speech and language pathology. For example, charges by speech and language pathology providers for "language development--facial physical," "voice therapy--facial physical" or "appropriate outlets for reducing stress";

SECTION 58. HSS 107.23(1)(c) and (4)(f) are amended to read:

HSS 107.23(1)(c) Transportation by non-emergency vehicle. Specialized medical vehicle (SMV) transportation shall be a covered service if the recipient is ~~confined to a wheelchair~~ legally blind or permanently disabled as documented by a physician with the documentation maintained by the provider, or if the recipient's condition contraindicates transportation by a common carrier and the recipient's physician has prescribed specialized medical vehicle transportation. This type of transportation service, and the return trip, is covered only if the transportation is to a facility at which the recipient primarily receives

MA-covered medical services. SMV trips by cot or stretcher are covered if they have been prescribed by a physician and meet the prescription requirements of s. HSS 107.06(4)(a)3. In this paragraph, ~~"confined to a wheelchair means permanently confined to a wheelchair due to a chronic debilitating physical or mental condition~~ "permanent disability" means a chronic debilitating physical or mental impairment which includes an inability to ambulate without personal assistance or requires the use of mechanical walking aids such as a wheelchair, a walker or crutches.

(4)(f) Specialized medical vehicle transportation of ambulatory recipients. When the recipient ~~is not confined to a wheelchair~~ has not been declared legally blind or has not been determined to be permanently disabled by a physician, a physician's prescription for SMV transportation stating the specific medical problem preventing the use of public- carrier transportation and the specific period of time the service should be provided, shall be obtained. A check-off form is not acceptable. This prescription shall be obtained prior to the transport and shall be valid for a maximum of 90 days from the physician's signature date. The provider shall indicate on the claim form that a prescription is on file with the provider, and shall indicate the name and provider number of the prescribing physician.

SECTION 59. HSS 107.31, 107.32 and 107.33 are created to read:

HSS 107.31 HOSPICE CARE SERVICES. (1) DEFINITIONS. (a) "Attending physician" means a physician who is a doctor of medicine or osteopathy certified under s. HSS 105.05 and identified by the recipient as having the most significant role in the determination and delivery of his or her medical care at the time the recipient elects to receive hospice care.

(b) "Bereavement counseling" means counseling services provided to the recipient's family following the recipient's death.

(c) "Freestanding hospice" means a hospice that is not a physical part of any other type of certified provider.

(d) "Interdisciplinary group" means a group of persons designated by a hospice to provide or supervise care and services and made up of at least a physician, a registered nurse, a medical worker and a pastoral counselor or other counselor, all of whom are employes of the hospice.

(e) "Medical director" means a physician who is an employe of the hospice and is responsible for the medical component of the hospice's patient care program.

(f) "Respite care" means services provided by a residential facility that is an alternate place for a terminally ill recipient to stay to temporarily relieve persons caring for the recipient in the recipient's home or caregiver's home from that care.

(g) "Supportive care" means services provided to the family and other individuals caring for a terminally ill person to meet their psychological, social and spiritual needs during the final stages of the terminal illness, and during dying and bereavement, including personal adjustment counseling, financial counseling, respite care and bereavement counseling and follow-up.

(h) "Terminally ill" means that the medical prognosis for the recipient is that he or she is likely to remain alive for no more than 6 months.

(2) COVERED SERVICES. (a) General. Hospice services covered by the MA program effective July 1, 1988 are, except as otherwise limited in this chapter, those services provided to an eligible recipient by a provider certified under s. HSS 105.50 which are necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided

to the family and other individuals caring for the terminally ill recipient. Hospice services shall be provided only to those medical assistance recipients residing in a skilled nursing or intermediate care facility who are entitled, under medicare, to receive hospice care.

(b) Conditions for coverage. Conditions for coverage of hospice services are:

1. Written certification by the hospice medical director, the physician member of the interdisciplinary team or the recipient's attending physician that the recipient is terminally ill;

2. An election statement shall be filed with the hospice by a recipient who has been certified as terminally ill under subd. 1 and who elects to receive hospice care. The election statement shall designate the effective date of the election. A recipient who files an election statement waives any MA covered services pertaining to his or her terminal illness and related conditions otherwise provided under this chapter, except those services provided by an attending physician not employed by the hospice. However, the recipient may revoke the election of hospice care at any time and thereby have all MA services reinstated. A recipient may choose to reinstate hospice care services subsequent to revocation. In that event, the requirements of this section again apply;

3. A written plan of care shall be established by the attending physician, the medical director or physician designee and the interdisciplinary team for a recipient who elects to receive hospice service prior to care being provided. The plan shall include:

a. An assessment of the needs of the recipient;

b. The identification of services to be provided, including management of discomfort and symptom relief;

c. A description of the scope and frequency of services to the recipient and the recipient's family; and

d. A schedule for periodic review and updating of the plan; and

4. A statement of informed consent. The hospice shall obtain the written consent of the recipient or recipient's representative for hospice care on a consent form signed by the recipient or recipient's representative that indicates that the recipient is informed about the type of care and services that may be provided to him or her by the hospice during the course of illness and the effect of the recipient's waiver of regular MA benefits.

(c) Core services. The following services are core services which shall be provided directly by hospice employes unless the conditions of sub. (3) apply:

1. Nursing care by or under the supervision of a registered nurse;

2. Physician services;

3. Medical social services provided by a social worker under the direction of a physician. The social worker shall have at least a bachelor's degree in social work from a college or university accredited by the council of social work education;

4. Counseling services, including but not limited to bereavement counseling, dietary counseling and spiritual counseling.

(d) Other services. Other services which shall be provided as necessary are:

1. Physical therapy;

2. Occupational therapy;

3. Speech pathology;

4. Home health aide and homemaker services;

5. Durable medical equipment and supplies;

6. Drugs; and

7. Short-term inpatient care for pain control, symptom management and respite purposes.

(3) OTHER LIMITATIONS. (a) Short-term inpatient care. 1. General inpatient care necessary for pain control and symptom management shall be provided by a hospital or skilled nursing facility certified under this chapter.

2. Inpatient care for respite purposes shall be provided by a facility under subd. 1 or by an intermediate care facility which meets the additional certification requirements regarding staffing, patient areas and 24 hour nursing service for skilled nursing facilities under subd. 1. An inpatient stay for respite care may not exceed 5 consecutive days at a time.

3. Use of inpatient care for a recipient may not exceed 20% of the total number of hospice care days of all MA recipients enrolled in the recipient's hospice.

(b) Care during periods of crisis. Care may be provided 24 hours a day during a period of crisis as long as the care is predominately nursing care provided by a registered nurse. Other care may be provided by a home health aide or homemaker during this period. "Period of crisis" means a period during which an individual requires continuous care to achieve palliation or management of acute medical symptoms.

(c) Sub-contracting for services. 1. Services required under sub. (2)(c) shall be provided directly by the hospice unless an emergency or extraordinary circumstance exists.

2. A hospice may contract for services required under sub. (2)(d). The contract shall include identification of services to be provided, the qualifications of the contractor's personnel, the role and responsibility of

each party and a stipulation that all services provided will be in accordance with applicable state and federal statutes, rules and regulations and will conform to accepted standards of professional practice.

3. When a resident of a skilled nursing facility or an intermediate care facility elects to receive hospice care services, the hospice shall contract with that facility to provide the recipient's room and board. Room and board includes assistance in activities of daily living and personal care, socializing activities, administration of medications, maintaining cleanliness of the recipient's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

(d) Reimbursement for services. 1. The hospice shall be reimbursed for care of a recipient at per diem rates set by the department. A maximum amount shall be established by the department for care of a recipient, to be applied to all recipients participating in the hospice's program.

2. The hospice shall reimburse any provider with whom it has contracted for service, including a facility providing inpatient care under par. (a).

3. Skilled nursing facilities and intermediate care facilities providing room and board for residents who have elected to receive hospice care services shall be reimbursed for that room and board by the hospice.

4. Bereavement counseling and services and expenses of hospice volunteers are not reimbursable under MA.

HSS 107.32 CASE MANAGEMENT SERVICES. (1) COVERED SERVICES. (a) General. 1. Case management services covered by MA are services described in this section and provided by an agency certified under s. HSS 105.51 or by a qualified person under contract to an agency certified under s. HSS 105.51 to help a recipient,

and, when appropriate, the recipient's family gain access to, coordinate or monitor necessary medical, social, educational, vocational and other services.

2. Case management services under pars. (b) and (c) are provided under s. 49.45(25), Stats., as benefits to those recipients in a county in which case management services are provided who are over age 64, are diagnosed as having Alzheimer's disease or other dementia, or are members of one or more of the following target populations: developmentally disabled, chronically mentally ill who are age 21 or older, alcoholic or drug dependent, physically or sensory disabled, or under the age of 21 and severely emotionally disturbed. In this subdivision, "severely emotionally disturbed" means having emotional and behavioral problems which:

a. Are expected to persist for at least one year;

b. Have significantly impaired the person's functioning for 6 months or more and, without treatment, are likely to continue for a year or more. Areas of functioning include: developmentally appropriate self-care; ability to build or maintain satisfactory relationships with peers and adults; self-direction, including behavioral controls, decisionmaking, judgment and value systems; capacity to live in a family or family equivalent; and learning ability, or meeting the definition of "child with exceptional educational needs" under ch. PI 11 and 115.76(3), Stats.;

c. Require the person to receive services from 2 or more of the following service systems: mental health, social services, child protective services, juvenile justice and special education; and

d. Include mental or emotional disturbances diagnosable under DSM-III-R. Adult diagnostic categories appropriate for children and adolescents are organic mental disorders, psychoactive substance use disorders, schizophrenia, mood

disorders, schizophreniform disorders, somatoform disorders, sexual disorders, adjustment disorder, personality disorders and psychological factors affecting physical condition. Disorders usually first evident in infancy, childhood and adolescence include pervasive developmental disorders (Axis II), conduct disorder, anxiety disorders of childhood or adolescence and tic disorders.

Note: DSM-111-R is the 1987 revision of the 3rd edition (1980) of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

3. Case management services under par. (d) are available as benefits to a recipient identified in subd. 2 if:

a. The recipient is eligible for and receiving services in addition to case management from an agency or through medical assistance which enable the recipient to live in a community setting; and

b. The agency has a completed case plan on file for the recipient.

4. The standards specified in s. 46.27, Stats., for assessments, case planning and ongoing monitoring and service coordination shall apply to all covered case management services.

(b) Case assessment. A comprehensive assessment of a recipient's abilities, deficits and needs is a covered case management service. The assessment shall be made by a qualified employe of the certified case management agency or by a qualified employe of an agency under contract to the case management agency. The assessment shall be completed in writing and shall include face-to-face contact with the recipient. Persons performing assessments shall possess skills and knowledge of the needs and dysfunctions of the specific target population in which the recipient is included. Persons from other relevant disciplines shall be included when results of the assessment are interpreted. The assessment shall document gaps in service and the recipient's unmet needs, to enable the case management provider to act as an advocate for the recipient and assist

other human service providers in planning and program development on the recipient's behalf. All services which are appropriate to the recipient's needs shall be identified in the assessment, regardless of availability or accessibility of providers or their ability to provide the needed service. The written assessment of a recipient shall include:

1. Identifying information;

2. A record of any physical or dental health assessments and consideration of any potential for rehabilitation;

3. A record of the multi-disciplinary team evaluation required for a recipient who is a severely emotionally disturbed child under s. 49.45(25);

4. A review of the recipient's performance in carrying out activities of daily living, including moving about, caring for self, doing household chores and conducting personal business, and the amount of assistance required;

5. Social status and skills;

6. Psychiatric symptomatology, and mental and emotional status;

7. Identification of social relationships and support, as follows:

a. Informal caregivers, such as family, friends and volunteers; and

b. Formal service providers;

8. Significant issues in the recipient's relationships and social environment;

9. A description of the recipient's physical environment, especially in regard to safety and mobility in the home and accessibility;

10. The recipient's need for housing, residential support, adaptive equipment and assistance with decision-making;

11. An in-depth financial resource analysis, including identification of insurance, veterans' benefits and other sources of financial and similar assistance;

12. If appropriate, vocational and educational status, including prognosis for employment, rehabilitation, educational and vocational needs, and the availability and appropriateness of educational, rehabilitation and vocational programs;

13. If appropriate, legal status, including whether there is a guardian and any other involvement with the legal system;

14. Accessibility to community resources which the recipient needs or wants; and

15. Assessment of drug and alcohol use and misuse, for AODA target population recipients.

(c) Case planning. Following the assessment with its determination of need for case management services, a written plan of care shall be developed to address the needs of the recipient. Development of the written plan of care is a covered case management service. To the maximum extent possible, the development of a care plan shall be a collaborative process involving the recipient, the family or other supportive persons and the case management provider. The plan of care shall be a negotiated agreement on the short and long term goals of care and shall include:

1. Problems identified during the assessment;

2. Goals to be achieved;

3. Identification of all formal services to be arranged for the recipient and their costs and the names of the service providers;

4. Development of a support system, including a description of the recipient's informal support system;

5. Identification of individuals who participated in development of the plan of care;

6. Schedules of initiation and frequency of the various services to be made available to the recipient; and

7. Documentation of unmet needs and gaps in service.

(d) Ongoing monitoring and service coordination. Ongoing monitoring of services and service coordination are covered case management services when performed by a single and identifiable employe of the agency or person under contract to the agency who meets the requirements under s. HSS 105.51(2)(b). This person, the case manager, shall monitor services to ensure that quality service is being provided and shall evaluate whether a particular service is effectively meeting the client's needs. Where possible, the case manager shall periodically observe the actual delivery of services and periodically have the recipient evaluate the quality, relevancy and desirability of the services he or she is receiving. The case manager shall record all monitoring and quality assurance activities and place the original copies of these records in the recipient's file. Ongoing monitoring of services and service coordination includes:

1. Face to face and phone contacts with recipients for the purpose of assessing or reassessing their needs or planning or monitoring services. Included in this activity are travel time to see a recipient and other allowable overhead costs that must be incurred to provide the service;

2. Face to face and phone contact with collaterals for the purposes of mobilizing services and support, advocating on behalf of a specific eligible recipient, educating collaterals on client needs and the goals and services specified in the plan, and coordinating services specified in the plan. In this paragraph, "collateral" means anyone involved with the recipient, including a paid provider, a family member, a guardian, a housemate, a school

representative, a friend or a volunteer. Collateral contacts also include case management staff time spent on case-specific staffings and formal case consultation with a unit supervisor and other professionals regarding the needs of a specific recipient. All contacts with collaterals shall be documented and may include travel time and other allowable overhead costs that must be incurred to provide the service; and

3. Recordkeeping necessary for case planning, service implementation, coordination and monitoring. This includes preparing court reports, updating case plans, making notes about case activity in the client file, preparing and responding to correspondence with clients and collaterals, gathering data and preparing application forms for community programs, and reports. All time spent on recordkeeping activities shall be documented in the case record. A provider, however, may not bill for recordkeeping activities if there was no client or collateral contact during the billable month.

(2) OTHER LIMITATIONS. (a) Reimbursement for assessment and case plan development shall be limited to no more than one each for a recipient in a calendar year unless the recipient's county of residence has changed, in which case a second assessment or case plan may be reimbursed.

(b) Reimbursement for ongoing monitoring and service coordination shall be limited to one claim for each recipient by county per month and shall be only for the services of the recipient's designated case manager.

(c) Ongoing monitoring or service coordination is not available to recipients residing in hospitals, intermediate care or skilled nursing facilities. In these facilities, case management is expected to be provided as part of that facility's reimbursement.

(d) Case management services are not reimbursable when rendered to a recipient who, on the date of service, is enrolled in a health maintenance organization under s. HSS 107.28.

(e) Persons who require institutional care and who receive services beyond those available under the MA state plan but which are funded by MA under a federal waiver are ineligible for case management services under this section. Case management services for these persons shall be reimbursed as part of the regular per diem available under federal waivers and included as part of the waiver fiscal report.

(f) A recipient receiving case management services, or the recipient's parents, if the recipient is a minor child, or guardian, if the recipient has been judged incompetent by a court, may choose a case manager to perform ongoing monitoring and service coordination, and may change case managers, subject to the case manager's or agency's capacity to provide services under this section.

(3) NON-COVERED SERVICES. Services not covered as case management services or included in the calculation of overhead charges are any services which:

a. Involve provision of diagnosis, treatment or other direct services, including:

1. Diagnosis of a physical or mental illness;

2. Monitoring of clinical symptoms;

3. Administration of medications;

4. Client education and training;

5. Legal advocacy by an attorney or paralegal;

6. Provision of supportive home care;

7. Home health care;

8. Personal care; and

9. Any other professional service which is a covered service under this chapter and which is provided by an MA certified or certifiable provider, including time spent in a staffing or case conference for the purpose of case management; or

b. Involve information and referral services which are not based on a plan of care.

HSS 107.33 AMBULATORY PRENATAL SERVICES FOR RECIPIENTS WITH PRESUMPTIVE ELIGIBILITY. (1) COVERED SERVICES. Ambulatory prenatal care services are covered services. These services include treatment of conditions or complications that are caused by, exist or are exacerbated by a pregnant woman's pregnant condition.

(2) PRIOR AUTHORIZATION. An ambulatory prenatal service may be subject to a prior authorization requirement, when appropriate, as described in this chapter.

(3) OTHER LIMITATIONS. (a) Ambulatory prenatal services shall be reimbursed only if the recipient has been determined to have presumptive MA eligibility under s. 49.465, Stats., by a qualified provider under s. HSS 103.11.

(b) Services under this section shall be provided by a provider certified under ch. HSS 105.

The rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.22(2), Stats., except that sections 17 to 22 of this order shall take effect on July 1, 1988.

WISCONSIN DEPARTMENT OF HEALTH
AND SOCIAL SERVICES

Date: December 30, 1987

By: _____
Timothy F. Cullen, Secretary

Seal:

The rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.22(2), Stats., except that sections 17 to 22 of this order shall take effect on July 1, 1988.

WISCONSIN DEPARTMENT OF HEALTH
AND SOCIAL SERVICES

Date: December 30, 1987

By: Tim Cullen
Timothy F. Cullen, Secretary

Seal:

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES
1 West Wilson Street, Madison, Wisconsin 53702

Tommy G. Thompson
Governor

Timothy F. Cullen
Secretary

Mailing Address:
Post Office Box 7850
Madison, WI 53707

December 30, 1987

Mr. Orlan Prestegard
Revisor of Statutes
7th Floor - 30 on the Square
Madison, Wisconsin 53702

Dear Mr. Prestegard:

As provided in s. 227.20, Stats., there is hereby submitted a certified copy of HSS 101 and 103 to 107, administrative rules relating to the Medical Assistance Program.

These rules are also being submitted to the Secretary of State as required by s. 227.20, Stats.

Sincerely,

Timothy F. Cullen
SECRETARY

Enclosure