Chapter HSS 107

COVERED SERVICES

HSS 107.01 General statement of coverage. Pursuant to s. 49.45 (1), 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.02 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 dispended 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 HSS 107.07 (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 s. 49.65, 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 IS 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 deliquent act), inmate status is interrupted if the child becomes an inpatient in a medical facility.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.03 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 s. 150.02, 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 s. 150.45, Stats., effective at the time specified in 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 s. 51.20 (10), Stats., except that this provision shall not prevent a recipient from using medical assistance benefits as a means of exercising rights under s. 51.20 (10), 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 s. 972.15, Stats.

(12) Physical or psychiatric examinations ordered by a juvenile court for purposes of disposition of a case, pursuant to s. 48.24, Stats.

(13) Consultations between or among providers, except as specified in HSS 107.06 (3).

Cr. 107.035 eff. 8/21/82

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

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

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.05 Coverage of emergency services provided by a person not a certified provider. Emergency services necessary to prevent the death or serious impairment of the health of a recipient 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 HSS 105.05. The appropriate consultant(s) to the department shall determine whether a service was an emergency service.

HSS 107.06 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 s. 448.01 (9), 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 HSS 107.02 (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 metabolic rate (BMR).

(z) Protein bound iodine (PBI).

(za) Ballistocardiogram.

(zb) Icterus index.

(zc) Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study.

(zd) Angiocardiography, utilizing C02 method, supervision and interpretation only.

(ze) Angiocardiography—single plane, supervision and interpretation in conjunction with cineradiography or—multi-plan, supervision and interpretation in conjunction with cineradiography.

(zf) Angiography—coronary, unilateral selective injection supervision and interpretation only, single view unless emergency.

(zg) Angiography—extremity, unilateral, supervision and interpretation only, single view unless emergency.

(zh) Fabric wrapping of abdominal aneurysm.

(zi) Extra-intra cranial arterial bypass for stroke.

(zj) Reversal of tubal ligation or vasectomy.

(zk) *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) (zk) 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 individual is not covered.* Sterilization of a mentally incompetent or institutionalized individual is not covered.

3. *Sterilization by hysterectomy.* a. A hysteretomy 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 indivudal 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) (zk) 1.d.

b. Suitable arrangements were made to insure that the information specified in HSS 107.06 (3) (zk) 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) (zk) 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 indivudal'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 instruction 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 7.12 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 tranportation. One copy of the prescription shall be sent to the fiscal agent where it shall be kept on file; one copy shall be kep on file with the tranportation 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 calendar year per recipient shall be covered.

(h) Abortions performed which do not comply with s. 20.927, 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.07 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 s. 447.02, 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 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 fistual 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/extraoral;

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 section HSS 107.02(3).

(a) The department may require prior authorization for covered dental services, where necessary to meet the program objectives stated in section HSS 107.02(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 HSS 107.02(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 HSS 107.02(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 6 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. Orthodontics are covered as required by federal regulation or, if necessary to prevent acute dental problems or irreversible damage to teeth or supporting structures.

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 HSS 107.03 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;

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.08 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 HSS 107.06 (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 HSS 107.06 (2) (zk) 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 Costridium 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 Carcinoma
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 HSS 107.03 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

Note: The former Wis. Adm. Code chapter PW-MA 27 is repealed and recreated in this section.

HSS 107.09 Nursing home services. (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 s. 49.45 (6m) (a), 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.

Note: For more information on prior authorization, see HSS 107.02 (3). The following services require prior authorization of the department:

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (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 HSS 107.24.

(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 HSS 107.09 (1) (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 s. 49.45 (6m) (b), 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 HSS 107.09 (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 extend 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 5 days a week. Accordingly, where a facility provides physical therapy on only 5 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 sub. (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 3 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; 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 HSS 107.03 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.10 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 s. 448.04, Stats., by a dentist licensed pursuant to s. 447.05, Stats., or by a podiatrist licensed pursuant to s. 448.04, 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) SERVICE REQUIRING PRIOR AUTHORIZATION.

Note: For more information on prior authorization see HSS 107.02 (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 5 refills, or 6 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 HSS 107.09 (3).

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

1. Laxatives.

2. Antacids.

3. Analgesics.

4. Insulins.

5. Minerals and vitamins.

6. Antibiotics—Topical.

7. Antidiarrheals.

8. Hemorrhoidal products.

9. Certain cold and allergy products (e.g., nasal sprays, cough syrups, etc.).

10. Asthma products.

11. Contraceptives.

12. Ophthalmic products (e.g., eye washes, artificial tears).

(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 sub. (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. antisepticcs, bandaids).

(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 nursing home regardless of the person's residing in the home.

(k) Over-the-counter drugs not specified in the Drug Index and not included in the categories in subsection (3) above, and legend drugs not included in the Drug Index maintained by the department.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.11 Nursing, home health care, and personal care services. (1) COVERED SERVICES. (a) Services provided by an agency certified under HSS 105.16. Services provided by an agency certified under HSS 105.16 which are covered by the medical assistance program are part-time or intermittent nursing, home health aide, and personal care 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 s. 441.11 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.

(c) *Services provided by personal care workers.* Personal care services may include:

1. 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);

2. Household services related to keeping a comfortable and healthy 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

3. 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 HSS 107.02(3).

Prior authorization shall be required for:

(a) Long-term private duty nursing services provided in a recipient's place of residence.

(b) Personal care services in excess of 30 hours in any 12-month period.

(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.

(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.

(d) Personal care services may be provided only after an evaluation based on a functional assessment scale provided by the department, pursuant to HSS 105.16 (8) (c) 1.

(e) Personal care services shall be reported and billed as a separate service on Medicaid claim forms provided by the department.

(f) 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.

(g) 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.

(4) NON-COVERED SERVICES.

(a) Private duty nursing services provided in a nursing home are not covered by the medical assistance program.

(b) Medical social services are not a covered service.

(c) Christian Science nursing services are not covered.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.13 Mental health services. (1) INPATIENT PSYCHIATRIC SERVICES. (a) *Covered 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 HSS 105.09, or when provided by a JCAH-accredited psychiatric facility within the limitations enumerated below.

(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 certification; 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. Recertification 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 evaluation 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 though 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) *Other Limitations—Inpatient psychiatric services.*

1. 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 5 hours of such interviews shall be covered.

2. Psychotherapy is a covered service when provided to inpatients for whom the therapy is prescribed as a component of the plan of care.

(d) *Non-Covered Services—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.

(2) OUTPATIENT PSYCHOTHERAPY SERVICES. (a) *Covered services.* Outpatient psychotherapy services are covered services when prescribed by a physician and when provided by a provider who meets the requirements of section HSS 105.22, 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 HSS 105.22(1) (a) or (b), and who is:

i. Working in an outpatient facility defined under HSS 105.22(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 HSS 105.22(2) (a) (1), (2) or (3) who is:

i. Working in an outpatient facility defined in HSS 105.22(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.

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 or $500 per recipient 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) [(3)] 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. Likewise, if several psychotherapy providers are treating the same recipient during a 12-month period, all the psychotherapy shall be considered in the $500 or 15 hour total. If a recipient is hospitalized as an inpatient in an acute care general hospital with a diagnosis of, or for a procedure associated with, a psychiatric condition, reimbursement for any inpatient psychotherapy services will not be considered a concurrent part of the amount available for outpatient psychotherapy. 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.

(b) *Services Requiring Prior Authorization—Outpatient psychotherapy services.*

1. Reimbursement beyond 15 hours or $500 of service may be claimed for treatment services furnished after receipt of authorization by the department. Services reimbursed by any third party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified number of hours of 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 of 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.

(c) *Other Limitations—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 10 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 HSS 105.22 (3). Subsequent treatment may be provided if HSS 107.13 (1) (c) [(2)] 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 HSS 107.13 (3) (b) (2) [(2) (c) 2.]. Under no circumstances shall more than 2 providers be reimbursed for the same session.

(d) *Non-Covered Services—Outpatient psychotherapy services.*

1. Collateral interviews with persons not stipulated in HSS 107.12 (2) (c) and consultations are not covered services.

2. Court appearances or evaluations, except as noted in HSS 107.03 (10) are not covered services.

3. Psychotherapy is not a covered service for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention.

4. Psychotherapy provided in a person's home.

5. Self-referrals are not covered. For purposes of this section, a self-referral means a provider referring a recipient to an agency in which the

provider has a direct financial interest, or to himself or herself acting as a practitioner in private practice.

(3) ALCOHOL AND OTHER DRUG ABUSE SERVICES.

(a) Outpatient alcohol and drug abuse treatment services are covered when prescribed by a physician and when provided by a provider who meet the requirements of HSS 105.23, 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 $500 or 15 hours in a 12-month period may be reimbursed without prior authorization. The medical evaluation shall be covered as an additional item.

(b) *Services Requiring Prior Authorization—Outpatient Alcohol or Other Drug Abuse Treatment Services.*

1. Reimbursement beyond 15 hours or $500 of service may be claimed for treatment services furnished after receipt of authorization by the department. Services reimbursed by any third party payer shall be included when calculating the 15 hours or $500 of service.

2. The department may authorize reimbursement for a specified number of hours of 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 medical evaluation and performing AODA services.

b. The physician's original prescription for treatment.

c. A copy of the treatment plan which shall relate to the findings of the medical evaluation and specify behavior and personality changes being sought.

d. 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.

(c) *Non-Covered Services—Alcoholism/Drug Abuse Treatment.*

1. Court appearances or evaluations, except as noted in HSS 107.03 (10) are not covered services.

2. Collateral interviews and consultations are not covered services.

(4) DAY TREATMENT OR DAY HOSPITAL SERVICE. *Covered services.*

(a) 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 HSS 105.245, and when the following conditions are met:

1. The day treatment services are furnished 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 undergo an evaluation through the use of the functional assessment scale provided by the department, to determine the medical necessity for day treatment and the person's ability to benefit from it.

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

4. Reimbursement may be made without prior authorization from the department for up to 120 hours of day treatment service in a 12-month period which begins on the first date day treatment services are provided. Psychotherapy services or occupational therapy services provided as component parts of a person's day treatment package shall not be billed separately, but shall be billed and reimbursed as part of the day treatment program.

5. Day treatment or day hospital services provided to recipients with inpatient status in a hospital shall be limited to 20 hours per inpatient admission, and shall only be available to patients scheduled for discharge, to prepare them for discharge.

6. Reimbursement shall not be made for day treatment services provided in excess of 30 hours of treatment in any week.

7. Day treatment services are covered only for the chronically mentally ill and acutely mentally ill who have a need for day treatment, and an ability to benefit from the service, as measured by the functional assessment scale authorized by the department.

8. Billing for day treatment services shall be submitted by the 51.42 board. Reimbursement shall be at 90% of the rate established by the department. Day treatment services shall be billed as such, and not as psychotherapy, occupational therapy or any other modality.

(b) *Services Requiring Prior Authorization—Day Treatment or Day Hospital Services.*

1. Prior authorization is required for day treatment services provided beyond 120 hours of service in a 12-month period.

2. Prior authorization is required for all day treatment or day hospital services provided to recipients with inpatient status in a nursing home. Only those patients scheduled for discharge are eligible for day treatment. No more than 40 hours of service will be authorized in a 12-month period.

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.

(c) *Non-Covered Services—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 HSS 107.03 (10), are not covered services.

6. Day treatment is not covered for recipients with a primary diagnosis of mental retardation.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.14 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. Arteriosclerosis obliterans evidenced by claudication;

3. Peripheral neuropathies involving the feet, which are associated with:

a. malnutrition or vitamin deficiency;

b. carcinoma;

c. diabetes mellitus;

d. drugs and toxins;

e. multiple sclerosis;

f. uremia.

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.

(b) Initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring non-covered care.

(c) Physical medicine is a covered service but is limited to ultrasound and diathermy only for the following diagnoses:

1. symptomatic osteoarthritis.

2. tendonitis.

3. bursitis.

(d) 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.

(e) For mulutiple surgical procedures performed on the same day the podiatrist will be reimbursed as follows:

1. first procedure at 100%;

2. second procedure at 50%;

3. third procedure at 25%;

4. fourth procedure at 12.5%.

Additional surgical procedures performed on the same foot within 120 days of the original surgery will be paid at 50%. Post-operative care, office calls and dressings are considered part of the surgical fee.

(f) The administration of antibiotics is limited to LA, AP, or penicillin for the purpose of treating cellulitis or an acute "itis" associated with foot disease.

(g) Debridement of mycotic conditions and mycotic nails are a covered service per utilization guidelines established by the department of health and social services.

(h) The application of unna boots is allowed once per two weeks.

(3) NON-COVERED SERVICES. The following are non-covered services (in addition to HSS 107.03):

(a) Procedures which do not relate to the diagnosis or treatment of the ankle and foot are not covered.

(b) Palliative or maintenance care, except as enumerated in subsection (2) above.

(c) Orthopedic shoes and supportive devices such as arch supports, shoe inlays, and pads.

(d) Services directed toward the care and correction of "flat feet."

(e) Treatment of subluxation of the foot.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.15 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 HSS 105.26.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [Note: For more information on prior authorization, see HSS 107.02(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 HSS 107.15 (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 existence 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.16 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. Isokinetic evaluation;

7. Range of motion measure;

8. Length measurement;

9. Electrical testing:

a. Nerve conduction velocity;

b. Strength duration curve—chronaxie;

c. Reaction of degeneration;

d. Jolly test (twitch tetanus);

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 proceudres 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 HSS 107.02 (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 sclerois;

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: HSS 107.16 (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 HSS 107.03):

(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) (1-5), those services that can be performed by restorative nursing shall not be covered physical therapy services.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.17 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
Strength 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 Test
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. 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.

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

(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. Mulitple 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 authorizaton 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 (l) (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 HSS 107.16 (3) apply to occcupational therapy services.

(4) NON-COVERED SERVICES. The following services are not covered (in addition to HSS 107.03):

(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, s. H 32.11 (1) (d) 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; reprinted to correct error in (2) and (4) (b), Register, December, 1981, No. 312.

HSS 107.18 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 HSS 107.02 (3).] Prior authorizaton 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 HSS 107.16 (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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.19 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 HSS 105.31. 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 HSS 107.02 (3).] The following services require prior authorization from the department:

(a) Speech and audio therapy;

(b) Aural rehabiliation, 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 HSS 107.16 (3) apply for audiology services.

(4) NON-COVERED SERVICES. See S. HSS 107.03 for services which are not covered services.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.20 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 s. 449.01, Stats., and by physicians.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [Note: For more information on prior authorization, see HSS 107.02 (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 lense therapy, 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.21 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 inflammatory 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 prescription;

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 HSS 107.02 (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 HSS 107.06 (2) (zk) 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.22 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 adminstration 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 HSS 105.37 (1) and when performed and documented pursuant to HSS 105.37. 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 HSS 105.37 (3).

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.23 Transportation. (1) COVERED SERVICES. (a) Ambulance transportation shall be a covered service if the recipient is suffering from

an illness or injury which contraindicates tranportation 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 tranportation. This type of transportation service is covered only if the transportation is to a facility at which the recipient receives medical services.

(c) Transporation, 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 transportation 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 transporation 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 HSS 107.02 (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 HSS 107.23 (1) (c) of a recipient to an out-of-state provider, or to a Wisconsin provider if the round trip exceeds 100 miles, must be approved by the county social service department before departure. In either case, the county

agency may require a physician's documentation for the service received at the specific location.

(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 tranport 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 tranportation 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 ambulance 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.24 medical supplies and equipment. (1) COVERED SERVICES. The following are covered within the limitations of this section, when prescribed by a physician or other person eligible to prescribe such services [NOTE: These items may not be billed by hospitals or nursing homes, but only by certified providers of the special service.]:

(a) Medical supplies and devices.

(b) Basic and necessary durable medical equipment (e.g., standard wheelchairs, walkers, canes, crutches, hospital beds, bed rails, and mattresses, oxygen equipment and cylinders, braces, casts, home dialysis equipment).

(c) Corrective shoes, with the following frequency rates:

1. Three pair per/year (from original date of service) for children up to 15 years of age; and

2. 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.

(d) Hearing aids.

(e) Prosthetic and orthotic devices, when provided by either an orthotist or a prosthetist certified as a provider.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [NOTE: For more information on prior authorization, see subsection HSS 107.02 (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 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.

(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 HSS 107.24(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) The services covered under this section are not covered for recipients who are nursing home residents or who are inpatients in a hospital, 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.

(b) Hearing aid accessories, batteries and repairs do not require a physician's prescription.

(c) Only items in the following generic categories of medical supplies are covered:

1. Colostomy Appliances

2. Urostomy Appliances

3. Ostomy Appliances

4. Ileostomy Appliances

5. Catheters

6. Incontinence Equipment

7. Irrigation Apparatus

8. Head Halters

9. Parenteral Admin. Apparatus

10. Restraints

11. Support Stockings

12. Trusses

13. Urine Collection (external) Appliance

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

(a) Temporary breast prostheses.

(b) Medical supplies and devices not included in the categories listed in subsection (3) above, (e.g., heat lamps, hot water bottles, vaporizers, etc.), except when the provider documents to the satisfaction of the department's consultants, that the supply will prevent the recipient from being institutionalized, or that it is required to keep the recipient vocationally occupied, or both.

(c) Durable equipment such as but not limited to: waterbeds, air conditioners, seat lifts, medic-alerts, etc., except when the provider documents to the satisfaction of the department's consultants, that the equipment will prevent the recipient from being institutionalized, or that is required to keep the recipient vocationally occupied, or both.

(d) 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.

(e) Repair of rented durable medical equipment.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.25 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.

(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.

(d) Reimbursement for diagnostic testing services shall be in accordance with limitations set by federal regulation.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.26 Dialysis service. (1) COVERED SERVICES. Dialysis services are covered services when provided by facilities certified pursuant to section HSS 105.45 of this rule.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.27 Blood. (1) COVERED SERVICES. The provision of blood is a covered service when provided by a physician certified pursuant to section HSS 105.07; a blood bank certified pursuant to section HSS 105.46; or a hospital certified pursuant to section HSS 105.09 of this rule.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.28 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 107.29 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.