(g) *Other coverage.* Treatment days covered by medicare or other third-party insurance shall be included in computing the 35-day per spell of illness total.

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

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

(3) OTHER LIMITATIONS. (a) *Plan of care for therapy services.* Services shall be furnished to a recipient under a plan of care established and periodically reviewed by a physician. The plan shall be reduced to writing before treatment is begun, 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. The plan shall be promptly signed by the ordering physician and incorporated into the provider's permanent record for the recipient. The plan shall:

1. 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 or physician on the staff of the provider pursuant to the attending physician's oral orders; and

2. Be reviewed by the attending physician, in consultation with the therapist providing services, at whatever intervals the severity of the recipient's condition requires but at least every 90 days. Each review of the plan shall contain the initials of the physician and the date performed. The plan for the recipient shall be retained in the provider's file.

(b) *Restorative therapy services.* Restorative therapy services shall be covered services except as provided under sub. (4) (b).

(c) *Evaluations.* Evaluations shall be covered services. The need for an evaluation or re-evaluation shall be documented in the plan of care. Evaluations shall be counted toward the 35-day per spell of illness prior authorization threshold.

(d) *Maintenance therapy services.* Preventive or maintenance therapy services shall be covered services only when one or more of the following conditions are met:

1. The skills and training of a therapist are required to execute the entire preventive and maintenance program;

2. The specialized knowledge and judgment of a speech 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 re-evaluations required; or

3. When, due to the severity or complexity of the recipient's condition, nursing personnel cannot handle the recipient safely and effectively.

(e) *Extension of therapy services.* Extension of therapy services shall not be approved in any of the following circumstances:

1. The recipient has shown no progress toward meeting or maintaining established and measurable treatment goals over a 6-month period, or the recipient has shown no ability within 6 months to carry over abilities gained from treatment in a facility to the recipient's home;

2. The recipient's chronological or developmental age, way of life or home situation indicates that the stated therapy goals are not appropriate for the recipient or serve no functional or maintenance purpose;

3. The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel;

4. The evaluation indicates that the recipient's abilities are functional for the person's present way of life;

5. The recipient shows no motivation, interest, or desire to participate in therapy, which may be for reasons of an overriding severe emotional disturbance;

6. Other therapies are providing sufficient services to meet the recipient's functioning needs; or

7. The procedures requested are not medical in nature or are not covered services. Inappropriate diagnoses for therapy services and procedures of questionable medical necessity may not receive departmental authorization, depending upon the individual circumstances.

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

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

(b) Those services that can be performed by restorative nursing, as under s. HSS 132.60 (1) (b) to (d); and

(c) Activities such as end-of-the-day clean-up time, transportation time, consultations and required paper reports. These are considered components of the provider's overhead costs and are not covered as separately reimbursable items.

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

History: Cr Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (a), (b) (intro.), (c) (intro.) (2) (b), (d), (e), (h) and (4) (a), Register, February 1988, No. 386, eff. 3-1-88; emerg. am. (2) (b), (d), (g) and (3) (c), eff. 7-1-88; am. (2) (b), (d), (g), and (3) (c), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.19 Audiology services. (1) COVERED SERVICES. Covered audiology services are those medically necessary diagnostic, screening, preventive or corrective audiology services prescribed by a physician and provided by an audiologist certified pursuant to s. HSS 105.31. These 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; and

(h) Speech and audiotherapy.

(2) PRIOR AUTHORIZATION. (a) *Services requiring prior authorization.* The following covered services require prior authorization from the department:

1. Speech and audiotherapy;

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2. Aural rehabilitation:

a. Use of residual hearing;

b. Speech reading or lip reading;

c. Compensation techniques; and

d. Gestural communication techniques; and

3. Dispensing of hearing aids.

(b) *Conditions for review of requests for prior authorization.* Requests for prior authorization of audiological services shall be reviewed only if these requests contain the following information:

1. The type of treatment and number of treatment days requested;

2. The name, address and MA 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, an indication of the 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 the service cannot be obtained in the state.

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

(3) OTHER LIMITATIONS. (a) *Plan of care for therapy services.* Services shall be furnished to a recipient under a plan of care established and periodically reviewed by a physician. The plan shall be reduced to writing before the treatment is begun, 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. The plan shall be promptly signed by the ordering physician and incorporated into the provider's permanent record for the recipient. The plan shall:

1. 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 or physician on the staff of the provider pursuant to the attending physician's oral orders; and

2. Be reviewed by the attending physician in consultation with the therapist providing services, at whatever intervals the severity of the recipient's condition requires but at least every 90 days. Each review of the plan shall contain the initials of the physician and the date performed. The plan for the recipient shall be retained in the provider's file.

(b) *Restorative therapy services.* Restorative therapy services shall be covered services.

(c) *Maintenance therapy services.* Preventive or maintenance therapy services shall be covered services only when one of the following conditions are met:

1. The skills and training of an audiologist are required to execute the entire preventive or maintenance program;

2. The specialized knowledge and judgment of an audiologist 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 re-evaluations required; or

3. When, due to the severity or complexity of the recipient's condition, nursing personnel cannot handle the recipient safely and effectively.

(d) *Evaluations.* Evaluations shall be covered services. The need for an evaluation or a re-evaluation shall be documented in the plan of care.

(e) *Extension of therapy services.* Extension of therapy services shall not be approved in the following circumstances:

1. The recipient has shown no progress toward meeting or maintaining established and measurable treatment goals over a 6-month period, or the recipient has shown no ability within 6 months to carry over abilities gained from treatment in a facility to the recipient's home;

2. The recipient's chronological or developmental age, way of life or home situation indicates that the stated therapy goals are not appropriate for the recipient or serve no functional or maintainance purpose;

3. The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel;

4. The evaluation indicates that the recipient's abilities are functional for the person's present way of life;

5. The recipient shows no motivation, interest, or desire to participate in therapy, which may be for reasons of an overriding severe emotional disturbance;

6. Other therapies are providing sufficient services to meet the recipient's functioning needs; or

7. The procedures requested are not medical in nature or are not covered services. Inappropriate diagnoses for therapy services and procedures of questionable medical necessity may not receive departmental authorization, depending upon the individual circumstances.

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

(a) Activities such as end-of-the-day clean-up time, transportation time, consultations and required paper reports. These are considered components of the provider's overhead costs and are not covered as separately reimbursable items; and

(b) Services performed by individuals not certified under s. HSS 105.31.

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 107.20 Vision care services. (1) COVERED SERVICES. Covered vision care services are eyeglasses and those medically necessary services provided by licensed optometrists within the scope of practice of the profession of optometry as defined in s. 449.01, Stats., who are certified under s. HSS 105.32, and by opticians certified under s. HSS 105.33 and physicians certified under s. HSS 105.05.

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

(a) Vision training, which shall only be approved for patients with one or more of the following conditions:

1. Amblyopia;

2. Anopsia;

3. Disorders of accommodation; and

4. Convergence insufficiency;

(b) Aniseikonic services for recipients whose eyes have unequal refractive power;

(c) Tinted eyeglass lenses, occupational frames, high index glass, blanks (55 mm. size and over) and photochromic lens;

(d) Eyeglass frames and all other vision materials which are not obtained through the MA vision care volume purchase plan;

Note: Under the department's vision care volume purchase plan, MA-certified vision care providers must order all eyeglasses and component parts prescribed for MA recipients directly from a supplier under contract with the department to supply those items.

(e) All contact lenses and all contact lens therapy, including related materials and services, except where the recipient's diagnosis is aphakia or keratoconus;

(f) Ptosis crutch services and materials;

(g) Eyeglass frames or lenses beyond the original and one unchanged prescription replacement pair from the same provider in a 12-month period; and

(h) Low vision services.

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

(3) OTHER LIMITATIONS. (a) Eyeglass frames, lenses, and replacement parts shall be provided by dispensing opticians, optometrists and opthalmologists in accordance with the department's vision care volume purchase plan. The department may purchase from one or more optical laboratories some or all ophthalmic materials for dispensing by opticians, optometrists or ophthalmologists as benefits of the program.

(b) Lenses and frames shall comply with ANSI standards.

(c) The dispensing provider shall be reimbursed only once for dispensing a final accepted appliance or component part.

(d) The department may define minimal prescription levels for lenses covered by MA. These limitations shall be published by the department in the MA vision care provider handbook.

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

(a) Anti-glare coating;

(b) Spare eyeglasses or sunglasses; and

(c) Services provided principally for convenience or cosmetic reasons, including but not limited to gradient focus, custom prosthesis, fashion or cosmetic tints, engraved lenses and anti-scratch coating.

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

History: Cr. Register, February, No. 362, eff. 3-1-86.

HSS 107.21 Family planning services. (1) COVERED SERVICES. (a) *General.* Covered family planning services are the services included in this subsection when prescribed by a physician and provided to a recipient, including initial physical exam and health history, annual office visits and follow-up office visits, laboratory services, prescribing and supplying contraceptive supplies and devices, counseling services and prescribing medication for specific treatments. All family planning services performed in family planning clinics shall be prescribed by a physician, and furnished, directed or supervised by a physician, registered nurse, nurse practitioner, licensed practical nurse or nurse midwife under s. 441.15 (1) and (2) (b), Stats.

(b) *Physical examination.* An initial physical examination with health history is a covered service and shall include the following:

1. Complete obstetrical history including menarche, menstrual, gravidity, parity, pregnancy outcomes and complications of pregnancy or delivery, and abortion history;

2. History of significant illness-morbidity, hospitalization and previous medical care, particularly in relation to thromboembolic disease, any breast or genital neoplasm, any diabetic or prediabetic condition, cephalelgia and migraine, pelvic inflammatory disease, gynecologic disease and venereal disease;

3. History of previous contraceptive use;

4. Family, social, physical health, and mental health history, including chronic illnesses, genetic aberrations and mental depression;

5. Physical examination. Recommended procedures for examination are:

a. Thyroid palpation;

b. Examination of breasts and axillary glands;

c. Auscultation of heart and lungs;

d. Blood pressure measurement;

3. Orthoses. These are devices which limit or assist motion of any segment of the human body. They are designed to stabilize a weakened part or correct a structural problem. Examples are arm braces and leg braces.

4. Other home health care durable medical equipment. This is medical equipment used in a recipient's home to increase the independence of a disabled person or modify certain disabling conditions. Examples are patient lifts, hospital beds and traction equipment.

5. Oxygen therapy equipment. This is medical equipment used in a recipient's home for the administration of oxygen or medical formulas or to assist with respiratory functions. Examples are a nebulizer, a respirator and a liquid oxygen system.

6. Physical therapy splinting or adaptive equipment. This is medical equipment used in a recipient's home to assist a disabled person to achieve independence in performing daily activities. Examples are splints and positioning equipment.

7. Prostheses. These are devices which replace all or part of a body organ to prevent or correct a physical disability or malfunction. Examples are artificial arms, artificial legs and hearing aids.

8. Wheelchairs. These are chairs mounted on wheels usually specially designed to accommodate individual disabilities and provide mobility. Examples are a standard weight wheelchair, a lightweight wheelchair and an electrically-powered wheelchair.

(d) *Categories of medical supplies.* Only approved items within the following generic categories of medical supplies are covered:

1. Colostomy, urostomy and ileostomy appliances;

2. Contraceptive supplies;

3. Diabetic urine and blood testing supplies;

4. Dressings;

5. Gastric feeding sets and supplies;

6. Hearing aid batteries;

7. Incontinence supplies, catheters and irrigation apparatus;

8. Parenteral-administered apparatus; and

9. Tracheostomy and endotracheal care supplies.

(3) SERVICES REQUIRING PRIOR AUTHORIZATION. The following services require prior authorization:

(a) Purchase of all items indicated as requiring prior authorization in the Wisconsin DME and medical supplies indices, published periodically and distributed to appropriate providers by the department;

(b) Repair or modification of an item which exceeds the department-established maximum reimbursement without prior authorization. Reimbursement parameters are published periodically in the DME and medical supplies provider handbook;

(c) Purchase, rental, repair or modification of any item not contained in the current DME and medical supplies indices;

(d) Purchase of items in excess of department-established frequencies or dollar limits outlined in the current Wisconsin DME and medical supplies indices;

(e) The second and succeeding months of rental use, with the exception that all hearing aid rentals require prior authorization;

(f) Purchase of any item which is not covered by medicare, part b, when prescribed for a recipient who is also eligible for medicare;

(g) Any item required by a recipient in a nursing home which meets the requirements of sub. (4) (c); and

(h) Purchase or rental of a hearing aid as follows:

1. A request for prior authorization of a hearing aid shall be reviewed only if the request consists of an otological report from the recipient's physician, an audiological report from an audiologist and is on forms designated by the department and contains information requested by the department;

2. After a new or replacement hearing aid has been worn for a 30-day trial period, the recipient shall obtain a performance check from a certified audiologist or at a 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 45 days has elapsed with no response from the recipient;

3. Special modifications other than those listed in the MA speech and hearing provider handbook shall require prior authorization; and

4. Provision of services in excess of the life expectancies of equipment enumerated in the MA speech and hearing provider handbook require prior authorization, except for hearing aid batteries and repair services.

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

(4) OTHER LIMITATIONS. (a) The services covered under this section are not covered for recipients who are inpatients in hospitals. Payment for medical supplies ordered for a patient in a medical institution is considered part of the institution's cost and may not be billed directly to the program by a provider.

(b) Prescriptions shall be provided in accordance with s. HSS 107.06 (4) (a) 2. and may not be filled more than one year from the date the medical equipment or supply is ordered.

(c) The services covered under this section are not covered for recipients who are nursing home residents except for:

1. Oxygen. Prescriptions for oxygen shall provide the required amount of oxygen flow in liters;

2. Durable medical equipment which is personalized in nature or custom-made for a recipient and is to be used by the recipient on an individual basis for hygienic or other reasons. These items are orthoses, prostheses including hearing aids, orthopedic or corrective shoes, special adaptive positioning wheelchairs and electric wheelchairs. Coverage of a

special adaptive positioning wheelchair or electric wheelchair shall be justified by the diagnosis and prognosis and the occupational or vocational activities of the resident recipient; and

3. A wheelchair prescribed by a physician if the wheelchair will contribute towards the rehabilitation of the resident recipient through maximizing his or her potential for independence, and if 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 the recipient is about to transfer from a nursing home to an alternate and more independent setting.

(d) The provider shall weigh the costs and benefits of the equipment and supplies when considering purchase or rental of DME and medical supplies.

Note: The program's listing of covered services and the maximum allowable reimbursement schedules are based on basic necessity. Although the program does not intend to exclude any manufacturer of equipment, reimbursement is based on the cost-benefit of equipment when comparable equipment is marketed at less cost. Several medical supply items are reimbursed according to generic pricing.

(e) The department may determine whether an item is to be rented or purchased on behalf of a recipient. In most cases equipment shall be purchased; however, in those cases where short-term use only is needed or the recipient's prognosis is poor, only rental of equipment shall be authorized.

(f) Orthopedic or corrective shoes or foot orthoses shall be provided only for postsurgery conditions, gross deformities, or when attached to a brace or bar. These conditions shall be described in the prior authorization request.

(g) Each of the following hearing aid accessories shall be limited to one per year per recipient: earmold; single cord; 4-cord; harness; cross fitting; new receiver; and bone condition receiver with headband.

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

(a) Foot orthoses or orthopedic or corrective shoes for the following conditions:

1. Flattened arches, regardless of the underlying pathology;

2. Incomplete dislocation or subluxation metatarsalgia with no associated deformities;

3. Arthritis with no associated deformities; and

4. Hypoallergenic conditions;

(b) Services denied by medicare for lack of medical necessity;

(c) Items which are not primarily medical in nature, such as dehumidifiers and air conditioners;

(d) Items which are not appropriate for home usage, such as oscillating beds;

(e) Items which are not generally accepted by the medical profession as being therapeutically effective, such as a heat and massage foam cushion pad;

(f) Items which are for comfort and convenience, such as cushion lift power seats or elevators, or luxury features which do not contribute to the improvement of the recipient's medical condition;

(g) Repair, maintenance or modification of rented durable medical equipment;

(h) Delivery or set-up charges for equipment as a separate service;

(i) Fitting, adapting, adjusting or modifying a prosthetic or orthotic device or corrective or orthopedic shoes as a separate service;

(j) All hearing aid repairs performed by a dealer within 12 months after the purchase of the hearing aid. These are included in the purchase payment and not as separate services; and

(k) Hearing aid batteries and repairs which are provided in excess of the guidelines enumerated in the MA speech and hearing provider handbook.

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 107.25 Diagnostic testing services. (1) COVERED SERVICES. Professional and technical diagnostic services covered by MA 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 services prescribed by a physican 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 or dentist.

(b) Laboratory tests performed which are outside the laboratory's certified areas are not 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 P.L. 98-369, Sec. 2303.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 107.26 Dialysis services. Dialysis services are covered services when provided by facilities certified pursuant to s. HSS 105.45.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 107.27 Blood. The provision of blood is a covered service when provided to a recipient by a physician certified pursuant to s. HSS 105.05, a blood bank certified pursuant to s. HSS 105.46 or a hospital certified pursuant to s. HSS 105.07.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 107.28 Health maintenance organization and prepaid health plan services. (1) COVERED SERVICES. (a) *HMOs.* 1. Except as provided in