Chapter HSS 107

COVERED SERVICES

Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.

HSS 107.01 General statement of coverage. (1) The department shall reimburse providers for medically necessary and appropriate health care services listed in ss. 49.46 (2) and 49.47 (6) (a), Stats., when provided to currently eligible medical assistance recipients, including emergency services provided by persons or institutions not currently certified. The department shall also reimburse providers certified to provide case management services as defined in s. HSS 107.32 to eligible recipients.

(2) Services provided by a student during a practicum are reimbursable under the following conditions:

(a) The services meet the requirements of this chapter;

(b) Reimbursement for the services is not reflected in prospective payments to the hospital, skilled nursing facility or intermediate care facility at which the student is providing the services;

(c) The student does not bill and is not reimbursed directly for his or her services;

(d) The student provides services under the direct, immediate on-premises supervision of a certified provider; and

(e) The supervisor documents in writing all services provided by the student.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1), Register, February, 1988, No. 386, eff. 3-1-88.

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

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

(2) NON-REIMBURSABLE SERVICES. The department may reject payment for a service which ordinarily would be covered if the service fails to meet program requirements. Non-reimbursable services include:

(a) Services which fail to comply with program policies or state and federal statutes, rules and regulations, for instance, sterilizations performed without prior authorization and without following proper informed consent procedures, or controlled substances prescribed or dispensed illegally;

(b) Services which the department's or its fiscal agent's professional consultants determine to be not medically necessary, inappropriate or in excess of accepted standards of reasonableness;

(c) Inpatient hospital services or lengths of stay which are not approved by the department, the PRO review process or, pursuant to s. 49.46 (2) (b)7, Stats., by the appropriate board;

(d) Non-emergency services provided by a person who is not a certified provider; and

(e) Services provided to recipients who were not eligible on the date of service, except as provided under a prepaid health plan or HMO.

(3) PRIOR AUTHORIZATION. (a) *Procedures for prior authorization.* The department may require prior authorization for covered services. In addition to services designated for prior authorization under each service category in this chapter, the department may require prior authorization for any other covered service for any reason listed in par. (b). The department shall notify in writing all affected providers of any additional services for which it has decided to require prior authorization. The department or its fiscal agent shall act on 95% of requests for prior authorization within 10 working days and on 100% of requests for prior authorization within 20 working days from the receipt of all information necessary to make the determination. The department or its fiscal agent shall make a reasonable attempt to obtain from the provider the information necessary for timely prior authorization decisions. When prior authorization decisions are delayed due to the department's need to seek further information from the provider, the recipient shall be notified by the provider of the reason for the delay.

11. Meal preparation, food purchasing and meal serving;

12. Simple transfers including bed to chair or wheelchair and reverse; and

13. Accompanying the recipient to obtain medical diagnosis and treatment.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) Prior authorization is required for personal care services in excess of 250 hours per calendar year.

(b) Prior authorization is required for specific services listed in s. HSS 107.11 (2) (a) to (j), under the conditions cited in s. HSS 107.11 (3) (f).

(3) OTHER LIMITATIONS. (a) Personal care services shall be performed under the supervision of a registered nurse by a personal care worker who meets the requirements of s. HSS 105.17 (3) and who is employed by or is under contract to a provider certified under s. HSS 105.17.

(b) Services shall be performed according to a written plan of care for the recipient developed by a registered nurse for purposes of providing necessary and appropriate services, allowing appropriate assignment of a personal care worker and setting standards for personal care activities, giving full consideration to the recipient's preferences for service arrangements and choice of personal care workers. The plan shall be based on the registered nurse's visit to the recipient's home and shall include:

1. Review and interpretation of the physician's orders;

2. Frequency and anticipated duration of service;

3. Evaluation of the recipient's needs and preferences; and

4. Assessment of the recipient's social and physical environment, including family involvement, living conditions, the recipient's level of functioning and any pertinent cultural factors such as language.

(c) Review of the plan of care, evaluation of the recipient's condition and supervisory review of the personal care worker shall be made by a registered nurse at least every 60 days. The review shall include a visit to the recipient's home, review of the personal care worker's daily written record and discussion with the physician of any necessary changes in the plan of care.

(d) Reimbursement for registered nurse supervisory visits is limited to one visit per month.

(e) No more than one-third of the time spent by a personal care worker may be in performing housekeeping activities.

(f) Home health aide services may not include personal care services under sub. (1) (b) unless the recipient is ill and is bed-bound as defined in s. HSS 107.11 (2) (k).

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

(a) Personal care services provided in a hospital or a nursing home or in a community-based residential facility, as defined in s. 50.01 (1), Stats., with more than 20 beds;

(b) Homemaking services and cleaning of areas not used during personal care service activities, unless directly related to the care of the person and essential to the recipient's health;

(c) Personal care services not documented in the plan of care;

(d) Personal care services provided by a responsible relative under s. 49.90, Stats.;

(e) Personal care services provided in excess of 250 hours per calendar year without prior authorization;

(f) Services other than those listed in sub. (1) (b);

(g) Skilled nursing services, including:

1. Insertion and sterile irrigation of catheters;

2. Giving of injections;

3. Application of dressings involving prescription medication and use of aseptic techniques; and

4. Administration of medicine that is not usually self-administered; and

(h) Therapy services.

History: Cr. Register, April, 1988, No. 388, eff. 7-1-88; renum. (2) to be (2) (a), cr. (2) (b), am. (3) (e), Register, December, 1988, No. 396, eff. 1-1-89.

HSS 107.12 Independent nursing and nurse-midwife services. (1) COVERED SERVICES. (a) Services provided by a certified registered nurse in independent practice which are covered by the MA program are those part-time or intermittent nursing services which comprise the practice of professional nursing as defined in s. 441.11 (4) Stats., when documentation is provided to the department that an existing agency cannot provide the services and when the services are prescribed by a physician.

(b) Certified registered nurses or licensed practical nurses may provide private duty nursing services when the services are prescribed by a physician and if the prescription calls for a level of care which the nurse is licensed to provide.

(c) Covered services provided by certified nurse-midwives may include the care of mothers and their babies throughout the maternity cycle, including pregnancy, labor, normal childbirth and the immediate postpartum period, provided that the nurse-midwife services are provided within the limitations established in s. 441.15 (2), Stats., and ch. N 6.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. Prior authorization shall be required for:

(a) Part-time or intermittent nursing services beyond 20 hours per recipient per calendar year; and

(b) Private duty nursing services beyond 30 hours per recipient per calendar year.

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

(3) OTHER LIMITATIONS. (a) Private duty and part-time or intermittent nursing services provided by a certified nurse in independent prac-

tice 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 30 days. The plan of care shall include diagnosis, specific medical orders, specific services required and any other appropriate items. The nurse shall retain the plan of care.

(b)Prior to the provision of part-time or intermittent nursing services, the nurse shall contact the district public health nursing consultant in the area to receive orientation to acceptable clinical and administrative recordkeeping.

(c) Each nurse shall document the care and services provided and shall make that documentation available to the department upon request.

(d) Private duty nursing services shall only be provided when the recipient requires individual and continuous care beyond that available on a part-time or intermittent basis. If a change in level of care is necessary, the recipient's physician shall be notified and an appropriate referral shall be made.

(e) Nurses certified under ch. N 6 and s. HSS 105.20 (3) to provide nurse-midwife services shall end the management and care of the mother and newborn child after the sixth week of postpartum care.

(4) NON-COVERED SERVICES. (a) Private duty nursing services provided in a hospital or nursing home are not covered services.

(b) Christian Science nursing services rendered in connection with treatment by prayer or spiritual means alone are not covered services.

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

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

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HSS 107.13 Mental health services. (1) INPATIENT PSYCHIATRIC SERVICES. (a) *Covered services.* Inpatient psychiatric care shall be covered when prescribed by a physician and when provided within a psychiatric hospital or by a psychiatric unit of a general hospital which meets the requirements of ss. HSS 105.07 and 105.21, except as provided in par. (b).

(b) *Conditions for coverage of recipients under 21 years of age.* 1. Definition. In this paragraph, "individual plan of care" or "plan of care" means a written plan developed for each recipient under 21 years of age who receives inpatient psychiatric care for the purpose of improving the recipient's condition to the extent that inpatient care is no longer necessary.

2. General conditions. Inpatient psychiatric service for recipients under age 21 shall be provided under the direction of a physician, by a general hospital, a psychiatric facility or an inpatient program in a psychiatric facility, and, 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.

3. Certification of need for services. a. Before a recipient is admitted for inpatient care or, in the case of a person who already is receiving inpatient care before that care may be reimbursed by MA, the team spec-

ified under subpar. b., c. or d., as appropriate, shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, that 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. The certification specified in this subdivision satisfies the requirement for physician certification in subd. 7.

b. Certification under subpar. a. for an individual who is a recipient when admitted to a facility or program shall be made by the team responsible for the plan of care in subd. 5.

c. Certification under subpar. a. for an individual who applies for MA while in the facility or program shall be made by the team responsible for the plan of care in subd. 5., and may cover any period before application for which claims are made.

d. Certification under subpar. a. for an emergency admission shall be made within 14 days after admission by the team responsible for the plan of care.

4. Active treatment. Inpatient psychiatric services shall involve active treatment. An individual plan of care described in subd. 5. shall be developed and implemented no later than 14 days after admission and shall be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

5. Individual plan of care. a. The individual plan of care shall 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; be developed by a team of professionals specified under subpar. b. in consultation with the recipient and parents, legal guardians or others into whose care the recipient will be released after discharge; specify treatment objectives; prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and 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 individual plan of care shall be developed by an interdisciplanary team that includes a board-eligible or board-certified psychiatrist; a clinical psychologist who has a doctorate and a physician licensed to practice medicine or osteopathy; or a physician licensed to practice medicine or osteopathy who has 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 is certified by the state. The team shall also include a psychiatric social worker, a registered nurse with specialized training or one year's experience in treating mentally ill individuals, an occupational therapist who is certified by the American occupation therapy association and who has specialized training or one year of experience in treating mentally ill individuals, or a psychologist who has a master's degree in clinical psychology or who has been certified by the state. Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing

1. Case management services provided under s. HSS 107.32 by a provider not certified under s. HSS 105.255 to provide CSP services;

2. Services provided to a resident of an intermediate care facility, skilled nursing facility or an institution for mental diseases, or to a hospital patient unless the services are performed to prepare the recipient for discharge form the facility to reside in the community;

3. Services related to specific job-seeking, job placement and work activities;

4. Services performed by volunteers;

5. Services which are primarily recreation-oriented; and

6. Legal advocacy performed by an attorney or paralegal.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (f) 8., Register, February, 1988, No. 386, eff. 3-1-88; emerg. cr. (3m), eff. 3-9-89; cr. (3m), Register, December, 1989, No. 408, eff. 1-1-90; emerg. cr. (2) (c) 5., (3) (c) 2., (4) (c) 4. and (6), eff. 1-1-90; cr. (2) (c) 5., (3) (c) 2., (4) (c) 4. and (6), Register, September, 1990, No. 417, eff. 10-1-90.

HSS 107.15 Chiropractic services. (1) DEFINITION. In this section, "spell of illness" means a condition characterized by the onset of a spinal subluxation. "Subluxation" means the alteration of the normal dynamics, anatomical or physiological relationships of contiguous articular structures. A subluxation may have biomechanical, pathophysiological, clinical, radiologic and other manifestations.

(2) COVERED SERVICES. Chiropractic services covered by MA are manual manipulations of the spine used to treat a subluxation. These services shall be performed by a chiropractor certified pursuant to s. HSS 105.26.

(3) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) *Requirement.* 1. Prior authorization is required for services beyond the initial visit and 20 spinal manipulations per spell of illness. The prior authorization request shall include a justification of why the condition is chronic and why it warrants the scope of service being requested.

2. Prior authorization is required for spinal supports which have been prescribed by a physician or chiropractor if the purchase or rental price of a support is over $75. Rental costs under $75 shall be paid for one month without prior approval.

(b) *Conditions justifying spell of illness designation.* The following conditions may justify designation of a new spell of illness if treatment for the condition is medically necessary:

1. An acute onset of a new spinal subluxation;

2. An acute onset of an aggravation of pre-existing spinal subluxation by injury; or

3. An acute onset of a change in pre-existing spinal subluxation based on objective findings.

(c) *Onset and termination of spell of illness.* The spell of illness begins with the first day of treatment or evaluation following the onset of a condition under par. (b) and ends when the recipient improves so that treatment by a chiropractor for the condition causing the spell of illness is no longer medically necessary, or after 20 spinal manipulations, whichever comes first.

(d) *Documentation.* The chiropractor shall document the spell of illness in the patient plan of care.

(e) *Non-transferability of treatment days.* Unused treatment days from one spell of illness shall not be carried over into a new spell of illness.

(f) *Other coverage.* Treatment days covered by medicare or other third-party insurance shall be included in computing the 20 spinal manipulation per spell of illness total.

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

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

(4) OTHER LIMITATIONS. (a) An x-ray or set of x-rays, such as anterior-posterior and lateral, is a covered service only for an initial visit if the x-ray 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.

(b) A diagnostic urinalysis is a covered service only for an initial office visit when related to the diagnosis of a spinal subluxation, or when verifying a symptomatic condition beyond the scope of chiropractic.

(c) The billing for an initial office visit shall clearly describe all procedures performed to ensure accurate reimbursement.

(5) NON-COVERED SERVICES. Consultations between providers regarding a diagnosis or treatment are not covered services.

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 107.16 Physical therapy. (1) COVERED SERVICES. (a) *General.* Covered physical therapy services are those medically necessary modalities, procedures and evaluations enumerated in pars. (b) to (d), when prescribed by a physician and performed by a qualified physical therapist (PT) or a certified physical therapy assistant under the direct, immediate, on-premises supervision of a physical therapist. Specific services performed by a physical therapy aide under par. (e) are covered when provided in accordance with supervision requirements under par. (e) 3.

(b) *Evaluations.* Covered evaluations, the results of which shall be set out in a written report to accompany the test chart or form in the recipient's medical record, are the following:

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); and

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