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Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.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, the PRO review process or the department fiscal agent's professional consultants determine to be medically unnecessary, inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration;

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

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

(e) Services for which records or other documentation were not prepared or maintained, as required under s. HSS 106.02 (9);

(f) Services provided by a provider who fails or refuses to prepare or maintain records or other documentation as required under s. HSS 106.02 (9);

(g) Services provided by a provider who fails or refuses to provide access to records as required under s. HSS 106.02 (9) (e) 4;

(h) Services for which the provider failed to meet any or all of the requirements of s. HSS 106.03, including but not limited to the requirements regarding timely submission of claims;

(i) Services provided inconsistent with an intermediate sanction or sanctions imposed by the department under s. HSS 106.08; and

(j) Services provided by a provider who fails or refuses to meet and maintain any of the certification requirements under ch. HSS 105 applicable to that provider.

(2m) SERVICES REQUIRING A PHYSICIAN'S ORDER OR PRESCRIPTION. (a) The following services require a physician's order or prescription to be covered under MA:

1. Skilled nursing services provided in a nursing home;

2. Intermediate care services provided in a nursing home;

3. Home health care services;

4. Independent nursing services;

5. Respiratory care services for ventilator-dependent recipients;

6. Physical and occupational therapy services;

7. Mental health and alcohol and other drug abuse (AODA) services;

8. Speech pathology and audiology services;

9. Medical supplies and equipment, including rental of durable equipment, but not hearing aid batteries, hearing aid accessories or repairs;

10. Drugs, except when prescribed by a nurse practitioner under s. HSS 107.122, or a podiatrist under s. HSS 107.14;

11. Prosthetic devices;

12. Laboratory, diagnostic, radiology and imaging test services;

13. Inpatient hospital services;

14. Outpatient hospital services;

15. Inpatient hospital IMD services;

16. Hearing aids;

17. Specialized transportation services for persons not requiring a wheelchair, except when prescribed by a nurse practitioner under s. HSS 107.122;

18. Hospital private room accommodations;

19. Personal care services; and

20. Hospice services.

(b) Except as otherwise provided in federal or state statutes, regulations or rules, a prescription or order shall be in writing or be given orally and later be reduced to writing by the provider filling the prescription or order, and shall include the date of the prescription or order, the name and address of the prescriber, the prescriber's MA provider number, the name and address of the recipient, the recipient's MA eligibility number, an evaluation of the service to be provided, the estimated length of time required, the brand of drug or drug product equivalent medically required and the prescriber's signature. For hospital patients and nursing home patients, orders shall be entered into the medical and nursing charts and shall include the information required by this paragraph. Ser-

vices prescribed or ordered shall be provided within one year of the date of the prescription.

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

(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.

(b) *Reasons for prior authorization.* Reasons for prior authorization are:

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) *Penalty for non-compliance.* If prior authorization is not requested and obtained before a service requiring prior authorization is provided, reimbursement shall not be made except in extraordinary circumstances such as emergency cases where the department has given verbal authorization for a service.

(d) *Required information.* A request for prior authorization submitted to the department or its fiscal agent shall, unless otherwise specified in chs. HSS 101 to 108, identify at a minimum:

1. The name, address and MA number of the recipient for whom the service or item is requested;

2. The name and provider number of the provider who will perform the service requested;

3. The person or provider requesting prior authorization;

4. The attending physician's or dentist's diagnosis including, where applicable, the degree of impairment;

5. A description of the service being requested, including the procedure code, the amount of time involved, and dollar amount where appropriate; and

6. Justification for the provision of the service.

(e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:

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 imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;

10. The need to ensure that there is 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; and

12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

(f) *Professional consultants.* The department or its fiscal agent may use the services of qualified professional consultants in determining whether requests for prior authorization meet the criteria in par. (e).

(g) *Authorization not transferrable.* Prior authorization, once granted, may not be transferred to another recipient or to another provider. In certain cases the department may allow multiple services to be divided among non-billing providers certified under one billing provider. For example, prior authorization for 15 visits for occupational therapy may be performed by more than one therapist working for the billing provider for whom prior authorization was granted. In emergency circumstances the service may be provided by a different provider.

(h) *Medical opinion reports.* 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 injury, damage or a wrongful act caused by another person;

2. Services for these injuries are covered under the MA program;

3. The recipient or the recipient's representative has initiated 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 the 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.

(i) *Significance of prior authorization approval.* 1. Approval or modification by the department or its fiscal agent of a prior authorization request, including any subsequent amendments, extensions, renewals, or reconsideration requests:

a. Shall not relieve the provider of responsibility to meet all requirements of federal and state statutes and regulations, provider handbooks and provider bulletins;

b. Shall not constitute a guarantee or promise of payment, in whole or in part, with respect to any claim submitted under the prior authorization; and

c. Shall not be construed to constitute, in whole or in part, a discretionary waiver or variance under s. HSS 106.13.

2. Subject to the applicable terms of reimbursement issued by the department, covered services provided consistent with a prior authorization, as approved or modified by the department or its fiscal agent, are reimbursable provided:

a. The provider's approved or modified prior authorization request and supporting information, including all subsequent amendments, renewals and reconsideration requests, is truthful and accurate;

b. The provider's approved or modified prior authorization request and supporting information, including all subsequent amendments, extensions, renewals and reconsideration requests, completely and accurately reveals all facts pertinent to the recipient's case and to the review process and criteria provided under s. HSS 107.02 (3);

c. The provider complies with all requirements of applicable state and federal statutes, the terms and conditions of the applicable provider agreement pursuant to s. 49.45 (2) (a) 9, Stats, all applicable requirements of chs. HSS 101 to 108, including but not limited to the requirements of ss. HSS 106.02, 106.03, 107.02, and 107.03, and all applicable prior authorization procedural instructions issued by the department under s. HSS 108.02 (4);

d. The recipient is MA eligible on the date of service; and

e. The provider is MA certified and qualified to provide the service on the date of the service.

(4) COST-SHARING. (a) *General policy.* The department shall establish cost-sharing provisions for MA recipients, pursuant to s. 49.45 (18),

Stats. Cost-sharing requirements for providers are described under s. HSS 106.04 (2), and services and recipients exempted from cost-sharing requirements are listed under s. HSS 104.01 (12) (a).

(b) *Notification of applicable services and rates.* All services for which cost-sharing is applicable shall be identified by the department to all recipients and providers prior to enforcement of the provisions.

(d) *Limitation on copayments for prescription drugs.* Providers may not collect copayments in excess of $5 a month from a recipient for prescription drugs if the recipient uses one pharmacy or pharmacist as his or her sole provider of prescription drugs.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. (1) and am. (14) (c) 12. and 13., Register, February, 1988, No. 386, eff. 3-1-88; cr. (4) (c) 14., Register, April, 1988, No. 388, eff. 7-1-88; r. and recr. (4) (c), Register, December, 1988, No. 396, eff. 1-1-89; emerg. am. (4) (a), r. (4) (c), eff. 1-1-90; am. (4) (a) r. (4) (c), Register, September, 1990, No. 417, eff. 10-1-90; am. (2) (b), r. (2) (c), renum. (2) (d) and (e) to be (2) (c) and (d), cr. (2m), Register, September, 1991, No. 429, eff. 10-1-91; emerg. cr. (3) (i), eff. 7-1-92; am. (2) (c) and (d), cr. (2) (e) to (j) and (3) (i), Register, February, 1993, No. 446, eff. 3-1-93.

HSS 107.03 Services not covered. The following services are not covered services under MA:

(1) Charges for telephone calls;

(2) Charges for missed appointments;

(3) Sales tax on items for resale;

(4) Services provided by a particular provider that are considered experimental in nature;

(5) Procedures considered by the department to be obsolete, inaccurate, unreliable, ineffectual, unnecessary, imprudent or superfluous;

(6) Personal comfort items, such as radios, television sets and telephones, which do not contribute meaningfully to the treatment of an illness;

(7) Alcoholic beverages, even if prescribed for remedial or therapeutic reasons;

(8) Autopsies;

(9) Any service requiring prior authorization for which prior authorization is denied, or for which prior authorization was not obtained prior to the provision of the service except in emergency circumstances;

(10) Services subject to review and approval pursuant to s. 150.21, Stats., but which have not yet received approval;

(11) Psychiatric examinations and evaluations ordered by a court following a person's conviction of a crime, pursuant to s. 972.15, Stats.;

(12) Consultations between or among providers, except as specified in s. HSS 107.06 (4) (e);

(13) Medical services for adult inmates of the correctional institutions listed in s. 53.01, Stats.;

(14) Medical services for a child placed in a detention facility;

(15) Expenditures for any service to an individual who is an inmate of a public institution or for any service to a person 21 to 64 years of age who is a resident of an institution for mental diseases (IMD), unless the person is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, except that expenditures for a service to an individual on convalescent leave from an IMD may be reimbursed by MA.

Next page is numbered 123

6. Proper storage;

7. Prescription refill information; and

8. Action to be taken in the event of a missed dose.

(c) The pharmacist shall make a reasonable effort to obtain, record and maintain at least the following information regarding each MA recipient for whom the pharmacist dispenses drugs under the MA program:

1. The individual's name, address, telephone number, date of birth or age and gender;

2. The individual's history where significant, including any disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices; and

3. The pharmacist's comments relevant to the individual's drug therapy.

(d) Nothing in this subsection shall be construed as requiring a pharmacist to provide consultation when an MA recipient, the recipient's legal representative or the recipient's caregiver refuses the consultation.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (3) (h), Register, February, 1988, No. 386, eff. 3-1-88; emerg. am. (2) (e) and (f), (4) (k), cr. (2) (g), (3) (j) and (k), (4) (l), eff. 4-27-91; r. and recr. Register, December, 1991, No. 432, eff. 1-1-92.

HSS 107.11 Home health services. (1) DEFINITIONS. In this section:

(a) "Community-based residential facility" has the meaning prescribed in s. 50.01 (1g), Stats.

(b) "Home health aide services" means medically oriented tasks, assistance with activities of daily living and incidental household tasks required to facilitate treatment of a recipient's medical condition or to maintain the recipient's health.

(c) "Home health visit" or "visit" means a period of time of any duration during which home health services are provided through personal contact by agency personnel of less than 8 hours a day in the recipient's place of residence for the purpose of providing a covered home health service. The services are provided by a home health provider employed by a home health agency, by a home health provider under contract to a home health agency according to the requirements of s. HSS 133.19 or by arrangement with a home health agency. A visit begins when the home health provider enters the residence to provide a covered service and ends when the worker leaves the residence.

(d) "Home health provider" means a person who is an RN, LPN, home health aide, physical or occupational therapist, speech pathologist, certified physical therapy assistant or certified occupational therapy assistant.

(e) "Initial visit" means the first home health visit of any duration in a calendar day provided by a registered nurse, licensed practical nurse, home health aide, physical or occupational therapist or speech and language pathologist for the purpose of delivering a covered home health service to a recipient.

(f) "Subsequent visit" means each additional visit of any duration following the initial visit in a calendar day provided by an RN, LPN or

home health aide for the purpose of delivering a covered home health service to a recipient.

(g) "Unlicensed caregiver" means a home health aide or personal care worker.

(2) COVERED SERVICES. Services provided by an agency certified under s. HSS 105.16 which are covered by MA are those reasonable and medically necessary services required in the home to treat the recipient's condition. Covered services are: skilled nursing services, home health aide services and medical supplies, equipment and appliances suitable for use in the recipient's home, and therapy and speech pathology services which the agency is certified to provide. These services are covered only when performed according to the requirements of s. HSS 105.16 and provided in a recipient's place of residence which is other than a hospital or nursing home. Home health skilled nursing and therapy services are covered only when provided to a recipient who, as certified in writing by the recipient's physician, is confined to a place of residence except that intermittent, medically necessary, skilled nursing or therapy services are covered if they are required by a recipient who cannot reasonably obtain these services outside the residence or from a more appropriate provider. Home health aide services may be provided to a recipient who is not confined to the home, but services shall be performed only in the recipient's home. Services are covered only when included in the written plan of care with supervision and coordination of all nursing care for the recipient provided by a registered nurse. Home health services include:

(a) Skilled nursing services provided in a recipient's home under a plan of care which requires less than 8 hours of skilled nursing care per calendar day and specifies a level of care which the nurse is qualified to provide. These are:

1. Nursing services performed by a registered nurse, or by a licensed practical nurse under the supervision of a registered nurse, according to the written plan of care and accepted standards of medical and nursing practice, in accordance with ch. N 6;

2. Services which, due to the recipient's medical condition, may be only safely and effectively provided by an RN or LPN;

3. Assessments performed only by a registered nurse; and

4. Teaching and training of the recipient, the recipient's family or other caregivers requiring the skills on an RN or LPN.

Note: For a further description of skilled nursing services, refer to the Wisconsin Medical Assistance Home Health Agency Provider Handbook, Part L, Division II.

(b) Home health aide services. Home health aide services are:

1. Medically oriented tasks which cannot be safely delegated by an RN as determined and documented by the RN to a personal care worker who has not received special training in performing tasks for the specific individual, and which may include, but are not limited to, medically oriented activities directly supportive of skilled nursing services provided to the recipient. These may include assistance with and administration of oral, rectal and topical medications ordinarily self-administered and supervised by an RN according to 42 CFR 483.36 (d), ch. HSS 133 and ch. N 6, and assistance with activities directly supportive of current and active skilled therapy and speech pathology services and further de-

scribed in the Wisconsin medical assistance home health agency provider handbook;

2. Assistance with the recipient's activities of daily living only when provided on conjunction with a medically oriented task that cannot be safely delegated to a personal care worker as determined and documented by the delegating RN. Assistance with the recipient's activities of daily living consists of medically oriented tasks when a reasonable probability exists that the recipient's medical condition will worsen during the period when assistance is provided, as documented by the delegating RN. A recipient whose medical condition has exacerbated during care activities sometime in the past 6 months is considered to have a condition which may worsen when assistance is provided. Activities of daily living include, but are not limited to, bathing, dressing, grooming and personal hygiene activities, skin, foot and ear care, eating, elimination, ambulation, and changing bed positions; and

3. Household tasks incidental to direct care activities described in subds. 1 and 2.

Note: For further description of home health aide services, refer to the Wisconsin Medical Assistance Home Health Agency Provider Handbook, Part L, Division II.

(c) Therapy and speech pathology services. 1. These are services provided in the recipient's home which can only be safely and effectively performed by a skilled therapist or speech pathologist or by a certified therapy assistant who receives supervision by the certified therapist according to 42 CFR 484.32 for a recipient confined to his or her home.

2. Based on the assessment by the recipient's physician of the recipient's rehabilitation potential, services provided are expected to materially improve the recipient's condition within a reasonable, predictable time period, or are necessary to establish a safe and effective maintenance program for the recipient.

3. In conjunction with the written plan of care, a therapy evaluation shall be conducted prior to the provision of these services by the therapist or speech pathologist who will provide the services to the recipient.

4. The therapist or speech pathologist shall provide a summary of activities, including goals and outcomes, to the physician at least every 62 days, and upon conclusion of therapy services.

(3) PRIOR AUTHORIZATION. Prior authorization is required to review utilization of services and assess the medical necessity of continuing services for:

(a) All home health visits when the total of any combination of skilled nursing, home health aide, physical and occupational therapist and speech pathologist visits by all providers exceeds 30 visits in a calendar year, including situations when the recipient's care is shared among several certified providers;

(b) All home health aide visits when the services are provided in conjunction with private duty nursing under s. HSS 107.12 or the provision of respiratory care services under s. HSS 107.113;

(c) All medical supplies and equipment for which prior authorization is required under s. HSS 107.24;

(d) All home health aide visits when 4 or more hours of continuous care is medically necessary; and

(e) All subsequent skilled nursing visits.

(4) OTHER LIMITATIONS. (a) The written plan of care shall be developed and reviewed concurrently with and in support of other health sustaining efforts for the recipient in the home.

(b) All durable medical equipment and disposable medical supplies shall meet the requirements of s. HSS 107.24.

(c) Services provided to a recipient who is a resident of a community-based residential facility shall be rendered according to the requirements of ch. HSS 3 and shall not duplicate services that the facility has agreed to provide.

(d) 1. Except as provided in subd. 2, home health skilled nursing services provided by one or more providers are limited to less than 8 hours per day per recipient as required by the recipient's medical condition.

2. If the recipient's medical condition worsens so that 8 or more hours of direct, skilled nursing services are required in a calendar day, a maximum of 30 calendar days of skilled nursing care may continue to be reimbursed as home health services, beginning on the day 8 hours or more of skilled nursing services became necessary. To continue medically necessary services after 30 days, prior authorization for private duty nursing is required under s. HSS 107.12 (2).

(e) An intake evaluation is a covered home health skilled nursing service only if, during the course of the initial visit to the recipient, the recipient is admitted into the agency's care and covered skilled nursing services are performed according to the written physician's orders during the visit.

(f) A skilled nursing ongoing assessment for a recipient is a covered service:

1. When the recipient's medical condition is stable, the recipient has not received a covered skilled nursing service, covered personal care service, or covered home visit by a physician service within the past 62 days, and a skilled assessment is required to re-evaluate the continuing appropriateness of the plan of care. In this paragraph, "medically stable" means the recipient's physical condition is non-acute, without substantial change or fluctuation at the current time.

2. When the recipient's medical condition requires skilled nursing personnel to identify and evaluate the need for possible modification of treatment;

3. When the recipient's medical condition requires skilled nursing personnel to initiate additional medical procedures until the recipient's treatment regimen stabilizes, but is not part of a longstanding pattern of care; or

4. If there is a likelihood of complications or an acute episode.

(g) Teaching and training activities are covered services only when provided to the recipient, recipient's family or other caregiver in con-

junction with other covered skilled nursing care provided to the recipient.

(h) A licensed nurse shall administer medications to a minor child or to an adult who is not self-directing, as determined by the physician, to direct or administer his or her own medications, when a responsible adult is not present to direct the recipient's medication program.

(i) Services provided by an LPN which are not delegated by an RN under s. N 6.03 are not covered services.

(j) Skilled physical and occupational therapy and speech pathology services are not to include activities provided for the general welfare of the recipient or activities to provide diversion for the recipient or to motivate the recipient.

(k) Skilled nursing services may be provided for a recipient by one or more home health agencies or by an agency contracting with a nurse or nurses only if the agencies meet the requirements of ch. HSS 133 and are approved by the department.

(l) RN supervision and administrative costs associated with the provision of services under this section are not separately reimbursable MA services.

(m) Home health aide service limitations are the following:

1. A home health aide may provide assistance with a recipient's medications only if the written plan of care documents the name of the delegating registered nurse and the recipient is aged 18 or more;

2. Home health aide services are primarily medically oriented tasks, as determined by the delegating RN, when the instability of the recipient's condition as documented in the medical record is such that the recipient's care cannot be safely delegated to a personal care worker under s. HSS 107.112;

3. A home health aide visit which is a covered service shall include at least one medically oriented task performed during a visit which cannot, in the judgment of the delegating RN, be safely delegated to a personal care worker; and

4. A home health aide, rather than a personal care worker, shall always provide medically oriented services for recipients who are under age 18.

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

(a) Services that are not medically necessary;

(b) Skilled nursing services provided for 8 or more hours per recipient per day;

(c) More than one initial visit per day by a home health skilled nurse, home health aide, physical or occupational therapist or speech and language pathologist;

(d) Private duty nursing services under s. HSS 107.12, unless the requirements of sub. (4) (d) 2 apply;

(e) Services requiring prior authorization that are provided without prior authorization;

(f) Supervision of the recipient when supervision is the only service provided at the time;

(g) Hospice care provided under s. HSS 107.31;

(h) Mental health and alcohol or other drug abuse services provided under s. HSS 107.13 (2), (3), (3m), (4) and (6);

(i) Medications administration by a personal care worker or administration by a home health aide which has not been delegated by an RN according to the relevant provisions of ch. HSS 133.

(j) Skilled nursing services contracted for by a home health agency unless the requirements of s. HSS 133.19 are met and approved by the department;

(k) Occupational therapy, physical therapy or speech pathology services requiring only the use of equipment without the skills of the therapist or speech pathologist;

(l) Skilled nursing visits:

1. Solely for the purpose of ensuring that a recipient who has a demonstrated history of noncompliance over 30 days complies with the medications program;

2. To administer or assist with medication administration of an adult recipient who is capable of safely self-administering a medication as determined and documented by the RN;

3. To inject a recipient who is capable of safely self-injecting a medication, as described and documented by the RN;

4. To prefill syringes for self-injection when, as determined and documented by the RN, the recipient is capable of prefilling or a pharmacy is available to prefill; and

5. To set up medication for self-administration when, as determined and documented by the RN, the recipient is capable or a pharmacy is available to assist the recipient;

(m) Home health services to a recipient who is eligible for covered services under the medicare program or any other insurance held by the recipient;

(n) Services that are not medically appropriate. In this paragraph, "medically appropriate" means a service that is proven and effective treatment for the condition for which it is intended or used;

(o) Parenting;

(p) Services to other members of the recipient's household;

(q) A visit made by a skilled nurse, physical or occupational therapist or speech pathologist solely to train other home health workers;

(r) Any home health service included in the daily rate of the community-based residential facility where the recipient is residing;

(s) Services when provided to a recipient by the recipient's spouse or parent if the recipient is under age 18;

(t) Skilled nursing and therapy services provided to a recipient who is not confined to a place of residence when services are reasonably available outside the residence;

(u) Any service which is performed in a place other than the recipient's residence; and

(v) Independent nursing services under sub. (6).

(6) UNAVAILABILITY OF A HOME HEALTH AGENCY. (a) *Definition.* In this subsection, "part-time, intermittent care" means skilled nursing services provided in a recipient's home under a plan of care which requires less than 8 hours of skilled care in a calendar day.

(b) *Covered services.* 1. Part-time, intermittent nursing care may be provided by an independent nurse certified under s. HSS 105.19 when an existing home health agency cannot provide the services as appropriately documented by the nurse, and the physician's prescription specifies that the recipient requires less than 8 hours of skilled nursing care per calendar day and calls for a level of care which the nurse is licensed to provide as documented to the department.

2. Services provided by an MA-certified registered nurse are those services prescribed by a physician which comprise the practice of professional nursing as described under s. 441.11 (3), Stats., and s. N 6.03. Services provided by an MA-certified licensed practical nurse are those services which comprise the practice of practical nursing under s. 441.11 (4), Stats., and s. N 6.04. An LPN may provide nursing services delegated by an RN as delegated nursing acts under the requirements of ss. N 6.03 and 6.04 and guidelines established by the state board of nursing.

3. A written plan of care shall be established for every recipient admitted for care and shall be signed by the physician and incorporated into the recipient's medical record. A written plan of care shall be developed by the registered nurse or therapist within 72 hours after acceptance. The written plan of care shall be developed by the registered nurse or therapist in consultation with the recipient and the recipient's physician and shall be signed by the physician within 20 working days following the recipient's admission for care. The written plan of care shall include, in addition to the medication and treatment orders:

a. Measurable time-specific goals;

b. Methods for delivering needed care, and an indication of which, if any, professional disciplines are responsible for delivering the care;

c. Provision for care coordination by an RN when more than one nurse is necessary to staff the recipient's case;

d. Identification of all other parties providing care to the recipient and the responsibilities of each party for that care; and

e. A description of functional capabilities, mental status, dietary needs and allergies.

4. The written plan of care shall be reviewed, signed and dated by the recipient's physician as often as required by the recipient's condition but

at least every 62 days. The RN shall promptly notify the physician of any change in the recipient's condition that suggests a need to modify the plan of care.

5. Drugs and treatment shall be administered by the RN or LPN only as ordered by the recipient's physician or his or her designee. The nurse shall immediately record and sign oral orders and shall obtain the physician's countersignature within 10 working days.

6. Supervision of an LPN by an RN or physician shall be performed according to the requirements under ss. N 6.03 and 6.04 and the results of supervisory activities shall be documented and communicated to the LPN.

(c) *Prior authorization.* 1. Prior authorization requirements under sub. (3) apply to services provided by an independent nurse.

2. A request for prior authorization of part-time, intermittent care performed by an LPN shall include the name and license number of the registered nurse supervising the LPN.

(d) *Other limitations.* 1. Each independent RN or LPN shall document the care and services provided. Documentation required under par. (b) of the unavailability of a home health agency shall include names of agencies contacted, dates of contact and any other pertinent information.

2. Discharge of a recipient from nursing care under this subsection shall be made in accordance with s. HSS 105.19 (9).

3. The limitations under sub. (4) apply.

4. Registered nurse supervision of an LPN is not separately reimbursable.

(e) *Non-covered services.* The following services are not covered services under this subsection:

1. Services listed in sub. (5);

2. Private duty nursing services under s. HSS 107.12; and

3. Any service that fails to meet the recipient's medical needs or places the recipient at risk for a negative treatment outcome.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. Register, April, 1988, No. 388, eff. 7-1-88; am. (3) (d) and (e), cr. (3) (f), Register, December, 1988, No. 396, eff. 1-1-89; emerg. r. and recr. eff. 7-1-92; r. and recr. Register, February, 1993, No. 446, eff. 3-1-93.

HSS 107.112 Personal care services. (1) COVERED SERVICES. (a) Personal care services are medically oriented activities related to assisting a recipient with activities of daily living necessary to maintain the recipient in his or her place of residence in the community. These services shall be provided upon written orders of a physician by a provider certified under s. HSS 105.17 and by a personal care worker employed by the provider or under contract to the provider who is supervised by a registered nurse according to a written plan of care. The personal care worker shall be assigned by the supervising registered nurse to specific recipients to do specific tasks for those recipients for which the personal care worker has been trained. The personal care worker's training for these specific tasks

shall be assured by the supervising registered nurse. The personal care worker is limited to performing only those tasks and services as assigned for each recipient and for which he or she has been specifically trained.

(b) Covered personal care services are:

1. Assistance with bathing;

2. Assistance with getting in and out of bed;

3. Teeth, mouth, denture and hair care;

4. Assistance with mobility and ambulation including use of walker, cane or crutches;

5. Changing the recipient's bed and laundering the bed linens and the recipient's personal clothing;

6. Skin care excluding wound care;

7. Care of eyeglasses and hearing aids;

8. Assistance with dressing and undressing;

9. Toileting, including use and care of bedpan, urinal, commode or toilet;

10. Light cleaning in essential areas of the home used during personal care service activities;

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 under par. (a) for specific services listed in s. HSS 107.11 (2). Services listed in s. HSS 107.11 (2) (b) are covered personal care services, regardless of the recipient's age, only when:

1. Safely delegated to a personal care worker by a registered nurse;

2. The personal care worker is trained and supervised by the provider to provide the tasks; and

3. The recipient, parent or responsible person is permitted to participate in the training and supervision of the personal care worker.

(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.

(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 subs. (1) (b) and (2) (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; r. and recr. (2) (b), r. (3) (f), am. (4) (f), Register, February, 1993, No. 446, eff. 3-1-93.

HSS 107.113 Respiratory care for ventilator-assisted recipients. (1) COVERED SERVICES. Services, medical supplies and equipment necessary to provide life support for a recipient who has been hospitalized for at least 30 consecutive days for his or her respiratory condition and who is dependent on a ventilator for at least 6 hours per day shall be covered services when these services are provided to the recipient in the recipient's home. A recipient receiving these services is one who, if the services were not available in the home, would require them as an inpatient in a hospital or a skilled nursing facility, has adequate social support to be treated at home and desires to be cared for at home, and is one for whom respiratory care can safely be provided in the home. Respiratory care shall be provided as required under ss. HSS 105.16 and 105.19 and according to a written plan of care under sub. (2) signed by the recipient's physician for a recipient who lives in a residence that is not a hospital or a skilled nursing facility. Respiratory care includes:

(a) Airway management, consisting of:

1. Tracheostomy care: all available types of tracheostomy tubes, stoma care, changing a tracheostomy tube, and emergency procedures for tracheostomy care including accidental extubation;

2. Tracheal suctioning technique; and

3. Airway humidification;

(b) Oxygen therapy: operation of oxygen systems and auxiliary oxygen delivery devices;

(c) Respiratory assessment, including but not limited to monitoring of breath sounds, patient color, chest excursion, secretions and vital signs;

(d) Ventilator management, as follows:

1. Operation of positive pressure ventilator by means of tracheostomy to include, but not limited to, different modes of ventilation, types of alarms and responding to alarms, troubleshooting ventilator dysfunction, operation and assembly of ventilator circuit, that is, the delivery system, and proper cleaning and disinfection of equipment;

2. Operation of a manual resuscitator; and

3. Emergency assessment and management including cardiopulmonary resuscitation (CPR);

(e) The following modes of ventilatory support:

1. Positive pressure ventilation by means of a nasal mask or mouthpiece;

2. Continuous positive airway pressure (CPAP) by means of a tracheostomy tube or mask;

3. Negative pressure ventilation — iron lung, chest shell or pulmowrap;

4. Rocking beds;

5. Pneumobelts; and

6. Diaphragm pacing;

(f) Operation and interpretaion of monitoring devices:

1. Cardio-respiratory monitoring;

2. Pulse oximetry; and

3. Capnography;

(g) Knowledge of and skills in weaning from the ventilator;

(h) Adjunctive techniques:

1. Chest physiotherapy; and

2. Aerosolized medications; and

(i) Case coordination activities performed by the registered nurse designated in the plan of care as case coordinator. These activities include coordination of health care services provided to the recipient at home and coordination of these services with any other health or social service providers serving the recipient.

(2) PLAN OF CARE. A recipient's written plan of care shall be based on the orders of a physician, a visit to the recipient's home by the registered nurse and consultation with the family and other household members. The plan of care established by a home health agency or independent provider for a recipient to be discharged from a hospital shall consider the hospital's discharge plan for the recipient. The written plan of care shall be reviewed, signed and dated by the recipient's physician and renewed at least every 62 days and whenever the recipient's condition changes. Telephone orders shall be documented in writing and signed by the physician within 10 working days. The written physician's plan of care shall include:

(a) Physician orders for treatments provided by the necessary disciplines specifying the amount and frequency of treatment;

(b) Medications, including route, dose and frequency;

(c) Principal diagnosis, surgical procedures and other pertinent diagnosis;

(d) Nutritional requirements;

(e) Necessary durable medical equipment and disposable medical supplies;

(f) Ventilator settings and parameters;

(g) Procedures to follow in the event of accidental extubation;

(h) Identification of back-ups in the event scheduled personnel are unable to attend the case;

(i) The name of the registered nurse designated as the recipient's case coordinator;

(j) A plan for medical emergency, to include:

1. Description of back-up personnel needed;

2. Provision for reliable, 24-hour a day, 7 days a week emergency service for repair and delivery of equipment; and

3. Specification of an emergency power source; and

(k) A plan to move the recipient to safety in the event of fire, flood, tornado warning or other severe weather, or any other condition which threatens the recipient's immediate environment.

(3) PRIOR AUTHORIZATION. (a) All services covered under sub. (1) and all home health services under s. HSS 107.11 provided to a recipient receiving respiratory care shall be authorized prior to the time the services are rendered. Prior authorization shall be renewed every 12 calendar months if the respiratory care under this section is still needed. The prior authorization request shall include the name of the registered nurse who is responsible for coordination of all care provided under the MA program for the recipient in his or her home. Independent MA-certified respiratory therapists or nurses in private practice who are not employes of or contracted to a home health agency but are certified under s. HSS 105.19 (1) (b) to provide respiratory care shall include in the prior authorization request the name and license number of a registered nurse who will participate, on 24-hour call, in emergency assessment and management and who will be available to the respiratory therapist for consultation and assistance.

(4) OTHER LIMITATIONS. (a) Services under this section shall not be reimbursed if the recipient is receiving respiratory care from an RN, licensed practical nurse or respiratory therapist who is providing these services as part of the rental agreement for a ventilator or other respiratory equipment.

(b) Respiratory care provided to a recipient residing in a community-based residential facility (CBRF) as defined in s. 50.01 (1g), Stats., shall be in accordance with the requirements of ch. HSS 3.

(c) Durable medical equipment and disposable medical supplies shall be provided in accordance with conditions set out in s. HSS 107.24.

(d) Respiratory care services provided by a licensed practical nurse shall be provided under the supervision of a registered nurse and in accordance with standards of practice set out in s. N 6.04.

(e) Case coordination services provided by the designated case coordinator shall be documented in the clinical record, including the extent and scope of specific care coordination provided.

(f) In the event that a recipient receiving services at home who is discharged from the care of one respiratory care provider and admitted to the care of another respiratory care provider continues to receive services at home under this section, the admitting provider shall coordinate services with the discharging provider to ensure continuity of care. The admitting provider shall establish the recipient's plan of care as provided under sub. (2) and request prior authorization under sub. (3).

(g) Travel, recordkeeping and RN supervision of a licensed practical nurse are not separately reimbursable services.

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

(a) Parenting:

(b) Supervision of the recipient when supervision is the only service provided;

(c) Services provided without prior authorization;

(d) Services provided by one individual in excess of 12 continuous hours per day or 60 hours per week;

(e) Services provided in a setting other than the recipient's place of residence; and

(f) Services that are not medically appropriate.

History: Cr. Register, February, 1993, No. 446, eff. 3-1-93.

HSS 107.12 Private duty nursing sevices. (1) COVERED SERVICES. (a) Private duty nursing is skilled nursing care available for recipients with medical conditions requiring more continuous skilled care than can be provided on a part-time, intermittent basis. Only a recipient who requires 8 or more hours of skilled nursing care and is authorized to receive these services in the home setting may make use of the approved hours outside of that setting during those hours when normal life activities take him or her outside of that setting. Private duty nursing may be provided according to the requirements under ss. HSS 105.16 and 105.19 when the written plan of care specifies the medical necessity for this type of service.

(b) Private duty nursing services provided by a certified registered nurse in independent practice are those services prescribed by a physician which comprise the practice of professional nursing as described under s. 441.11 (3), Stats., and s. N 6.03. Private duty nursing services provided by a certified licensed practical nurse are those services which comprise the practice of practical nursing under s. 441.11 (4), Stats., and s. N 6.04. An LPN may provide private duty nursing sevices delegated by a registered nurse as delegated nursing acts under the requirements of ch. N 6 and guidelines established by the state board of nursing.

(c) Services may be provided only when prescribed by a physician and the prescription calls for a level of care which the nurse is licensed and competent to provide.

(d) 1. A written plan of care, including a functional assessment, medication and treatment orders, shall be established for every recipient admitted for care and shall be incorporated in the recipient's medical record within 72 hours after acceptance in consultation with the recipient and the recipient's physician and shall be signed by the physician within 20 working days following the recipient's admission for care. The physician's plan of care shall include, in addition to the medication and treatment orders:

a. Measurable time-specific goals;

b. Methods for delivering needed care, and an indication of which other professional disciplines, if any, are responsible for delivering the care;

c. Provision for care coordination by an RN when more than one nurse is necessary to staff the recipient's case; and

d. A description of functional capability, mental status, dietary needs and allergies.

2. The written plan of care shall be reviewed and signed by the recipient's physician as often as required by the recipient's condition, but not less often than every 62 days. The RN shall promptly notify the physician of any change in the recipient's condition that suggests a need to modify the plan of care.

(e) Drugs and treatment shall be administered by the RN or LPN only as ordered by the recipient's physician or his or her designee. The nurse shall immediately record and sign oral orders and shall obtain the physician's countersignature within 10 working days.

(f) Medically necessary actual time spent in direct care that requires the skills of a licensed nurse is a covered service.

(2) PRIOR AUTHORIZATION. (a) Prior authorization is required for all private duty nursing services.

(b) Private duty nursing for which prior authorization is requested is limited to 12 continuous hours in each 24 hour period and no more than 60 hours in a calendar week for the number of weeks care continues to be medically necessary, when provided by a single provider for all recipients combined who are receiving services from the provider. A prior authorization request for 2 consecutive 12-hour periods shall not be approved.

(c) A request for prior authorization of private duty nursing services performed by an LPN shall include the name and license number of the registered nurse or physician supervising the LPN.

(d) A request for prior authorization for care for a recipient who requires more than one private duty nurse to provide medically necessary care shall include the name and license number of the RN performing care coordination responsibilities.

(3) OTHER LIMITATIONS. (a) Discharge of a recipient from private duty nursing care shall be made in accordance with s. HSS 105.19 (9).

(b) An RN supervising an LPN performing services under this section shall supervise the LPN as often as necessary under the requirements of s. N 6.03 during the period the LPN is providing services, and shall communicate the results of supervisory activities to the LPN. These activities shall be documented by the RN.

(c) Each private duty nurse shall document the nature and scope of the care and services provided to the recipient in the recipient's medical record.

(d) Services performed in two consecutive 12-hour periods under sub. (2) (b) are not reimbursable.

(e) Travel time, recordkeeping and RN supervision of an LPN are not separately reimbursable services.

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

(a) Any services not included in the physician's plan of care;

(b) Any services under s. HSS 107.11;

(c) Skilled nursing services performed by a recipient's spouse or parent if the recipient is under age 21;

(d) Services that were provided but not documented; and

(e) Any service that fails to meet the recipient's medical needs or places the recipient at risk for a negative treatment outcome.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; emerg. r. and recr. eff. 7-1-90; r. and recr. Register, January, 1991, No. 421, eff. 2-1-91; emerg. r. and recr. eff. 7-1-92; r. and recr. Register, February, 1993, No. 446, eff. 3-1-93.

HSS 107.121 Nurse-midwife services. (1) COVERED SERVICES. Covered services provided by a certified nurse-midwife 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 4.

(2) LIMITATION. Coverage for nurse-midwife services for management and care of the mother and newborn child shall end after the sixth week of postpartum care.

HSS 107.122 Independent nurse practitioner services. (1) COVERED SERVICES. Services provided by a nurse practicioner, including a clinical nurse specialist, which are covered by the MA program are those medical services delegated by a licensed physician by a written protocol developed with the nurse practitioner pursuant to the requirements set forth in s. N 6.03 (2) and guidelines set forth by the medical examining board and the board of nursing. General nursing procedures are covered services when performed by a certified nurse practitioner or clinical nurse specialist in accordance with the requirements of s. N 6.03 (1). These services may include those medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative services provided in a medical setting, the recipient's home or elsewhere. Specific reimbursable delegated medical acts and nursing services are the following:

(a) Under assessment and nursing diagnosis:

1. Obtaining a recipient's complete health history and recording the findings in a systematic, organized manner;

2. Evaluating and analyzing a health history critically;

3. Performing a complete physical assessment using techniques of observation, inspection, auscultation, palpation and percussion, ordering appropriate laboratory and diagnostic tests and recording findings in a systematic manner;

4. Performing and recording a developmental or functional status evaluation and mental status examination using standardized procedures; and

5. Identifying and describing behavior associated with developmental processes, aging, life style and family relationships;

(b) Under analysis and decision-making:

1. Discriminating between normal and abnormal findings associated with growth and development, aging and pathological processes;

2. Discriminating between normal and abnormal patterns of behavior associated with developmental processes, aging, life style, and family relationships as influenced by illness;

3. Exercising clinical judgment in differentiating between situations which the nurse practitioner can manage and those which require consultations or referral; and

4. Interpreting screening and selected diagnostic tests;

(c) Under management, planning, implementation and treatment:

Next page is numbered 163

or to inpatients in IMDs are not considered inpatient services. Reimbursement shall be made to the psychiatrist or psychologist billing provider certified under s. HSS 105.22 (1) (a) or (b) or 105.23 who provides AODA treatment services to hospital inpatients in accordance with requirements under this subsection.

4. Medical detoxification services are not considered inpatient services if provided outside an inpatient general hospital or IMD.

(d) *Non-covered services.* The following services are not covered services:

1. Collateral interviews and consultations, except as provided in s. HSS 107.06 (4) (d);

2. Court appearances except when necessary to defend against commitment; and

3. Detoxification provided in a social setting, as described in s. HSS 61.58, is not a covered service.

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

(3m) ALCOHOL AND OTHER DRUG ABUSE DAY TREATMENT SERVICES. (a) *Covered services.* Alcohol and other drug abuse day treatment services shall be covered when prescribed by a physician, provided by a provider certified under s. HSS 105.25 and performed according to the recipient's treatment program in a non-residential, medically supervised setting, and when the following conditions are met:

1. An initial assessment is performed by qualified medical professionals under s. HSS 61.61 (6) for a potential participant. Services under this section shall be covered if the assessment concludes that AODA day treatment is medically necessary and that the recipient is able to benefit from treatment;

2. A treatment plan based on the initial assessment is developed by the interdisciplinary team in consultation with the medical professionals who conducted the initial assessment and in collaboration with the recipient;

3. The supervising physician or psychologist approves the recipient's written treatment plan;

4. The treatment plan includes measureable individual goals, treatment modes to be used to achieve these goals and descriptions of expected treatment outcomes; and

5. The interdisciplinary team monitors the recipient's progress, adjusting the treatment plan as required.

(b) *Prior authorization.* 1. All AODA day treatment services except the initial assessment shall be prior authorized.

2. Any recommendation by the county human services department under s. 46.23, Stats., or the county community programs department under s. 51.42, Stats., shall be considered in review and approval of the prior authorization request.

3. Department representatives who review and approve prior authorization requests shall meet the same minimum training requirements as

those mandated for AODA day treatment providers under s. HSS 105.25.

(c) *Other limitations.* 1. AODA day treatment services in excess of 5 hours per day are not reimbursable under MA.

2. AODA day treatment services may not be billed as psychotherapy, AODA outpatient treatment, case management, occupational therapy or any other service modality except AODA day treatment.

3. Reimbursement for AODA day treatment services may not include time devoted to meals, rest periods, transportation, recreation or entertainment.

4. Reimbursement for AODA day treatment assessment for a recipient is limited to 3 hours in a calendar year. Additional assessment hours shall be counted towards the mental health outpatient dollar or hour limit under sub. (2) (a) 6 before prior authorization is required or the AODA outpatient dollar or hour limit under sub. (3) (a) 4 before prior authorization is required.

(d) *Non-covered services.* The following are not covered services:

1. Collateral interviews and consultations, except as provided in s. HSS 107.06 (4) (d);

2. Time spent in the AODA day treatment setting by affected family members of the recipient;

3. AODA day treatment services which are primarily recreation-oriented or which are provided in non-medically supervised settings. These include but are not limited to sports activities, exercise groups, and activities such as crafts, leisure time, social hours, trips to community activities and tours;

4. Services provided to an AODA day treatment recipient which are primarily social or only educational in nature. Educational sessions are covered as long as these sessions are part of an overall treatment program and include group processing of the information provided;

5. Prevention or education programs provided as an outreach service or as case-finding; and

6. AODA day treatment provided in the recipient's home.

(4) DAY TREATMENT OR DAY HOSPITAL SERVICES. (a) *Covered services.* Day treatment or day hospital services are covered services when prescribed by a physician, when provided by a provider who meets the requirements of s. HSS 105.24, and when the following conditions are met:

1. Before becoming involved in a day treatment program, the recipient is evaluated 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;

2. The supervising psychiatrist approves, signs and dates a written treatment plan for each recipient and reviews and signs the plan no less frequently than once every 60 days. The treatment plan shall be based on the initial evaluation and shall include the individual goals, the treatment modalities including identification of the specific group or groups to be used to achieve these goals and the expected outcome of treatment;

3. Up to 90 hours of day treatment services in a calendar year may be reimbursed without prior authorization. Psychotherapy services or occupational therapy services provided as component parts of a person's day treatment package may not be billed separately, but shall be billed and reimbursed as part of the day treatment program;

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

5. Reimbursement is not made for day treatment services provided in excess of 5 hours in any day or in excess of 120 hours in any month;

6. 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 provided by the department; and

7. Billing for day treatment is submitted by the provider. Day treatment services shall be billed as such, and not as psychotherapy, occupational therapy or any other service modality.

8. The groups shall be led by a qualified professional staff member, as defined under s. HSS 105.24 (1) (b) 4 a, and the staff member shall be physically present throughout the group sessions and shall perform or direct the service.

(b) *Services requiring prior authorization.* 1. Providers shall obtain authorization from the department before providing the following services, as a condition for coverage of these services:

a. Day treatment services provided beyond 90 hours of service in a calendar year;

b. 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 in a calendar year may be authorized for a recipient residing in a nursing home;

c. All day treatment services provided to recipients who are concurrently receiving psychotherapy, occupational therapy or AODA services;

d. All day treatment services in excess of 90 hours provided to recipients who are diagnosed as acutely mentally ill.

2. The prior authorization request shall include:

a. The name, address, and MA number of the recipient;

b. The name, address, and provider number of the provider of the service and of the billing provider;

c. A photocopy of the physician's original prescription for treatment;

d. A copy of the treatment plan and the expected outcome of treatment;

e. A statement of the estimated additional dates of service necessary and total cost; and

f. The demographic and client information form from the initial and most recent functional assessment. The assessment shall have been conducted within 3 months prior to the authorization request.

3. The department's decision on a prior authorization request shall be communicated to the provider in writing. If the request is denied, the department shall provide the recipient with a separate notification of the denial.

(c) *Other limitations.* 1. All assessment hours beyond 6 hours in a calendar year shall be considered part of the treatment hours and shall become subject to the relevant prior authorization limits. Day treatment assessment hours shall be considered part of the 6 hour per 2-year mental health evaluation limit.

2. Reimbursement for day treatment services shall be limited to actual treatment time and may not include time devoted to meals, rest periods, transportation, recreation or entertainment.

3. Reimbursement for day treatment services shall be limited to no more than 2 series of day treatment services in one calendar year related to separate episodes of acute mental illness. All day treatment services in excess of 90 hours in a calendar year provided to a recipient who is acutely mentally ill shall be prior-authorized.

4. Services under this subsection are not reimbursable if the recipient is receiving community support program services under sub. (6).

(d) *Non-covered services.* The following services are not covered services:

1. Day treatment services which are primarily recreation-oriented and which are provided in non-medically supervised settings such as 24 hour day camps, or other social service programs. These include sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities and tours;

2. Day treatment services which are primarily social or educational in nature, in addition to having recreational programming. These shall be considered non-medical services and therefore non-covered services regardless of the age group served;

3. Consultation with other providers or service agency staff regarding the care or progress of a recipient;

4. Prevention or education programs provided as an outreach service, case-finding, and reading groups;

5. Aftercare programs, provided independently or operated by or under contract to boards;

6. Medical or AODA day treatment for recipients with a primary diagnosis of alcohol or other drug abuse;

7. Day treatment provided in the recipient's home; and

8. Court appearances except when necessary to defend against commitment.

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

(6) COMMUNITY SUPPORT PROGRAM (CSP) SERVICES. *Covered services.* Community support program (CSP) services shall be covered services when prescribed by a physician and provided by a provider certified under s. HSS 105.255 for recipients who can benefit from the services. These non-institutional services make medical treatment and related care and rehabilitative services available to enable a recipient to better manage the symptoms of his or her illness, to increase the likelihood of the recipient's independent, effective functioning in the community and to reduce the incidence and duration of institutional treatment otherwise brought about by mental illness. Services covered are as follows:

1. Initial assessment. At the time of admission, the recipient, upon a psychiatrist's order, shall receive an initial assessment conducted by a psychiatrist and appropriate professional personnel to determine the need for CSP care;

2. In-depth assessment. Within one month following the recipient's admission to a CSP, a psychiatrist and a treatment team shall perform an in-depth assessment to include all of the following areas:

a. Evaluation of psychiatric symptomology and mental status;

b. Use of drugs and alcohol;

c. Evaluation of vocational, educational and social functioning;

d. Ability to live independently;

e. Evaluation of physical health, including dental health;

f. Assessment of family relationships; and

g. Identification of other specific problems or needs;

3. Treatment plan. A comprehensive written treatment plan shall be developed for each recipient and approved by a psychiatrist. The plan shall be developed by the treatment team with the participation of the recipient or recipient's guardian and, as appropriate, the recipient's family. Based on the initial and in-depth assessments, the treatment plan shall specify short-term and long-term treatment and restorative goals, the services required to meet these goals and the CSP staff or other agencies providing treatment and psychosocial rehabilitation services. The treatment plan shall be reviewed by the psychiatrist and the treatment team at least every 30 days to monitor the recipient's progress and status;

4. Treatment services, as follows:

a. Family, individual and group psychotherapy;

b. Symptom management or supportive psychotherapy;

c. Medication prescription, administration and monitoring;

d. Crisis intervention on a 24-hour basis, including short-term emergency care at home or elsewhere in the community; and

e. Psychiatric and psychological evaluations;

5. Psychological rehabilitation services as follows;

a. Employment-related services. These services consist of counseling the recipient to identify behaviors which interfere with seeking and maintaining employment; development of interventions to alleviate problem behaviors; and supportive services to assist the recipient with grooming, personal hygiene, acquiring appropriate work clothing, daily preparation for work, on-the-job support and crisis assistance;

b. Social and recreational skill training. This training consists of group or individual counseling and other activities to facilitate appropriate behaviors, and assistance given the recipient to modify behaviors which interfere with family relationships and making friends;

c. Assistance with and supervision of activities of daily living. These services consist of aiding the recipient in solving everyday problems; assisting the recipient in performing household tasks such as cleaning, cooking, grocery shopping and laundry; assisting the recipient to develop and improve money management skills; and assisting the recipient in using available tranaportation;

d. Other support services. These services consist of helping the recipient obtain necessary medical, dental, legal and financial services and living accomodations; providing direct assistance to ensure that the recipient obtains necessary government entitlements and services, and counseling the recipient in appropriately relating to neighbors, landlords, medical personnel and other personal contacts; and

6. Case management in the form of ongoing monitoring and service coordination activities described in s. HSS 107.32 (1) (d).

(b) *Other limitations.* 1. Mental health services under s. HSS 107.13 (2) and (4) are not reimbursable for recipients receiving CSP services.

2. An initial assessment shall be reimbursed only when the recipient is first admitted to the CSP and following discharge from a hospital after a short-term stay.

3. Group therapy is limited to no more than 10 persons in a group. No more than 2 professionals shall be reimbursed for a single session of group therapy. Mental health technicians shall not be reimbused for group therapy.

(c) *Non-covered services.* The following CSP services are not covered services:

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; emerg. r. and recr. (1) (b) 3., am. (1) (f) 6., eff. 1-1-91; am. (1) (a), (b) 1. and 2., (c), (f) 5., 6. and 8., (2) (a) 1., 3. a. and b., 4. f., 6., 7., (b) 1. and 2., (c) 2., (3) (a) (intro.), 4., 5., 7., (b) 1. and 2., (c) 1. (3) (d) 1. and 2., (4) (a) 3. and 6. and (d) 6., r. and recr. (1) (b) 3. and (e), r. (4) (b) 1. d., renum. (4) (b) 1. c. to be d., cr. (2) (c) 6., (3) (c) 3. and 4., (3) (d) 3., Register, September, 1991, No. 429, eff. 10-1-91; am. (4) (a) 2., cr. (4) (a) 8., Register, February, 1993, No. 446, eff. 3-1-93.

HSS 107.14 Podiatry services. (1) COVERED SERVICES. (a) Podiatry services covered by medical assistanace are those medically necessary services for the diagnosis and treatment of the feet and ankles, within the limitations described in this section, when provided by a certified podiatrist.

(b) The following categories of services are covered services when performed by a podiatrist:

1. Office visits;

2. Home visits;

3. Nursing home visits;

4. Physical medicine;

5. Surgery;

6. Mycotic conditions and nails;

7. Laboratory;

8. Radiology;

9. Plaster or other cast material used in cast procedures and strapping or tape casting for treating fractures, dislocations, sprains and open wounds of the ankle, foot and toes;

10. Unna boots; and

11. Drugs and injections.

(2) OTHER LIMITATIONS. (a) Podiatric services pertaining to the cleaning, trimming and cutting of toenails, often referred to as palliative or maintenance care, shall be reimbursed once per 61 day period only if the recipient is under the active care of a physician and 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. Diabetes mellitus;

c. Drugs and toxins;

d. Multiple sclerosis; or

e. Uremia;

4. Cerebral palsy;

5. Multiple sclerosis;

6. Spinal cord injuries;

7. Blindness;

8. Parkinson's disease;

9. Cerebrovascular accident; or

10. Scleroderma.

(b) The cutting, cleaning and trimming of toenails, corns, callouses and bunions on multiple digits shall be reimbursed at one fee for each service which includes either one or both feet.

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

(d) Physical medicine modalities may include, but are not limited to, hydrotherapy, ultrasound, iontophoresis, transcutaneous neurostimulator (TENS) prescription, and electronic bone stimulation. Physical medicine is limited to 10 modality services per calendar year for the following diagnoses only:

1. Osteoarthritis;

2. Tendonitis;

3. Enthesopathy;

4. Sympathetic reflex dystrophy;

5. Subclacaneal bursitis; and

6. Plantar fascitis, as follows:

a. Synovitis;

b. Capsulitis;

c. Bursitis; or

d. Edema.

(e) Services provided during a nursing home visit to cut, clean or trim toenails, corns, callouses or bunions of more than one resident shall be reimbursed at the nursing home single visit rate for only one of the residents seen on that day of service. All other claims for residents seen at the nursing home on the same day of service shall be reimbursed up to the multiple nursing home visit rate. The podiatrist shall identify on the claim form the single resident for whom the nursing home single visit rate is applicable, and the residents for whom the multiple nursing home visit rate is applicable.

(f) Debridement of mycotic conditions and mycotic nails is a covered service provided that utilization guidelines established by the department are followed.

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

(a) Procedures which do not relate to the diagnosis or treatment of the ankle or foot;

(b) Palliative or maintenance care, except under sub. (2);

(c) All orthopedic and orthotic services except plaster and other material cast procedures and strapping or tape casting for treating fractures, dislocations, sprains or open wounds of the ankle, foot or toes;

(d) Orthopedic shoes and supportive devices such as arch supports, shoe inlays and pads;

(e) Physical medicine exceeding the limits specfied under sub. (2) (d);

(f) Repairs made to orthopedic and orthotic appliances;

(g) Dispensing and repairing corrective shoes;

(h) Services directed toward the care and correction of "flat feet;"

(i) Treatment of subluxation of the foot; and

(j) All other services not specifially identified as covered in this section.

History: Emerg. cr. eff. 7-1-90; cr. Register, January, 1991, No. 421, eff. 2-1-91.

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

Next page is numbered 175