Chapter HSS 107

COVERED SERVICES

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Note: Chapter HSS 107 as it existed on February 28, 1986 was repealed and a new chapter HSS 107 was created effective March 1, 1986.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

cephalelgia and migraine, pelvic inflammatory disease, gynecologic disease and venereal disease;

3. History of previous contraceptive use;

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

5. Physical examination. Recommended procedures for examination are:

a. Thyroid palpation;

b. Examination of breasts and axillary glands;

c. Auscultation of heart and lungs;

d. Blood pressure measurement;

e. Height and weight measurement;

f. Abdominal examination;

g. Pelvic examination; and

h. Examination of extremities.

(c) *Laboratory and other diagnostic services.* Laboratory and other diagnostic services are covered services as indicated in this paragraph. These services may be performed in conjunction with an initial examination with health history, and are the following:

1. Routinely performed procedures:

a. CBC, or hematocrit or hemoglobin;

b. Urinalysis;

c. Papanicolaou smear for females between the ages of 12 and 65;

d. Bacterial smear or culture (gonorrhea, trichomonas, yeast, etc.) including VDRL — syphilis serology with positive gonorrhea cultures; and

e. Serology;

2. Procedures covered if indicated by the recipient's health history:

a. Skin test for TB;

b. Vaginal smears and wet mounts for suspected vaginal infection;

c. Pregnancy test;

d. Rubella titer;

e. Sickle-cell screening;

f. Post-prandial blood glucose; and

g. Blood test for cholesterol, and triglycerides when related to oral contraceptive prescription;

3. Procedures relating to fertility and infertility:

a. Semen analysis, including pelvic exam as necessary;

b. Endometrial biopsy when performed after a hormone blood test;

c. Hysterosalpingogram;

d. Laparoscopy;

e. Cervical mucus exam;

f. Vasectomies;

g. Culdoscopy; and

h. Coloscopy;

4. Procedures relating to genetics, including:

a. Ultrasound;

b. Amniocentesis;

c. Tay-Sachs screening;

d. Hemophilia screening;

e. Muscular dystrophy screening; and

f. Sickle-cell screening; and

5. Colposcopy, culdoscopy, and laparoscopy procedures which may be either diagnostic or treatment procedures.

(d) *Counseling services.* Counseling services in the clinic are covered as indicated in this paragraph. These services may be performed or supervised by a physician, registered nurse or licensed practical nurse. Counseling services may be provided as a result of request by a recipient or when indicated by exam procedures and health history. These services are limited to the following areas of concern:

1. Instruction on reproductive anatomy and physiology;

2. Overview of available methods of contraception, including natural family planning. An explanation of the medical ramifications and effectiveness of each shall be provided;

3. Counseling about venereal disease;

4. Counseling about sterility;

5. Counseling about sterilization accompanied by a full explanation of sterilization procedures including associated discomfort and risks, benefits, and irreversibility;

6. Genetic counseling accompanied by a full explanation of procedures utilized in genetic assessment, including information regarding the medical ramifications for unborn children and planning of care for unborn children with either diagnosed or possible genetic abnormalities;

7. Information regarding teratologic evaluations; and

8. Information and education regarding pregnancies at the request of the recipient, including pre-natal counseling and referral.

(e) *Contraceptive methods.* Procedures related to the prescription of a contraceptive method are covered services. The contraceptive method

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

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

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

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

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

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

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

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

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

1. Diagnosis of a physical or mental illness;

2. Monitoring of clinical symptoms;

3. Administration of medications;

4. Client education and training;

5. Legal advocacy by an attorney or paralegal;

6. Provision of supportive home care;

7. Home health care;

8. Personal care; and

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

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

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88.

HSS 107.33 Ambulatory prenatal services for recipients with presumptive eligibility. (1) COVERED SERVICES. Ambulatory prenatal care services are covered services. These services include treatment of conditions or complications that are caused by, exist or are exacerbated by a pregnant woman's pregnant condition.

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

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

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

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88.

(b) Incorporation by reference in certification procedures for all providers; and

(c) Incorporation in information provided to recipients regarding their rights and responsibilities.

(9) The secretary or a designee shall determine the appropriate application of this section to circumstances not covered expressly by this section. Use or disclosure not expressly provided for in this section may not occur prior to this determination.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 108.02 Department rights and responsibilities. (1) DIFFERENT BENEFITS FOR DIFFERENT GROUPS. The department may offer MA benefits to the categorically needy which are different from the benefits offered to the medically needy, subject to ss. 49.46 (2) (a) and 49.47 (6) (a), Stats. For the categorically needy, benefits shall meet federal minimum standards of coverage under 42 CFR 435.100-135. The department need not provide the same benefits that the categorically needy receive to individuals who are determined to be medically needy. The department is not required to provide the same amount, duration and scope of services to all the different groups who make up the medically needy population.

(2) REIMBURSEMENT METHODS AND PAYMENT LEVELS. The department may establish the reimbursement methods and payment levels for program services subject to the requirements of federal and state statutes, regulations and chs. HSS 101 to 107 and this chapter. Notice of specific changes or updates to payment levels shall be communicated to the service providers by the department through periodic publication of provider handbooks.

(3) ADVISORY COMMITTEES. The department may appoint and make use of professional advisory committees on an ad hoc basis to provide expertise for development of service or reimbursement policies.

(4) PROVIDER HANDBOOKS AND BULLETINS. The department shall publish provider handbooks, bulletins and periodic updates to inform providers of changes in state or federal law, policy, reimbursement rates and formulas, departmental interpretation, and procedural directives such as billing and prior authorization procedures, specific reimbursement changes and items of general information. The department shall inform providers in a handbook, bulletin or other publication of specific services requiring collection of benefits from medicare or other health care plans under s. HSS 106.03 (7) before benefits are claimed from the MA program. Information regarding eligibility for medicare or for another health care plan as identified on the recipient's MA identification card shall also be included in these publications.

(5) NOTIFICATION OF RECIPIENTS. The department shall publish periodic notification to eligible recipients, as necessary, to provide general information regarding MA program benefits and procedural requirements, and to notify recipients of any benefit or eligibility changes.

(6) NOTICE OF CHANGE IN METHOD OR LEVEL OF REIMBURSEMENT. (a) Except as provided in par. (b), the department shall publish a public notice in the Wisconsin administrative register of any significant proposed change in the statewide method or level of reimbursement for a

service, in compliance with 42 CFR 442.205. This notice shall include information on the procedure for obtaining details of the proposed change, why the change is proposed and how to provide public comment to the department.

(b) Changes for which no public notice is required include the following:

1. Changes to conform with medicare methods and federally-invoked upper limits on reimbursement;

2. Changes required of the department by court order; and

3. Changes in wholesalers' or manufacturers' prices of drugs or materials, if the department's method of reimbursement is based on direct or wholesale prices as reported in a national standard such as the American druggist blue book, plus a pharmacy dispensing fee.

(c) Notice in the Wisconsin administrative register shall constitute official notice by the department to its contracted health service providers of a contractual change.

(7) MAILINGS AND DISTRIBUTIONS. The department shall mail or distribute materials to applicants, recipients or medical providers, as follows:

(a) All materials shall be limited to purposes directly related to program administration.

(b) Materials which may not be mailed or distributed include:

1. "Holiday" greetings;

2. General public announcements;

3. Voting information;

4. Alien registration notices;

5. Names of individuals, unless:

a. The named individual is connected with direct program administration; or

b. The named individual is identified only in an official agency capacity; and

6. Any material with political implications.

(c) Materials which may be mailed or distributed include:

1. Information of immediate interest to applicants' or recipients' health and welfare;

2. Information regarding the deletion or reduction of covered services; and

3. Consumer protection information.

(8) THIRD PARTY LIABILITY FOR COST OF SERVICES. (a) The department shall make reasonable efforts to identify any third party insurer, including medicare, legally liable to contribute in whole or in part to the cost of services provided to a recipient under the MA program.

(b) When the department has determined that medicare or any other health care plan provides health care coverage to the recipient which is primary to MA, as stated in s. 632.755 (2), Stats., the medicare or other insurance coverage shall be identified on the recipient's MA identification card by specific codes.

(c) In the event payment for services otherwise covered by medicare or by another health care plan is unavailable, the provider may bill the department's MA fiscal agent, identifying the efforts to seek reimbursement from medicare or the other health care plan, on condition that the provider complies with the instructions issued by the department under sub. (4).

(9) DEPARTMENTAL RECOUPMENT OF OVERPAYMENTS. (a) *Recoupment methods.* If the department finds that a provider has received an overpayment, including but not limited to erroneous, excess, duplicative and improper payments regardless of cause, under the program, the department may recover the amount of the overpayment by any of the following methods, at its discretion:

1. Offsetting or making an appropriate adjustment against other amounts owed the provider for covered services;

2. Offsetting or crediting against amounts determined to be owed the provider for subsequent services provided under the program if:

a. The amount owed the provider at the time of the department's finding is insufficient to recover in whole the amount of the overpayment; and

b. The provider is claiming and receiving MA reimbursement in amounts sufficient to reasonably ensure full recovery of the overpayment within a reasonable period of time; or

3. Requiring the provider to pay directly to the department the amount of the overpayment.

(b) *Written notice.* No recovery by offset, adjustment or demand for payment may be made by the department under par. (a), except as provided under par. (c), unless the department gives the provider prior written notice of the department's intention to recover the amount determined to have been overpaid. The notice shall set forth the amount of the intended recovery, identify the claim or claims in question or other basis for recovery, summarize the basis for the department's finding that the provider has received amounts to which the provider is not entitled or in excess of that to which the provider is entitled, and inform the provider of a right to appeal the intended action under par. (e). Payment due the department shall be made by the provider within 30 days after the date of service of the notice of intent to recover. Final notices of intent to recover shall be sent by certified mail.

(c) *Exception.* The department need not provide prior written notice under par. (b) when the overpayment was made as a result of a computer processing or clerical error, for a recoupment of a manual partial payment, or when the provider requested or authorized the recovery to be made. In any of these cases the department or its fiscal agent shall provide written notice of any payment adjustments made on the next remittance issued the provider. This notice shall specify the amount of the

adjustment made and the claim or claims which were the subject of the adjustments.

(d) *Withholding of payment involving fraud or willful misrepresentation.* 1. The department may withhold MA payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for withholding of payments involve fraud or willful misrepresentation under the MA program. Reliable evidence of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges for those activities against the provider or one of its agents or employes by a prosecuting attorney. The department may withhold payments without first notifying the provider of its intention to withhold the payments. A provider is entitled to a hearing under s. HSS 106.12.

2. The department shall send written notice to the provider of the department's withholding of MA program payments within 5 days after taking that action. The notice shall generally set forth the allegations leading to the withholding, but need not disclose any specific information concerning the ongoing investigation of allegations of fraud and willful misrepresentation. The notice shall:

a. State that payments are being withheld in accordance with this paragraph;

b. State that the withholding action is for a temporary period, as defined under subd. 3, and cite the circumstances under which withholding will be terminated;

c. Specify, when appropriate, to which type or types of MA claims withholding is effective; and

d. Inform the provider that the provider has a right to submit to the department written evidence regarding the allegations of fraud and willful misrepresentation for consideration by the department.

3. Withholding of the provider's payments shall be temporary. Withholding of payment may not continue after:

a. The department determines after a preliminary investigation that there is not sufficient evidence of fraud or willful misrepresentation by the provider to require referral of the matter to an appropriate law enforcement agency pursuant to 42 CFR 455.15 and, to the extent of the department's knowledge, the matter is not already the subject of an investigation or a prosecution by a law enforcement agency or a prosecuting authority;

b. Any law enforcement agency or prosecuting authority which has investigated or commenced prosecution of the matter determines that there is insufficient evidence of fraud or misrepresentation by the provider to pursue criminal charges or civil forfeitures; or

c. Legal proceedings relating to the provider's alleged fraud or willful misrepresentation are completed and charges against the provider have been dismissed. In the case of a conviction of a provider for criminal or civil forfeiture offenses, those proceedings shall not be regarded as being completed until all appeals are exhausted. In the case of an acquittal in or dismissal of criminal or civil forfeiture proceedings against a provider, the proceedings shall be regarded as complete at the time of dismissal or

acquittal regardless of any opportunities for appeal which the prosecuting authority may have.

(e) *Request for hearing on recovery action.* If a provider chooses to contest the propriety of a proposed recovery under par. (a), the provider shall, within 20 days after receipt of the department's notice of intent to recover, request a hearing on the matter. The request shall be in writing and shall briefly identify the basis for contesting the proposed recovery. Receipt of a timely request for hearing shall prevent the department from making the proposed recovery while the hearing proceeding is pending. If a timely request for hearing is not received, the department may recover from current or future obligations of the program to the provider the amount specified in the notice of intent to recover and may take such other legal action as it deems appropriate to collect the amount specified. All hearings on recovery actions by the department shall be held in accordance with the provisions of ch.227, Stats. The date of service of a provider's request for a hearing shall be the date on which the department's office of administrative hearings receives the request.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; emerg. am. (4), cr. (8) and (9), eff. 7-1-92; am. (4), cr. (8) and (9), Register, February, 1993, No. 446, eff. 3-1-93.

HSS 108.03 County responsibilities. (1) DETERMINATION OF ELIGIBILITY. Agencies shall be responsible for determination of eligibility for MA. These determinations shall comply with standards for eligibility found in ss. 49.46 (1) and 49.47 (4), Stats., and ch. HSS 103.

(2) INFORMING RECIPIENTS OF RIGHTS AND DUTIES. Agencies shall inform recipients of the recipients' rights and duties under the program, including those rights enumerated in s. HSS 106.04 (3).

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