(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.

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HSS 107.23 Transportation. (1) COVERED SERVICES. (a) *Purpose.* Transportation is a covered service when it is necessary for a recipient to complete a visit to receive MA-covered medical services.

(b) *Transport by ambulance.* Ambulance transportation shall be a covered service if the recipient is suffering from an illness or injury which contraindicates transportation by other means, but only when provided:

1. From the recipient's residence or the site of an accident to a hospital or nursing home;

2. From a hospital or nursing home to the recipient's residence. This shall be considered non-emergency transportation;

3. From a nursing home to a hospital;

4. From a hospital to a nursing home. This shall be considered non-emergency transportation;

5. From a hospital to another hospital;

6. From a nursing home to another nursing home. This shall be considered non-emergency transportation;

7. From a recipient's residence or nursing home to a physician's or dentist's office, if the transportation is to obtain a physician's or dentist's services which require special equipment for diagnosis or treatment that cannot be obtained in the nursing home or recipient's residence. This shall be considered non-emergency transportation; or

8. In an isolette. This shall be considered non-emergency transportation.

(c) *Transport by non-emergency vehicle.* Specialized medical vehicle (SMV) transportation shall be a covered service if the recipient is legally blind or permanently disabled as documented by a physician with the documentation maintained by the provider, or if the recipient's condition contraindicates transportation by a common carrier and the recipient's physician has prescribed specialized medical vehicle transportation. This type of transportation service, and the return trip, is covered only if the transportation is to a facility at which the recipient primarily receives MA-covered medical services. SMV trips by cot or stretcher are covered if they have been prescribed by a physician and meet the prescription requirements of s. HSS 107.06 (4) (a) 3. In this paragraph, "permanent disability" means a chronic debilitating physical or mental impairment which includes an inability to ambulate without personal assistance or requires the use of mechanical walking aids such as a wheelchair, a walker or crutches.

(d) *More than one passenger.* A provider of transportation service may carry more than one recipient at a time.

(e) *Transport provided by the county agency.* County agencies shall pay for necessary transportation to MA-covered medical services by public carrier or private motor vehicle when this transportation is provided as an administrative service in accordance with sub. (3).

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

(a) *Air or water ambulance.* All non-emergency transportation of a recipient by air or water ambulance to receive medical services; and

(b) *Long distance transports.* Non-emergency transportation of a recipient to a provider in another state unless the non-emergency transportation is for the purpose of receiving services from a provider who is a certified Wisconsin border-status provider.

(3) COUNTY APPROVAL OF TRANSPORT BY PUBLIC CARRIER OR PRIVATE MOTOR VEHICLE. (a) *Covered service.* 1. Transportation by a non-certified public carrier, that is, by bus, taxi, train or airplane, or by private motor vehicle to a Wisconsin provider or a border-status provider to receive covered MA services shall be a covered administrative service if approved by the county agency under par. (b) or (c). The transportation costs shall include the cost of the public carrier or mileage expenses.

2. When the necessary transportation is more than routine, such as transportation to receive a service that is only available in another county or state, the travel time may warrant coverage of related travel expenses. These expenses may include the cost of meals and commercial lodging enroute to medical care, while receiving the care and when returning from the care, and the cost of an attendant to accompany the recipient if necessary. The cost of an attendant may include the attendant's transportation, lodging, meals and salary, except that no reimbursement may be paid to a member of the recipient's family.

3. The transportation service shall be reimbursed directly to the recipient or to the vendor by the county agency if the service is not provided directly by the county agency.

(b) *Non-emergency transportation.* 1. Non-emergency transportation of a recipient by public carrier or private motor vehicle is subject to approval by the county agency before departure.

2. The county agency may require documentation by the medical services provider of the service received at the specific location.

(c) *Emergency transportation.* If a recipient for emergency reasons beyond that person's control is unable to obtain the county agency's authorization for necessary transportation prior to the transportation, such as for a trip to a hospital emergency room on a weekend, the county agency may provide retroactive authorization. The county agency may require documentation from the medical services provider or the transportation provider, or both, to establish that the transportation was necessary.

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

(4) OTHER LIMITATIONS. (a) *Ambulance transportation for inter-facility transfers.* When hospital-to-hospital or nursing home-to-nursing home transfers are made by ambulance, the ambulance provider shall obtain a written certification from the recipient's physician that the discharging institution was not an appropriate facility for the patient's condition and that the admitting institution was the nearest one appropriate for that condition. This certification shall contain the reasons for which the discharging institution was considered inappropriate and the reasons for which the admitting institution was considered appropriate. The certification document shall be signed by the recipient's physician and shall also contain details pertinent to the recipient's condition. A checkoff

form is not acceptable. This document shall be kept by the ambulance provider.

(b) *Prescription requirements for nonemergency transportation.* For nonemergency ambulance transport:

1. The ambulance provider shall obtain a statement, signed by a physician or dentist. The statement shall include the recipient's name, the date of transport, the details about the recipient's condition that preclude transport by any other means, the specific circumstances requiring that the recipient be transported to the office or clinic to obtain a service and the services performed, and an explanation of why the service could not be performed in the nursing home or recipient's residence. The signature of the physician or dentist performing the service shall be dated. This statement shall be maintained by the provider of the transportation service;

2. The services obtained shall be performed by a physician or dentist or under the direct supervision of a physician or dentist; and

3. Trips by ambulance to obtain physical therapy, occupational therapy, speech therapy, audiology, chiropractic or psychotherapy are not covered.

(c) *Transportation to a non-medical facility.* If specialized medical vehicle (SMV) transportation is provided to a facility whose function is not primarily medical, the transportation shall be covered if the primary purpose of the trip is to receive medical services. The provider shall obtain from the provider of services at the destination a written statement of the medical services provided. This statement shall be maintained by the provider of transportation service.

(d) *Non-emergency transportation for nursing home outpatient services.* If ambulance or SMV transportation is to a nursing home for the provision of outpatient services, a statement of services received shall be obtained from the nursing home. This statement shall be maintained by the provider of transportation service.

(e) *Waiting time charges.* Charges for waiting time are covered charges. For non-emergency services, waiting time is allowable only when a continuous trip is being billed. In this paragraph, "waiting time" means time when the transportation provider is waiting for the recipient to receive medical services and return to the vehicle.

(f) *Specialized medical vehicle transportation of ambulatory recipients.* When the recipient has not been declared legally blind or has not been determined to be permanently disabled by a physician, a physician's prescription for SMV transportation stating the specific medical problem preventing the use of public-carrier transportation and the specific period of time the service should be provided, shall be obtained. A check-off form is not acceptable. This prescription shall be obtained prior to the transport and shall be valid for a maximum of 90 days from the physician's signature date. The provider shall indicate on the claim form that a prescription is on file with the provider, and shall indicate the name and provider number of the prescribing physician.

(g) *Attendant services.* 1. Services of a second SMV transportation attendant are covered only if the recipient's condition requires the physical presence of another person for purposes of restraint or lifting. Only recip-

ients evidencing violent behavior shall be considered to require restraints.

2. Services of a second ambulance attendant are covered only if the recipient's condition requires the physical presence of another person for purposes of restraint or lifting. Medical personnel who care for the recipient in transit shall bill the program separately.

(h) *Recipient's death before ambulance arrival.* 1. If a recipient is pronounced dead by a legally authorized person after an ambulance is called out but before the ambulance arrives at the pick-up site, emergency service to the point of pick-up is covered.

2. If ambulance service is provided to a recipient who is pronounced dead enroute or dead on arrival by a legally authorized person, the entire ambulance service is covered as an emergency service.

(i) *County transportation services.* Transportation provided by county agencies shall involve the least expensive means of transportation which the recipient is capable of using and which is reasonably available at the time the service is required. Reimbursement to the recipient may be limited to mileage to the nearest MA provider if the recipient has reasonable access to health care of adequate quality from that provider.

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

(a) Charges for reusable devices and equipment;

(b) Transportation of a recipient's personal belongings only;

(c) Transportation of a lab specimen only;

(d) Charges for sterilization of a vehicle after carrying a recipient with a contagious disease;

(e) Additional charges for services provided at night or on weekends, or on holidays;

(f) Emergency transportation of a recipient who is pronounced dead by a legally authorized person before an ambulance is called;

(g) Excessive mileage charges resulting from the use of indirect routes to and from medical destinations;

(h) Transport of a recipient's relatives;

(i) Unloaded ambulance or specialized medical vehicle mileage; and

(j) Additional charges by an ambulance provider for drugs used in transit, or for starting intravenous solutions or EKG monitoring.

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (c) and (4) (5), Register, February, 1988, No. 386, eff. 3-1-88.

HSS 107.24 Durable medical equipment and medical supplies. (1) DEFINITION. In this chapter, "medical supplies" means disposable, consumable, expendable or nondurable medically necessary supplies which have a very limited life expectancy. Examples are plastic bed pans, catheters, electric pads, hypodermic needles, syringes, continence pads and oxygen administration circuits.