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Chapter DHS 105

PROVIDER CERTIFICATION

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Note: Chapter HSS 105 as it existed on February 28, 1986 was repealed and a new chapter HSS 105 was created effective March 1, 1986. Chapter HSS 105 was renumbered Chapter HFS 105 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, January, 1997, No. 493. Chapter HFS 105 was renumbered to chapter DHS 105 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.01 Introduction. (1) PURPOSE. This chapter identifies the terms and conditions under which providers of health care services are certified for participation in the medical assistance program (MA).

(2) DEFINITIONS. In this chapter:

(a) "Group billing provider" means an entity which provides or arranges for the provision of medical services by more than one certified provider.

(b) "Provider assistant" means a provider such as a physical therapist assistant whose services must be provided under the supervision of a certified or licensed professional provider, and who, while required to be certified, is not eligible for direct reimbursement from MA.

(3) GENERAL CONDITIONS FOR PARTICIPATION. In order to be certified by the department to provide specified services for a reasonable period of time as specified by the department, a provider shall truthfully, accurately, completely and in a timely manner do all of the following:

(a) Affirm in writing that, with respect to each service for which certification is sought, the provider and each person employed by the provider for the purpose of providing the service holds all licenses or similar entitlements as specified in chs. DHS 101 to 108 and required by federal or state statute, regulation or rule for the provision of the service;

(b) Affirm in writing that neither the provider, nor any person in whom the provider has a controlling interest, nor any person having a controlling interest in the provider, has, since the inception of the medicare, medicaid, or title 20 services program, been convicted of a crime related to, or been terminated from, a federal-assisted or state-assisted medical program;

(c) Disclose in writing to the department all instances in which the provider, any person in whom the provider has a controlling interest, or any person having a controlling interest in the provider has been sanctioned by a federal-assisted or state-assisted medical program, since the inception of medicare, medicaid or the title 20 services program;

(d) Furnish the following information to the department, in writing:

1. The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

2. The names and addresses of all persons who have a controlling interest in the provider; and

3. Whether any of the persons named in compliance with subd. 1. or 2., is related to another as spouse, parent, child or sibling;

(e) Execute a provider agreement with the department; and

(f) 1. Accept and consent to the use, based on a methodology determined by the investigating or auditing agency, of statistical sampling and extrapolation as the means to determine amounts owed by the provider to MA as the result of an investigation or audit conducted by the department, the department of justice medicaid fraud control unit, the federal department of health and

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human services, the federal bureau of investigation, or an authorized agent of any of these.

2. The sampling and extrapolation methodologies, if any, used in the investigation or audit shall be generally consistent, as applicable, with the guidelines on audit sampling issued by the statistical sampling subcommittee of the American institute of certified public accountants. Extrapolation, when performed, shall apply to the same period of time upon which the sampling is derived.

3. The department and the other investigative agencies shall retain the right to use alternative means to determine, consistent with applicable and generally accepted auditing practices, amounts owed as the result of an investigation or audit.

4. Nothing in this paragraph shall be construed to limit the right of a provider to appeal a department recovery action brought under s. DHS 108.02 (9).

(4) PROVIDERS REQUIRED TO BE CERTIFIED. The following types of providers are required to be certified by the department in order to participate in the MA program:

(a) Institutional providers;

(b) Non-institutional providers;

(c) Provider assistants;

(d) Group billing providers; and

(e) Providers performing professional services for hospital inpatients under s. DHS 107.08 (4) (d). Hospitals which provide the setting for the performance of professional services to its inpatients shall ensure that the providers of those services are appropriately certified under this chapter.

(5) PERSONS NOT REQUIRED TO BE INDIVIDUALLY CERTIFIED. The following persons are not required to be individually certified by the department in order to participate in the MA program:

(a) Technicians or support staff for a provider, including:

1. Dental hygienists, except as provided under sub. (5m);

2. Medical record librarians or technicians;

3. Hospital and nursing home administrators, clinic managers, and administrative and billing staff;

4. Nursing aides, assistants and orderlies;

5. Home health aides;

6. Dieticians;

7. Laboratory technologists;

8. X-ray technicians;

9. Patient activities coordinators;

10. Volunteers; and

11. All other persons whose cost of service is built into the charge submitted by the provider, including housekeeping and maintenance staff; and

(b) Except for providers required to be separately certified under sub. (4) (b) to (e), providers employed by or under contract to certified institutional providers, including but not limited to physicians, therapists, nurses and provider assistants. These providers shall meet certification standards applicable to their respective provider type.

(5m) OPTIONAL CERTIFICATION. A dental hygienist licensed under s. 447.04 (2), Stats., may opt to be individually certified by the department for MA reimbursement for dental hygiene services.

(6) NOTIFICATION OF CERTIFICATION DECISION. Except as provided in s. DHS 105.17 (5), within 60 days after receipt by the department or its fiscal agent of a complete application for certification, including evidence of licensure or medicare certification, or both, if required, the department shall either approve the application and issue the certification or deny the application. If the application for certification is denied, the department shall give the applicant reasons, in writing, for the denial.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. (2) (b) and (c), (5) (a) 6., renum. (2) (d) and (5) (a) 7. to 12. to be (2) (b) and (5) (a) 6. to 11., Register, February, 1988, No. 386, eff. 3-1-88; am. (4) (c) and (d) and (5) (b), cr. (4) (e), Register, September, 1991, No. 429, eff. 10-1-91; emerg. am. (3) (d) 3. and (e), cr. (3) (f), eff. 7-1-92; am. (3) (d) 3. and (e), cr. (3) (f), Register, February, 1993, No. 446, eff. 3-1-93; CR 03-033: am. (3) (intro.) Register December 2003 No. 576, eff. 1-1-04; CR 05-033: am. (5) (a) 1., cr. (5m) Register August 2006 No. 608, eff. 9-1-06; corrections in (3) (a), (f) 4. and (4) (e) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 09-107: am. (6) Register August 2010 No. 656, eff. 9-1-10.

DHS 105.02 Requirements for maintaining certification. Providers shall comply with the requirements in this section in order to maintain MA certification.

(1) CHANGE IN PROVIDER STATUS. Providers shall report to the department in writing any change in licensure, certification, group affiliation, corporate name or ownership by the time of the effective date of the change. The department may require the provider to complete a new provider application and a new provider agreement when a change in status occurs. A provider shall immediately notify the department of any change of address but the department may not require the completion of a new provider application or a new provider agreement for a change of address.

(2) CHANGE IN OWNERSHIP. (a) *Non-nursing home provider.* In the event of a change in the ownership of a certified provider, except a nursing home, the provider agreement shall automatically terminate, except that the provider shall continue to maintain records required by subs. (4), (6) and (7) unless an alternative method of providing for maintenance of these records has been established in writing and approved by the department.

(b) *Nursing home provider.* In the event of a change in the ownership of a nursing home, the provider agreement shall automatically be assigned to the new owner.

(3) RESPONSE TO INQUIRIES. A provider shall respond as directed to inquiries by the department regarding the validity of information in the provider file maintained by the department or its fiscal agent.

(4) MAINTENANCE OF RECORDS. Providers shall prepare and maintain whatever records are necessary to fully disclose the nature and extent of services provided by the provider under the program. Records to be maintained are those enumerated in subs. (6) and (7). All records shall be retained by providers for a period of not less than 5 years from the date of payment by the department for the services rendered, unless otherwise stated in chs. DHS 101 to 108. In the event a provider's participation in the program is terminated for any reason, all MA-related records shall remain subject to the conditions enumerated in this subsection and sub. (2).

(5) PARTICIPATION IN SURVEYS. Providers shall participate in surveys conducted for research and MA policy purposes by the department or its designated contractors. Participation involves accurate completion of the survey questionnaire and return of the completed survey form to the department or to the designated contractor within the specified time period.

(6) RECORDS TO BE MAINTAINED BY ALL PROVIDERS. All providers shall maintain the following records:

(a) Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by MA;

(b) MA billings and records of services or supplies which are the subject of the billings, that are necessary to fully disclose the nature and extent of the services or supplies; and

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(c) Any and all prescriptions necessary to disclose the nature and extent of services provided and billed under the program.

(7) RECORDS TO BE MAINTAINED BY CERTAIN PROVIDERS. (a) *Specific types of providers.* The following records shall be maintained by hospitals, skilled nursing facilities (SNFs), intermediate care facilities (ICFs) and home health agencies, except that home health agencies are not required to maintain records listed in subds. 5., 11. and 14., and SNFs, ICFs and home health agencies are not required to maintain records listed in subd. 4.:

1. Annual budgets;

2. Patient census information, separately:

a. For all patients; and

b. For MA recipients;

3. Annual cost settlement reports for medicare;

4. MA patient logs as required by the department for hospitals;

5. Annual MA cost reports for SNFs, ICFs and hospitals;

6. Independent accountants' audit reports;

7. Records supporting historical costs of buildings and equipment;

8. Building and equipment depreciation records;

9. Cash receipt and receivable ledgers, and supporting receipts and billings;

10. Accounts payable, operating expense ledgers and cash disbursement ledgers, with supporting purchase orders, invoices, or checks;

11. Records, by department, of the use of support services such as dietary, laundry, plant and equipment, and housekeeping;

12. Payroll records;

13. Inventory records;

14. Ledger identifying dates and amounts of all deposits to and withdrawals from MA resident trust fund accounts, including documentation of the amount, date, and purpose of the withdrawal when withdrawal is made by anyone other than the resident. When the resident chooses to retain control of the funds, that decision shall be documented in writing and retained in the resident's records. Once that decision is made and documented, the facility is relieved of responsibility to document expenditures under this subsection; and

15. All policies and regulations adopted by the provider's governing body.

(b) *Prescribed service providers.* The following records shall be kept by pharmacies and other providers of services requiring a prescription:

1. Prescriptions which support MA billings;

2. MA patient profiles;

3. Purchase invoices and receipts for medical supplies and equipment billed to MA; and

4. Receipts for costs associated with services billed to MA.

(8) PROVIDER AGREEMENT DURATION. The provider agreement shall, unless terminated, remain in full force and effect for a maximum of one year from the date the provider is accepted into the program. In the absence of a notice of termination by either party, the agreement shall automatically be renewed and extended for a period of one year.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction in (4) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 20-039: am. (5) Register October 2021 No. 790, eff. 11-1-21.

DHS 105.03 Participation by non-certified persons.

(1) REIMBURSEMENT FOR EMERGENCY SERVICES. If a resident of Wisconsin or of another state who is not certified by MA in this state provides emergency services to a Wisconsin recipient, that person shall not be reimbursed for those services by MA unless the services are covered services under ch. DHS 107 and:

(a) The person submits to the fiscal agent a provider data form and a claim for reimbursement of emergency services on forms prescribed by the department;

(b) The person submits to the department a statement in writing on a form prescribed by the department explaining the nature of the emergency, including a description of the recipient's condition, cause of emergency, if known, diagnosis and extent of injuries, the services which were provided and when, and the reason that the recipient could not receive services from a certified provider; and

(c) The person possesses all licenses and other entitlements required under state and federal statutes, rules and regulations, and is qualified to provide all services for which a claim is submitted.

(2) REIMBURSEMENT PROHIBITED FOR NON-EMERGENCY SERVICES. No non-emergency services provided by a non-certified person may be reimbursed by MA.

(3) REIMBURSEMENT DETERMINATION. Based upon the signed statement and the claim for reimbursement, the department's professional consultants shall determine whether the services are reimbursable.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction in (1) (intro.) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.04 Supervision of provider assistants.

Provider assistants shall be supervised. Unless otherwise specified under ss. DHS 105.05 to 105.49, supervision shall consist of at least intermittent face-to-face contact between the supervisor and the assistant and a regular review of the assistant's work by the supervisor.

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

DHS 105.05 Physicians and assistants.

(1) PHYSICIANS. For MA certification, physicians shall be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 1, 2, 3, 4, 5 and 14.

(2) PHYSICIAN ASSISTANTS. For MA certification, physician assistants shall be certified and registered pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 8 and 14.

Note: For covered physician services, see s. DHS 107.06.

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

DHS 105.055 Nurse anesthetists and anesthesiologist assistants.

(1) CERTIFIED REGISTERED NURSE ANESTHETIST. For MA certification, a nurse anesthetist shall be licensed as a registered nurse pursuant to s. 441.06, Stats., and shall meet one of the following additional requirements:

(a) Be certified by either the council on certification of nurse anesthetists or the council on recertification of nurse anesthetists; or

(b) Have graduated within the past 18 months from a nurse anesthesia program that meets the standards of the council on accreditation of nurse anesthesia educational programs and be awaiting initial certification.

(2) ANESTHESIOLOGIST ASSISTANT. For MA certification, an anesthesiologist assistant shall meet the following requirements:

(a) Have successfully completed a 6 year program for anesthesiologist assistants, 2 years of which consists of specialized academic and clinical training in anesthesia; and

(b) Work under the direct supervision of an anesthesiologist who is physically present during provision of services.

History: Cr. Register, September, 1991, No. 429, eff. 10-1-91.

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DHS 105.06 Dentists and dental hygienists. (1) DENTISTS. For MA certification, dentists shall be licensed pursuant to ss. 447.03 and 447.04, Stats.

(2) DENTAL HYGIENISTS. For MA certification, dental hygienists shall be licensed pursuant to s. 447.04 (2), Stats.; have 2 years or 3,200 hours of active practice experience as a licensed dental hygienist; and operate within the scope of dental hygiene as defined under ss. 447.01 (3) and 447.06, Stats. Written documentation showing the required experience shall be provided to the department upon application for MA certification.

Note: For covered dental services, see s. DHS 107.07.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1994, No. 462; CR 05-033: renum. to be (1), cr. (2) Register August 2006 No. 608, eff. 9-1-06.

DHS 105.07 General hospitals. For MA certification a hospital shall be approved as a general hospital under s. 50.35, Stats., and ch. DHS 124, shall meet conditions of participation for medicare and shall have a utilization review plan that meets the requirements of 42 CFR 456.101. No facility determined by the department or the federal health care financing administration to be an institution for mental disease (IMD) may be certified as a general hospital under this section. In addition:

(1) A hospital providing outpatient psychotherapy shall meet the requirements specified in s. DHS 105.22 (1) and (2);

(2) A hospital providing outpatient alcohol and other drug abuse (AODA) services shall meet the requirements specified in s. DHS 105.23;

(3) A hospital providing mental health day treatment services shall be certified under s. DHS 105.24;

(4) A hospital participating in a PRO review program shall meet the requirements of 42 CFR 456.101 and any additional requirements established under state contract with the PRO; and

(5) A hospital providing AODA day treatment services shall be certified under s. DHS 105.25.

Note: For certification of a hospital that is an institution for mental disease, see s. DHS 105.21. For covered hospital services, see s. DHS 107.08.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. (intro.), am. (1) to (4), cr. (5), Register, September, 1991, No. 429, eff. 10-1-91; correction in (intro.) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.075 Rehabilitation hospitals. For MA certification, a rehabilitation hospital shall be approved as a general hospital under s. 50.35, Stats., and ch. DHS 124, and shall meet the conditions of participation for medicare and shall have a utilization review plan that meets the requirements of 42 CFR 456.101. No facility determined by the department or the federal health care financing administration to be an institution for mental disease (IMD) may be certified as a rehabilitation hospital under this section.

Note: For covered hospital services, see s. DHS 107.08.

History: Cr. Register, September, 1991, No. 429, eff. 10-1-91; corrections made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 23-046: am. Register April 2024 No. 820, eff. 5-1-24.

DHS 105.08 Skilled nursing facilities. For MA certification, skilled nursing facilities shall be licensed pursuant to s. 50.03, Stats., and ch. DHS 132.

Note: For covered nursing home services, see s. DHS 107.09.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.09 Medicare bed requirement. (1) DEFINITION. In this section, "sufficient number of medicare-certified beds" means a supply of beds that accommodates the demand for medicare beds from both the home county and contiguous counties so that no dual eligible recipient is denied access to medicare SNF benefits because of a lack of available beds. In this subsection, "dual eligible recipient" means a person who qualifies for both medical assistance and medicare.

(2) MEDICARE BED OBLIGATION. Each county shall have a sufficient number of skilled nursing beds certified by the medicare program pursuant to ss. 49.45 (6m) (g) and 50.02 (2), Stats. The number of medicare-certified beds required in each county shall be at least 3 beds per 1000 persons 65 years of age and older in the county.

(3) PENALTY. (a) If a county does not have sufficient medicare-certified beds as determined under sub. (1), each SNF within that county which does not have one or more medicare-certified beds shall be subject to a fine to be determined by the department of not less than $10 nor more than $100 for each day that the county continues to have an inadequate number of medicare-certified beds.

(b) The department may not enforce penalty in par. (a) if the department has not given the SNF prior notification of criteria specific to its county which shall be used to determine whether or not the county has a sufficient number of medicare-certified beds.

(c) If the number of medicare-certified beds in a county is reduced so that the county no longer has a sufficient number of medicare-certified beds under sub. (1), the department shall notify each SNF in the county of the number of additional medicare-certified beds needed in the county. The department may not enforce the penalty in par. (a) until 90 days after this notification has been provided.

(4) EXEMPTIONS. (a) In this subsection, a "swing-bed hospital" means a hospital approved by the federal health care financing administration to furnish skilled nursing facility services in the medicare program.

(b) A home or portion of a home certified as an ICF-IID is exempt from this section.

(c) The department may grant an exemption based on but not limited to:

1. Availability of a swing-bed hospital operating within a 30 mile radius of the nursing home; or

2. Availability of an adequate number of medicare-certified beds in a facility within a 30 mile radius of the nursing home.

(d) A skilled nursing facility located within a county determined to have an inadequate number of medicare-certified beds and which has less than 100 beds may apply to the department for partial exemption from the requirements of this section. An SNF which applies for partial exemption shall recommend to the department the number of medicare-certified beds that the SNF should have to meet the requirements of this section based on the facility's analysis of the demand for medicare-certified beds in the community. The department shall review all recommendations and issue a determination to each SNF requesting a partial exemption.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; renum. (1), (2), (3) (a) and (b) to be (2), (3), (4) (a) and (b) and am. (2) and (4) (b), cr. (1), (4) (c) and (d), Register, February, 1988, No. 386, eff. 7-1-88; 2019 Wis. Act 1: am. (4) (b) Register May 2019 No. 761, eff. 6-1-19.

DHS 105.10 SNFs and ICFs with deficiencies. If the department finds a facility deficient in meeting the standards specified in s. DHS 105.08, 105.09, 105.11 or 105.12, the department may nonetheless certify the facility for MA under the conditions specified in s. DHS 132.21 and 42 CFR 442, Subpart C.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

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DHS 105.11 Intermediate care facilities. For MA certification, intermediate care facilities shall be licensed pursuant to s. 50.03, Stats., and ch. DHS 132.

Note: For covered nursing home services, see s. DHS 107.09.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.12 ICFs for individuals with intellectual disabilities or individuals with related conditions. For MA certification, institutions for individuals with intellectual disabilities or individuals with related conditions shall be licensed pursuant to s. 50.03, Stats., and ch. DHS 134.

Note: For covered ICF/IID services, see s. DHS 107.09.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1991, No. 432; correction made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; 2019 Wis. Act 1: am. Register May 2019 No. 761, eff. 6-1-19.

DHS 105.14 Adult day care centers. (1) GENERAL PROVISIONS. (a) *Introduction.* In accordance with s. 49.45 (2) (a) 11. and (47) (a) and (b), Stats., this section is promulgated to establish regulations and standards for the care, treatment or services, and health, safety, rights, well-being and welfare of participants in certified adult day care centers (ADCCs). This section is promulgated to ensure that each ADCC provides a supportive environment in a community-based group setting that is the least restrictive of each participant's freedom, and that care and services are provided in a manner that protects the rights and dignity of each participant.

(b) *Definitions.* 1. "Abuse" has the meaning given in s. DHS 13.03 (1) (a).

2. "Accessible" means barriers are not present that prevent a person from entering, leaving, or functioning within an ADCC without physical help.

3. "Activities of daily living" or "ADL" means bathing, eating, oral hygiene, dressing, toileting, incontinence care, mobility and transferring from one surface to another such as from a bed to a chair.

4. "Adult" means an individual who is at least 18 years of age.

5. "Adult day care center" or "ADCC" means an entity that provides services for part of a day in a group setting to adults who need an enriched health, supportive or social experience, and who may need assistance with activities of daily living, supervision, or protection.

6. "Applicant" means the person seeking certification of an ADCC.

7. "Assessment" means gathering and analyzing information about a prospective or existing participant's needs and abilities as provided in sub. (7) (a).

8. "Caregiver" has the meaning given in s. 50.065 (1) (ag), Stats.

9. "Chemical restraint" means a psychotropic medication used for discipline or convenience, and not required to treat medical symptoms.

10. "Department" means the Wisconsin department of health services.

11. "Legal representative" means any of the following:

a. The health care agent under an activated power of attorney for health care under ch. 155, Stats.

b. A person appointed as a durable power of attorney under ch. 244, Stats.

c. A guardian, guardian of the estate, or guardian of the person, as defined in s. 54.01 (10), (11), or (12), Stats.

12. "Medication administration" means the direct injection, ingestion or other application of a prescription or over-the-counter drug or device to a participant, but does not include reminders to take the medication. Medication administration can be performed by any of the following:

a. A practitioner.

b. The practitioner's authorized agent.

c. An ADCC caregiver, or the participant, at the direction of the practitioner.

13. "Misappropriation of property" has the meaning given in s. DHS 13.03 (12).

14. "Neglect" has the meaning given in s. DHS 13.03 (14).

15. "Nursing care" means nursing procedures, other than personal or supportive care, that a registered nurse or a licensed practical nurse performs directly on or to a participant.

16. "Occupant" means any of the following:

a. A person who lives and sleeps in the ADCC, but who is not a participant.

b. A non-client resident, as defined in s. 50.065 (1) (cn), Stats.

17. "Operator" means an individual or business entity to whom a certification is granted and is legally responsible for the operation of the ADCC.

18. "Participant" means an adult who attends the ADCC during listed hours of operation and receives care, treatment, or services.

19. "Participant group" means a group of participants who need similar services because of a common disability, condition, or status. "Participant group" includes a group of individuals who have any of the following:

a. Functional impairments commonly associated with advanced age.

b. Irreversible dementia, such as Alzheimer's disease.

c. A developmental disability, as defined in s. 51.01 (5), Stats.

d. An emotional disturbance or a mental illness, as defined in s. 51.01 (13) (a), Stats.

e. A physical disability.

f. A traumatic brain injury.

20. "Physical restraint" means any manual method, article, device, or garment interfering with the free movement of the participant or the normal functioning of a portion of the participant's body or normal access to a portion of the participant's body, and which the participant is unable to remove easily, or confinement of a participant in a locked room.

21. "Program director" means an employee who is responsible for the management and day-to-day operation of the ADCC. A program director includes any of the following:

a. The operator.

b. An employee designated by the operator.

22. "Psychotropic medication" means a prescription drug, defined in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior.

23. "Qualified Caregiver" means an employee who is at least 18 years of age and has successfully completed all of the applicable orientation and training under sub. (4) (a) and (b).

24. a. "Seclusion" means physical or social separation of a participant from others by actions of caregivers.

b. "Seclusion" does not include separation to prevent the spread of communicable disease or voluntary cool-down periods in an unlocked room.

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25. "Serious injury" means an injury from any incident or accident which results in any of the following:

a. A temporary or permanent increase in the level of assistance needed in one or more ADL categories, such as bathing, eating, oral hygiene, dressing, toileting, incontinence care, or mobility and transferring.

b. A fracture.

c. A pronounced decline in communication or cognitive abilities.

26. "Significant change" in a participant's physical or mental condition means any of the following:

a. A decline in a participant's medical condition that results in further impairment.

b. A decline in 2 or more ADLs.

c. A pronounced decline in communication or cognitive abilities.

d. A decline in behavior or mood which requires either a temporary or permanent increase in the level of assistance needed in one or more ADL categories, such as bathing, eating, oral hygiene, dressing, toileting, incontinence care, or mobility and transferring.

27. "Standard precautions" are a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. These measures are used when providing care to all individuals, whether or not they appear infectious or symptomatic.

28. a. "Supervision" means oversight of a participant's functioning.

b. "Supervision" includes keeping track of a participant's whereabouts and providing guidance and intervention when needed by a participant.

28m. "Transferee" means the recipient of a property or business in a change of ownership process who will submit application for a new certification.

29. "Transferor" means the current operator in a change of ownership process who will voluntarily relinquish the current certification.

31. "Utensils" means dishes, silverware and pots and pans used for storing, preparing, serving, or consuming food.

32. "Variance" means an alternate means of meeting a requirement in this section, as approved by the department under par. (c).

33. "Volunteer" means any person who provides services for participants without compensation.

34. "Waiver" means an exemption from a requirement in this section, as approved by the department under par. (c).

(c) *Variances and waivers.* 1. The department may grant approval of a waiver or variance if the department determines that the proposed waiver or variance will not jeopardize the health, safety, welfare or rights of any participant.

2. A written request for a waiver or variance shall be sent to the department and include justification that the waiver or variance will not adversely affect the health, safety or welfare of any participant for the requested action.

3. A written request for a variance shall include a description of an alternative means planned to meet the intent of the requirement.

4. The department may terminate approval of a waiver or variance if any of the following occurs:

a. The department determines the waiver or variance has adversely affected the health, safety, well-being or welfare of a participant.

b. The ADCC fails to comply with any of the conditions of the waiver or variance as granted.

c. A change in circumstances from the time the waiver or variance approval was initially granted.

d. The ADCC failed to disclose a fact that is material to the approval.

(2) CERTIFICATION. (a) *General requirements.* 1. No person may receive reimbursement under s. 49.45 (7) (b), Stats., for the provision of services to a participant in an ADCC unless the ADCC is certified by the department. A person who assumes ownership interest in a certified ADCC, regardless of whether the transfer includes title to the real estate, or changes the location of the ADCC shall complete an application as required under this subsection.

2. An application for certification shall be on a form or web-based application provided by the department and shall include all of the following:

a. A program description as specified under par. (b).

b. A floor plan specifying dimensions of the ADCC, including exits and planned room usage.

c. A fire inspection report.

d. All required fees.

e. A balance sheet.

f. Evidence that the applicant has 60 days of projected operating funds in reserve.

g. Proof of transportation liability insurance if the ADCC provides transportation.

h. Well water test results if the ADCC uses well water.

i. A program evaluation plan.

j. Any additional information requested by the department.

3. An ADCC may not be located on a parcel of land zoned for industrial or manufacturing use.

(b) *Program description.* 1. The program description included as part of an application under par. (a) 2. shall include all of the following:

a. The name of the operator, the program director, and the caregiver position in charge when the operator or program director is away from the ADCC.

b. The participant capacity of the ADCC.

c. A definition of the program goals and a description of the services provided or made available to participants at the ADCC.

d. The days and hours of operation of the ADCC.

e. A description of any limits the program establishes for providing service to a participant with specific care needs.

f. A fee schedule which includes the daily charges and additional fees for specific services, goods, or supplies that are not included in the daily charge, and the method for notifying a participant or a legal representative of fee changes.

g. A procedure for informing the participant's legal representative, family, or caregiver of any major change in the participant's general functioning or medical condition.

h. A procedure for documenting any incident occurring at the site which would affect the health, safety or welfare of a participant.

i. The participant group to be served and, if serving more than one participant group, an explanation acceptable to the department of how each participant group is compatible with one another.

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j. A grievance procedure for investigating and resolving complaints made by a participant, legal representative, family member, caregiver, or other interested persons about the services provided by the ADCC which includes informing such persons of appropriate local, county and/or state agency contacts and informing such persons that pursuant to s. DHS 13.05 (4) (a) and s. 146.40 (4r) (a), Stats., any individual may report to the department that he or she believes that any person employed by or under contract with the ADCC has neglected or abused a participant or misappropriated the participant's property.

k. The criteria for voluntary and involuntary discharge of a participant from the program as defined in sub. (5) (c).

2. Before finalizing an agreement to provide care, the ADCC shall provide its program description to each person seeking services or to the person's legal representative, or both.

3. The program description shall be provided to each caregiver and any other person upon request.

(c) *Fit and qualified determination.* An applicant may not be certified unless the department determines the applicant is fit and qualified to operate an ADCC. To determine whether a person is fit and qualified, the department shall consider all of the following:

1. Whether the applicant, any operator, or any non-client residents, as defined in s. 50.065 (1) (cn), Stats., meet the requirements of ch. DHS 12 and s. 50.065, Stats.

2. The applicant's history of compliance with Wisconsin or any other state or federal licensing or certification requirements, including any license revocation or denial.

3. The applicant's arrest and criminal records, including any of the following:

a. Crimes or acts involving abuse, neglect or mistreatment of a person or misappropriation of property of a person.

b. Crimes or acts subject to elder abuse reporting under s. 46.90, Stats.

c. Crimes or acts related to the manufacture, distribution, use, or dispensing of a controlled substance.

d. Fraud or substantial or repeated violations of applicable laws and rules in the operation of any health care center or in the care of dependent persons.

e. A conviction or pending criminal charge which substantially relates to the care of adults or minors, to the funds or property of adults or minors, or to the operation of a residential or health care center.

4. The financial history and the financial viability of the applicant or the applicant's organization, including any outstanding debts, fees, or fines due to the department or other government agencies.

(d) *Department action.* 1. Within 70 days of receipt of a complete application, the department shall review the application and either approve or deny certification of the ADCC.

2. A certification issued by the department shall be only for the premises and operator named in the application. A certification may not be transferred or assigned to another operator without following the change of ownership provisions in par. (i).

3. A certification is valid until suspended or revoked by the department.

4. The department shall deny a certification to any applicant who does not substantially comply with any provision of this chapter or ch. 49, Stats., who is not deemed fit and qualified as specified in par. (c), or who has failed to pay any fee or any outstanding amounts due to the department.

5. The department shall provide the reasons for denial and the process for appeal of the denial in writing to the applicant.

(e) *Monitoring after certification.* The department shall conduct periodic inspections of the ADCC during the period of certification and may, without notice to the operator, visit an ADCC at any time to determine if the ADCC is compliant with this section. The operator shall be able to verify compliance with this section and shall provide the department access to the ADCC, its staff, each participant, and records.

(f) *Biennial reporting and fees.* Every 24 months, on a date determined by the department, the operator shall submit a biennial report on the form provided by the department, and shall submit payment of the certification continuation fees.

(g) *Sanctions for noncompliance.* 1. 'Notice of violation.' The department shall issue a written notice of violation when it finds that an ADCC is in violation of this section or with any federal, state, or local laws and codes that govern the operation of the ADCC. The notice shall explain the grounds for the notice of violation, the sanction to be imposed, if any, and, if certification is suspended or revoked, and the process for an appeal.

2. 'Plan of correction.' An ADCC may submit a written plan of correction to the department within 10 days after the date of receipt of the notice of violation.

3. 'Suspension.' The department may summarily suspend the ADCC's certification following procedures in ch. 227, Stats., when the department finds that participant health, safety or welfare requires emergency action.

4. 'Revocation.' The department may revoke the ADCC's certification whenever the department finds that the ADCC has failed to maintain substantial compliance with one or more of the requirements set forth in this section.

(h) *Appeals.* 1. Any person whose application for certification is denied under par. (d) or suspended or revoked under par. (g) 3. or 4. may request a hearing on that decision in accordance with s. 227.42, Stats.

2. A request for hearing shall be made in writing to the department of administration's division of hearings and appeals. The request for a hearing must be received by the division of hearings and appeals within 10 days of the department's written notice of certification denial under par. (d) 5., suspension under par. (g) 3., or revocation under par. (g) 4.

(i) *Change of ownership.* 1. When an ADDC seeks a change of ownership, the transferee shall submit a complete application for certification as required under par. (a) 2. at least 30 days prior to the change of ownership.

2. If a participant is given less than 30 days' notice of the change of ownership, neither the transferor nor the transferee may enforce any advanced notice requirements for discharge as specified in any participant's enrollment agreement.

3. The transferor shall notify the department within 30 days before a change of ownership of an ADCC and shall include the name and contact information of the transferee.

4. The transferor remains responsible for the operation of the ADCC until the department issues a certification to the transferee.

5. The transferor shall disclose to the transferee any waiver or variance granted by the department under sub. (1) (c), or outstanding deficiencies.

6. Any violation reported in a department inspection report shall be corrected prior to the change of ownership. Any correction must be verified by the department prior to the issuance of the certification to the transferee.

7. The department shall issue a certification only for the premises and persons named in the certification application. A

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certification may not be transferred or reassigned without following the change of ownership provisions in this paragraph.

(j) *ADCC closure.* 1. An ADCC that intends to close shall notify the department, each participant or legal representative, and case manager, if any, in writing at least 30 days before closing and comply with the discharge requirements under sub. (5) (c).

2. The ADCC shall surrender the certification to the department when the ADCC closes.

3. The ADCC shall surrender its certification if it has not served any participants for 24 months.

(k) *Death reporting requirements.* 1. If a participant dies while at or under the supervision of the ADCC, the ADCC shall report the following to the department no later than 3 days after any of the following occurs:

a. Death due to physical restraint, psychotropic medication, or suicide, if there is reasonable cause to believe that the death was related to physical restraint, psychotropic medication, or suicide.

b. Death due to accident or injury not attributable to physical restraint, psychotropic medication, or suicide.

2. An ADCC is not required to report a death to the department if the death is the result of natural causes, and none of the circumstances surrounding the death involve a condition under subd. 1.

(L) *Other reporting requirements.* An ADCC shall send a written report to the department within 3 working days after any of the following occurs:

1. Any time a participant's whereabouts are unknown, except those instances when a participant who is competent chooses not to disclose his or her whereabouts or location to the ADCC. The ADCC shall also notify the local law enforcement authority immediately upon discovering that a participant is missing.

2. Any time law enforcement is called to the ADCC as a result of an incident that jeopardizes the health, safety or welfare of a participant or caregiver. The ADCC's report to the department shall provide a description of the circumstances requiring the law enforcement intervention.

3. Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a participant.

4. A catastrophe causing structural damage to the ADCC that results in any change in services provided to the participants.

5. A fire occurs on the premises of the ADCC.

6. Anytime the ADCC must evacuate and temporarily relocate participants and caregivers from the ADCC for reasons other than a fire drill.

(m) *Investigation and reporting requirements.* 1. 'Misconduct reporting.' When an ADCC receives a report of an allegation of abuse or neglect of a participant, or misappropriation of property, the ADCC shall take immediate action to ensure the safety of each participant and security of their property. The ADCC shall do all of the following:

a. Thoroughly investigate any allegation of abuse or neglect of a participant, or misappropriation of property and document all allegations, investigations, and the results of investigations.

b. Report incidents to the department when the ADCC's investigation concludes the alleged abuse, or neglect of a participant or misappropriation of property meets the definition of abuse or neglect of a participant, or of misappropriation of property under ch. DHS 13. The ADCC shall maintain documentation of any investigations.

Note: Information and resources for reporting misconduct through the Misconduct Incident Reporting system are available at https://www.dhs.wisconsin.gov/caregiver/complaints.htm.

c. Use the form or web-based application provided by the department to submit all reportable incidents to the department within 7 days from the date the ADCC knew or should have known about the abuse, neglect, or misappropriation of property.

d. Document its conclusions and rationales in writing if it concludes, after investigation, that the incident did not meet the definition of abuse, neglect, or misappropriation.

2. 'Elder abuse and adults-at-risk reporting.' The ADCC shall follow the elder abuse reporting requirements under s. 46.90, Stats., and the adult at risk requirements under s. 55.043, Stats., whichever is applicable.

3. 'Injuries of unknown source.' When an ADCC receives a report of a participant's injury with an unknown cause, it shall thoroughly investigate, document, and report an injury of unknown source in a manner consistent with the requirements of subd. 1. or 2. when both of the following conditions are met:

a. The source of the injury was not observed by any person or the source of the injury could not be explained by the participant.

b. The injury appears suspicious because of the extent of the injury or the location of the injury on the participant.

c. The ADCC shall maintain documentation for each investigation of an injury referenced under subd. 3.

4. 'Other duties.' Filing reports under subd. 1. or 2. does not relieve the operator of any obligation to report an incident to any other authority, including law enforcement or the coroner, or both.

(n) *Notification of changes affecting a participant.* 1. The ADCC shall immediately notify the participant's legal representative and the participant's residential provider and document the notification when there is an incident or injury to the participant or a significant change in the participant's physical or mental condition.

2. The ADCC shall immediately notify the participant's legal representative and document the notification when there is an allegation of abuse or neglect of the participant.

3. The ADCC shall notify the participant's legal representative within 72 hours when there is an allegation of misappropriation of the participant's property and document the notification.

4. The ADCC shall give the participant or the participant's legal representative a 30-day written notice of any change in services available or in charges for services that will be in effect for more than 30 days.

(o) *Documentation requirement.* All written reports required under sub. (2) (k) to (n), shall include, at a minimum, all of the following:

1. The time, date, place, and details of the reportable occurrence.

2. Any individuals involved in the reportable occurrence.

3. The action taken by the provider to ensure the health, safety, welfare and well-being of each participant following the reportable occurrence.

(p) *Record retention.* 1. The ADCC shall retain all records required under this section for 2 years, unless otherwise specified in this section.

2. Participant records shall be retained for 7 years following the date of a participant's final discharge.

3. Employee records shall be retained for 3 years following a caregiver's separation from employment at the ADCC.

(3) PERSONNEL. (a) *Operator.* 1. 'Qualifications.' An operator shall be at least 21 years old and meet the caregiver background requirements under s. 50.065, Stats., and ch. DHS 12.

2. 'Responsibilities.' An operator shall:

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a. Ensure the ADCC and its operation comply with all laws governing the ADCC.

b. Comply with the requirements set by the Federal 1991 Americans with Disabilities Act, and by the occupation, safety and health administration.

c. Develop and implement a procedure for standard precautions.

d. Develop and implement written policies and procedures to investigate allegations of abuse, neglect, and misappropriation of property and injuries of unknown source as described in sub. (2) (m).

e. Report any change in participant group in writing to the department at least 30 days in advance of the anticipated change. The ADCC shall not implement the change until the operator receives written approval from the department.

f. Report any change in the ADCC's capacity in writing to the department. The operator shall not implement the change in capacity until the operator receives written approval from the department.

g. Provide to each participant, the participant's legal representative, or third party payer, a 30 day written notice of any change in the ADCC's capacity or client group.

h. Post the ADCC certification, any statement of deficiency, notice of revocation and any other notice of enforcement action in a public area that is visually and physically accessible. A statement of deficiency shall remain posted for 90 days following receipt. Notices of revocation or suspension of certification shall remain posted until a final determination is made.

i. Prohibit the existence or continuation of any condition which creates or may create a substantial risk to the health, safety, well-being or welfare of any participant.

j. Ensure that the presence of other occupants does not adversely affect the health, safety, well-being or welfare of a participant.

(b) *Program director.* 1. 'Qualifications.' The program director of an ADCC shall be at least 21 years of age and have the capacity to respond to the needs of each participant and manage the day to day operations of the ADCC. The program director shall have at least one of the following qualifications:

a. An associate degree or higher from an accredited college in a health care related field.

b. At least 2 years' experience working in a health care related field which served a population similar to the participant group at the ADCC.

2. 'Responsibilities.' The program director shall:

a. Supervise the daily operation of the ADCC, including participant care and services, personnel, finances, and physical plant.

b. Provide the supervision necessary to ensure that each participant receive proper care and treatment, that their health and safety are protected and promoted, and that their rights are respected.

c. Be responsible for the training and competency of each caregiver.

3. 'Exemptions.' The qualified program director of record at the ADCC, at the time this rule becomes effective, shall be exempt from the qualification requirements as specified in subd. 1.

4. 'Program director absence.' A qualified caregiver who is at least 18 years old shall be designated as in charge whenever the program director is absent from the ADCC.

(c) *Caregiver.* Each caregiver shall be at least 16 years old and have the skills, education, experience and ability to fulfill the caregiver's job requirements.

(d) *Hiring and employment.* 1. 'Caregiver background checks.' The ADCC shall obtain a background check pursuant to s. 50.065, Stats., and ch. DHS 12, for any person who is, or is expected to be, an employee or contractor of the ADCC, who is or is expected to be under the control of the ADCC, and who has, or is expected to have, regular, direct contact with participants.

2. 'Employee health communicable disease control.' a. The ADCC shall obtain documentation from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable diseases including tuberculosis. Screening for tuberculosis shall be conducted in accordance with current standards of practice. The screening and documentation shall be completed within 90 days before the start of employment or before assumption of duties in which the caregiver will have direct contact with any participant. The ADCC shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.

b. Employees shall be re-screened for clinically apparent communicable diseases as described in this subdivision based on the likelihood of exposure to communicable diseases, including tuberculosis.

c. A person who has a communicable disease shall not be permitted to work or be present in the ADCC if the disease would present a risk to the health or safety of any participant.

(e) *Employee records.* 1. A separate record for each employee shall be maintained and kept current. Employee records shall include, at minimum, all of the following information:

a. Beginning date of employment.

b. Educational qualifications for a program director.

c. A completed caregiver background check following procedures under s. 50.065, Stats., and ch. DHS 12.

d. Documentation of orientation and training.

2. Employee records shall be available upon request at the ADCC for review by the department.

(4) ORIENTATION AND TRAINING. (a) *Orientation.* Before performing any job duties, all employees shall receive appropriate orientation to their job responsibilities and to the ADCC and its policies, including emergency and evacuation procedures, participant rights, and prevention and reporting any allegation of participant abuse, neglect, and misappropriation of participant property.

(b) *Training.* 1. Within 90 days of employment, the ADCC shall provide, obtain or otherwise ensure each caregiver receives training in all the following areas:

a. Meeting the physical, social and mental health needs of each participant group served by an ADCC. Specific training shall include, as applicable, activities, safety risks, managing and responding to challenging behaviors, environmental considerations, disease processes, communication skills, and nutritional needs.

b. Recognizing and responding to changes in condition including first-aid.

c. Use of a fire extinguisher.

2. The ADCC shall provide, obtain, or otherwise ensure each caregiver receives and successfully completes specific task training prior to assuming these job duties, including all of the following:

a. Personal care training for all caregivers who provide assistance with activities of daily living. Training shall be appropriate to the care and services provided. Specific training topics may include toileting and incontinence care, mobility and transferring, eating, bathing, and dressing.

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b. Standard precaution training for all caregivers who may be exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood.

c. Medication administration and management training for all caregivers who manage, administer, or assist participants with prescribed or over-the-counter medications.

(c) *Caregiver supervision.* Until a caregiver has completed all required training, the caregiver shall be directly supervised by the program director or by a qualified caregiver.

(d) *Continuing education.* The program director and every caregiver shall receive at least 10 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following:

1. Standard precautions.

2. Participant rights.

3. Prevention and reporting of abuse, neglect and misappropriation.

4. Emergency and evacuation procedures.

(e) *Documentation.* 1. The ADCC shall maintain documentation of orientation and all the applicable training under sub. (4) (a), (b), and (d). Documentation shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training.

2. Orientation, training, and hours of continuing education shall be documented in the employee's file.

(5) PARTICIPANT ENROLLMENT, RETENTION, AND DISCHARGE. (a) *Limitations on enrollment and retention.* 1. No ADCC may serve more participants than the maximum participant capacity on its certification at any time during hours of operation.

2. No person under the age of 18 years may be enrolled as an ADCC participant, unless approved for enrollment by the department. Requests for approval to enroll a person under the age of 18 years shall be made in writing and shall include all of the following:

a. A statement from the referring physician stating the services required by the minor.

b. A statement from the program director certifying that the required services can be provided.

c. A statement from the persons or agencies assuming financial responsibility.

d. Evidence of guardianship and legal representative, if any.

(b) *Enrollment procedures.* 1. The ADCC shall assess each participant before enrollment as required under sub. (7) (a).

2. Upon acceptance into the program, the ADCC shall obtain and document all of the following information:

a. The participant's full name, address, telephone number, date of birth and living arrangement.

b. The name, address and telephone number of the participant's designated contact person, and legal representative, if any.

c. The name, address and telephone number of the participant's primary physician.

d. Name and address of the referring or coordinating agency and case manager, if applicable.

e. Any of the participant's advance directives, such as a power of attorney for health care, or a do-not-resuscitate order.

3. An enrollment agreement shall be signed by the participant or legal representative, if applicable, that includes a written description of the services to be provided, the cost of those services, and a statement that the participant's rights have been received.

4. Within 90 days before or 7 days after enrollment, a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse shall screen each participant for clinically apparent communicable diseases, including tuberculosis, and document the results of the screening. All screenings and immunizations shall be conducted in accordance with current standards of practice. The ADCC shall maintain the screening documentation in each participant's record.

(c) *Discharge.* 1. The ADCC shall develop criteria for voluntary and involuntary discharge of a participant from the program and a procedure for appeal of an involuntary discharge by the participant or legal representative.

2. The ADCC may not involuntarily discharge a participant unless any of the following occurs:

a. Nonpayment of charges, following reasonable opportunity to pay.

b. The participant requires care that is beyond the ADCC's certification.

c. The participant requires care that is inconsistent with the ADCC's program description and beyond that which the ADCC is required to provide under the terms of the enrollment agreement and this section.

d. The participant requires medical care that the ADCC cannot provide.

e. There is imminent risk of serious harm to the health or safety of the participant, other participants, or employees, as documented in the participant's record.

f. As otherwise permitted by law.

3. At least 30 days before involuntary discharge, the ADCC shall provide written notice of involuntary discharge to the participant or legal representative. If the continued presence of the participant endangers the health, safety or welfare of the participant or any other participant, the 30-day notice requirements of this subdivision do not apply.

(6) PARTICIPANT RIGHTS. (a) *Prohibitions.* Any form of coercion to discourage or prevent a participant or the participant's legal representative from exercising any of the rights under this subsection is prohibited. Any form of retaliation against a participant or the participant's legal representative for exercising any of the rights in this subsection, or against a caregiver or any other person who assists a participant or the participant's legal representative in the exercise of any of the participant rights in this subsection, is prohibited.

(b) *Participant rights.* Each participant shall have all of the following:

1. The right to be treated with respect and dignity.

2. The right to be free from physical, sexual, mental abuse and neglect, and from misappropriation of personal property.

3. The right to participate in the development of one's service plan, with support from a caregiver or legal representative, if needed.

4. The right to refuse to participate in an activity.

5. The right to privacy and confidentiality.

6. The right to be fully informed of all the services provided and the charge for each of those services.

7. The right to be informed of the reason for discharge and the procedure for appealing that decision.

8. The right to initiate a grievance and be informed of the grievance procedure.

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9. The right to be free from physical restraints, except upon prior review and approval by the department with written authorization from the participant's primary physician, physician assistant, or advanced practice nurse prescriber, as defined in s. N 8.02 (2). The department may place conditions on the use of a restraint to protect the health, safety, welfare, well-being and rights of the participant.

10. The right to be free from seclusion.

11. The right to be free from all chemical restraints.

12. The right to not be recorded, filmed or photographed without prior written informed consent by the participant or participant's legal representative. The ADCC may take a photograph for identification purposes. The department may photograph, record or film a participant pursuant to an inspection or investigation under s. 49.45 (2) (a) 11., Stats., without their written informed consent.

(7) PARTICIPANT CARE AND SERVICES. (a) *Assessment of participant's needs.* 1. Assessments shall be conducted by staff members having the expertise, experience, or training pertinent to the participant population served by the program. The assessment identifying the participant's needs shall be completed prior to enrollment. For emergency enrollments, the program will complete an assessment within 5 days.

2. A comprehensive written assessment of the participant's needs, at a minimum, shall include the areas of physical health to include physical disabilities and mobility status, mental and emotional health, nursing care, medications to include allergies, nutritional needs including risks for choking, emergency evacuation capabilities, preferences and interests and any other information helpful to developing the service plan.

(b) *Individual service plan.* 1. Within 30 days of enrollment and based on the assessment completed under par. (a), the ADCC shall develop and implement a service plan to identify the services and activities the program will provide in order to meet the individual needs and personal interests of the participant. The service plan shall be developed by staff members with experience, or training pertinent to the participant population served by the program.

2. The service plan will be reviewed and revised every 6 months or when necessary due to changes in the participant's functioning, health condition, or preferences. Changes shall be documented in the participant's record.

3. All caregivers who provide participant care and supervision shall have continual access to the participant's service plan.

(c) *Caregiver staffing requirements.* 1. In this paragraph, "severely impaired" means any impairment leading to a participant's inability at the program to perform any 3 or more ADLs. A severely impaired participant demonstrates an inability to perform these ADLs at the ADCC unless assistance, supervision or prompting is provided.

2. At least one qualified caregiver shall be on the premises at all times when one or more participant are present.

3. The ADCC shall provide sufficient caregiver staff at all times to implement the program goals and participant service plans based on a comprehensive assessment of each participant's needs, including physical health, physical disabilities and mobility status, mental and emotional health, emergency evacuation capabilities, and participant's preferences and interests.

4. There shall be a minimum of one caregiver for every 8 non-severely impaired participants at the ADCC.

5. There shall be a minimum of one caregiver for every 4 severely impaired participants at the ADCC.

6. The ADCC shall maintain a current written schedule for every caregiver at the ADCC. The schedule shall include each caregiver's full name, job assignment, and time worked.

7. A volunteer who meets the same standards, requirements, and training as a caregiver and who have signed a written job description may be counted as a caregiver to meet staffing requirements.

(d) *Medication administration.* 1. The ADCC shall have a written policy for medication management and shall designate which caregivers are authorized and trained to administer medications. The caregiver administering medications shall be 18 years of age or older. The policy shall indicate the program's role in the supervision of self-administered medications and caregiver administered medications.

2. Self-administered medications may be supervised by a caregiver who may prompt the participant and observe the participant taking the medication. To self-administer medications, the participant shall have the physical and mental capacity to obtain, dispense, and ensure the correct medications are taken in the prescribed dosages. When medications are self-administered, the medication list shall be reviewed and updated annually by the prescribing practitioner, physician, physician's assistant, or nurse practitioner.

3. Caregiver-administered medications shall be stored, obtained, and assembled for the participant. The caregiver is responsible for ensuring the correct medication, in the correct dose, at the correct time is administered to the correct participant. Medications administered by a caregiver shall meet all of the following conditions:

a. A written order from the prescribing practitioner shall be in the participant's record.

b. A listing of current medications with the dosage, frequency, and route of administration shall be in the participant's record.

c. Over-the-counter and prescription medications shall remain in the original labeled containers and be stored in a locked, safe place.

d. Non-licensed caregivers shall consult with the prescribing practitioner or pharmacist about each medication to be administered.

e. Written information describing side effects and adverse reactions of each medication shall be kept in the participant's record.

f. The administration of medications shall be documented in the participant's permanent record to include the name of the medication, dosage, method of administration, date and time administered, and name of the caregiver who administered the medication.

g. Medication administration by routes to include: injectable, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license, or may be delegated to a non-licensed caregiver pursuant to s. N 6.03 (3).

(e) *Program services.* Based on the written description of the program, the ADCC shall provide or arrange for services to meet the needs of each participant in all of the following areas:

1. 'Leisure activities.' The ADCC shall provide programming for individual and group activities that encourage creativity, social interaction, and physical exercise. Activities shall include outings to points of interest and involvement in the general community which take into consideration individual functional abilities, needs, and interests of each participant.

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2. 'Personal care.' The ADCC shall provide assistance to meet a participant's assessed needs for ADLs.

3. 'Supervision.' The ADCC shall provide supervision appropriate to the participant's needs.

4. 'Communication skills.' The ADCC shall provide services to meet the participant's communication needs.

5. 'Health monitoring.' The ADCC shall monitor the health of a participant by observing and documenting changes in each participant's health and referring a participant to health care providers when necessary. At a minimum, a quarterly note shall document how a participant is responding to the service plan. The ADCC shall immediately notify the participant's legal representative and the participant's residential provider, if any, when there is a significant change in a participant's physical or mental condition.

6. 'Behavior management.' The ADCC shall provide services to manage a participant's behaviors that may be harmful to themselves or others.

7. 'Transportation.' An ADCC program providing transportation for any participant shall carry liability insurance and ensure the vehicle is safe and well-maintained.

(f) *Food services.* 1. 'General requirements.' The ADCC shall obtain food from acceptable sources that meets the dietary needs of each participant.

2. 'Equipment and utensils.' The ADCC shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair. Single-use utensils may not be reused.

3. 'Dishwashing.' a. Whether washed by hand or mechanical means, all equipment and utensils shall be cleaned using separate steps for pre-washing, washing, rinsing, and sanitizing.

b. Mechanical washing of dishes and utensils in a residential type dishwasher will have a temperature setting of at least 120 degrees Fahrenheit. Upon removal from a residential-type dishwasher, a separate process must be completed for sanitization of all items that is in accordance with current standards of practice.

c. Mechanical washing of dishes and utensils in a commercial type dishwasher will be in accordance with manufacturer's recommendations.

d. Dishes and utensils shall be air dried, unless a dishwasher, which performs this function, is used.

Note: Wisconsin Food Code and Food Code Fact Sheets can be found at https://datcp.wi.gov/Pages/Programs_Services/FoodCode.aspx.

4. 'Nutrition.' a. The ADCC shall arrange for or provide a meal to each participant who is at the ADCC for 5 or more hours. Meals shall provide at least one-third of an adult's daily nutritional requirements.

b. The ADCC shall document the food served at each meal and maintain the documentation on file for at least 6 months.

c. A nutritious snack shall be made available consistent with each participant's dietary needs.

5. 'Sanitation.' a. Each caregiver who prepares or serves food shall be free from open, infected wounds and from communicable disease and shall maintain clean and safe work habits.

b. The ADCC shall provide hand-washing facilities in the kitchen for use by food handlers. Use of a common towel is prohibited.

c. Any participant who assists in preparing food shall adhere to the same food safety requirements as ADCC staff and be directly supervised by a caregiver.

6. 'Food safety.' Whether food is prepared at the ADCC or off-site, the ADCC shall store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The ADCC shall do all of the following:

a. Refrigerate and store all foods requiring refrigeration at or below 41 degrees Fahrenheit. Food items not in their original containers shall be covered, labeled and dated.

b. Maintain freezing units at 0 degrees Fahrenheit or below. Frozen foods shall be packaged, labeled, and dated.

c. Hold hot foods at 135 degrees Fahrenheit or above and cold foods at 41 degrees Fahrenheit or below until served.

d. Ensure that each refrigerator and freezer has an accurate thermometer inside the unit.

e. Keep food storage areas clean and dry and store food at least six inches off the floor.

(8) PHYSICAL ENVIRONMENT. (a) *Facility requirements.* 1. If required by the department of safety and professional services or local municipality, the ADCC shall have on file an inspection report signed by an authorized agent demonstrating that the ADCC including remodeling, has met applicable building codes.

2. The ADCC shall provide at least 50 square feet of usable floor space for each participant exclusive of passageways, bathrooms, lockers, office, storage areas, staff room, furnace rooms, and parts of rooms occupied by stationary equipment.

3. The ADCC shall be designed in such a way that it is accessible and functional in meeting the identified needs of the participant group it serves.

4. The ADCC shall have a telephone on the premises, which is immediately accessible during hours of operation.

5. Temperature at the ADCC shall be maintained at no less than 70 degrees Fahrenheit.

6. Toilets and fixtures shall function properly and shall be maintained in a sanitary condition.

7. The premises shall be clean, comfortable, and in good repair.

8. Pets kept on the premises shall be vaccinated against diseases including rabies.

(b) *Water supply.* 1. A supply of safe drinking water shall be available to any participant at all times.

2. If well water is used, wells shall be approved by the department of natural resources and water samples shall be tested annually at a state-approved laboratory. Documentation of test results shall be kept on file at the ADCC.

3. The ADCC shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140 degrees Fahrenheit. The temperature of hot water at plumbing fixtures used by residents may not exceed the range of 110 to 115 degrees Fahrenheit.

(c) *Furnishings.* 1. The center shall provide sufficient furniture and equipment for use by every participant that provides comfort, safety, and is appropriate for every participant.

2. The furnishings shall be clean, safe, and in good repair.

(d) *Exits.* Stairs, walkways, and ramps shall be maintained in a safe condition. All exits, sidewalks, and driveways used for exiting shall be kept free of ice, snow, and obstructions.

(e) *Delayed egress locks.* Delayed egress door locks are permitted with department approval only in an ADCC with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following:

1. No more than one device shall be present in a means of egress.

2. A sign shall be posted adjacent to the locking device indicating how the door may be opened.

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3. The doors shall unlock upon activation of the sprinkler system or fire detection system. The doors shall unlock upon loss of power controlling the lock or locking mechanism.

4. The door locks shall have the capability of being unlocked by a signal from the ADCC's fire command center.

5. An irreversible process will occur which will release the latch in not more than 15 seconds when a force of no more than 15 pounds is applied for 3 seconds to the release device. Initiation of the irreversible process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, re-locking shall be by manual means only.

6. To obtain department approval for a delayed egress lock, the ADCC shall:

a. Demonstrate the delayed egress lock is necessary to ensure the safety of every participant served by the ADCC, specifically persons at risk of elopement due to behavioral concerns, cognitive impairments or dementia, including Alzheimer's disease.

b. Obtain documentation from the local municipality that the delayed egress door lock system complies with the requirements under this paragraph and applicable building codes.

7. Upon installation of the approved delayed egress lock system, the operator shall obtain documentation from the installer that the system has been installed, tested, and is fully operational as designed and approved. The ADCC shall submit the documentation to the department within 10 days of completion of the installation.

(9) SAFETY. (a) *Emergency plan.* Each ADCC shall have a written plan for responding to fires, tornadoes, any missing participant, injuries, staff absenteeism, and other emergencies which includes:

1. Posting an evacuation plan.

2. Informing all staff members of their duties during an emergency.

3. Practicing and documenting annual tornado drills.

(b) *Fire safety.* Each ADCC shall:

1. Maintain written reports of fire safety inspections as well as any other inspection reports required by local authorities.

2. Install and maintain at least one 2A, 10-B-C fire extinguisher per 1,500 square feet of space. If only one extinguisher is necessary in the building, it is to be located near the cooking area.

3. Ensure fire extinguishers are operable at all times, inspected once a year by a qualified person, and shall bear a label indicating its condition and date of the last inspection.

4. Install and maintain smoke detectors in each activity room and hallways, unless the fire department indicates otherwise in writing. Each smoke detector shall be tested monthly.

5. Conduct and document quarterly fire drills.

(10) REQUIREMENTS FOR MULTI-USE FACILITIES. An ADCC located in a multi-use facility shall ensure the setting, programs, and physical environment will enhance the dignity and individual respect of every participant.

(a) *Nursing homes, community-based residential facilities, residential care apartment complexes and pre-vocational programs.* 1. 'Exterior.' a. Access to the ADCC shall be distinct and have separate entrance and exit doors so each participant and staff are not walking through the living or program areas of others. A multi-use facility may have a shared lobby leading to a distinct entrance door for the ADCC.

b. The ADCC shall have a separate door to the outside so each participant and staff are not walking through the living or program areas of others.

2. 'Interior.' a. The ADCC shall be separate from living areas, shall be in addition to space required for other programs, and shall meet the requirements of sub. (8) (a) 2.

b. Spaces designated for program activities, dining, toileting, exercise and ambulation are distinctly part of the adult day care area and limited to use by an ADCC participant. An ADCC participant may be provided personal care or therapy in space also used by residents or attendees of a multi-use facility provided that the ADCC services are scheduled at different times from any other occupants.

3. 'Staffing.' The ADCC shall have distinct and separate caregivers. No caregiver may be concurrently assigned to the ADCC and another program. All staff assigned to the ADCC shall meet requirements for orientation and training under sub. (4).

4. 'Activities.' The ADCC activity program shall be programmatically distinct from the weekly or monthly calendar of activities planned for residents or attendees of a multi-use facility, but may include special events provided on a non-routine basis.

(b) *Private family home.* If ADCC participants and other occupants are intermixed in a private family home and the common dining and living space is available to ADCC participants and other occupants, the common dining and living space shall be determined by the total capacity of the building as described in sub. (8) (a) 2.

(11) ANNUAL PROGRAM REVIEW. (a) An ADCC shall develop and implement an annual plan to evaluate and improve the effectiveness of the program's operation and services to ensure continuous improvement in service delivery. The evaluation process shall include:

1. A review of the existing program to identify quality of care issues.

2. The opportunity for each participant or their legal representative to complete a satisfaction survey regarding the services provided at the ADCC.

3. The development and implementation of plans of action to correct identified quality of care deficiencies as identified in an ADCC's internal review and the satisfaction survey.

4. A process for monitoring the effectiveness of the corrective actions taken by an ADCC.

(b) The department may not require disclosure of the records of the quality assessment process completed during the annual program review except to determine compliance with requirements of this subsection.

History: CR 20-006: cr. Register November 2021 No. 791, eff. 12-1-21; correction in (1) (b) 23., (2) (a) 2. a., (b) 1. (intro.), k., (d) 2., 4., (h), (i) 1., 5., 7., (j) 1., (k) 2., (m) 3. (intro.), c., 4., (o) (intro.), (3) (a) 2. d., (b) 3., (4) (e) 1., (5) (b) 1., (7) (b) 1., (8) (e) 6. b., (10) (a) 2. a., 3., (b) made under s. 13.92 (4) (b) 4., Stats., correction in (2) (a) 1. made under s. 13.92 (4) (b) 7., Stats., correction in (1) (a), (b) 12. (intro.), 16. b., 19. (intro.), c. to f., 28. b., (2) (m) 1. b., 2., (3) (d) 2. b., (e) 1. c., (6) (b) 9., 12., (7) (c) 4., 5., (f) 4. b. made under s. 35.17, Stats., and renumber (1) (b) 30. to (1) (b) 28m. and cons. and renum. (1) (b) 12. (intro.) and d. to 12. (intro.) under s. 13.92 (4) (b) 1., Stats., Register November 2021 No. 791.

DHS 105.15 Pharmacies. For MA certification, pharmacies shall meet the requirements for registration and practice under ch. 450, Stats., and chs. Phar 1 to 17.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. Register, December, 1991, No. 432, eff. 1-1-92; correction made under s. 13.92 (4) (b) 7., Stats., Register July 2011 No. 667.

DHS 105.155 Pharmacists. (1) For MA certification, a pharmacist must be licensed under ss. 450.03 and 450.05, Stats.

(2) When a pharmacist performs services under a delegation agreement in accordance with s. 450.033, they shall document and maintain the agreement in accordance with ch. Phar 7 and

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any guidelines set by the pharmacy examining board. Any pharmacist performing services under a delegation agreement shall make all of the following available for review by the department:

(a) Regarding the delegating authority of the physician, either of the following:

1. The name and license number of any delegating physicians.

2. The written protocol that identifies the organization's medical committee delegating the authority and is approved by the organization's physician staff.

(b) Regarding the delegated authority of the pharmacist, either of the following:

1. The name and license number of any pharmacist who may perform the delegated acts.

2. The written protocol from the delegating authority that identifies the authority delegated to the organization's pharmacist or pharmacists.

(c) The patient or groups of patients eligible to receive delegated services under the agreement, including any patient inclusion or exclusion criteria.

(d) The delegated services that the pharmacist may perform.

(e) The process for the physician or designee of the physician to monitor compliance with the delegation agreement by the pharmacist.

(f) The process for how the delegated services provided by the pharmacist will be documented or included in the patient's health record.

History: CR 24-047: cr. Register April 2025 No. 832, eff. 5-1-25; correction in (1) made under s. 13.92 (4) (b) 7., Stats., Register April 2025 No. 832.

DHS 105.16 Home health agencies. For MA certification, a home health agency shall be certified to participate in medicare as a home health agency, be licensed pursuant to ch. DHS 133 and meet the requirements of this section as follows:

(1) HOME HEALTH AGENCY SERVICES. For MA certification, a home health agency shall provide part-time, intermittent skilled nursing services performed by a registered nurse or licensed practical nurse and home health aide services and may provide physical therapy, occupational therapy, speech and language pathology services and medical supplies and equipment. Services may be provided only on visits to a recipient's home and that home may not be a hospital or nursing home. Home health services shall be provided in accordance with a written plan of care, which the physician shall review at least every 62 days or when the recipient's medical condition changes, whichever occurs first.

(1m) ELECTRONIC VISIT VERIFICATION. The home health provider is required to capture and retain EVV records.

(2) HOME HEALTH AIDES. (a) *Assignment and duties.* Home health aides shall be assigned to specific recipients by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse, a physical or occupational therapist or a speech and language pathologist, as appropriate. Duties shall include medically oriented tasks, assistance with the recipient's activities of daily living and household tasks as specified in s. DHS 107.11 (2) (b) and further described in the Wisconsin medical assistance home health agency provider handbook.

(b) *Supervision.* A registered nurse shall make supervisory visits to the recipient's home as often as necessary, but at least every 60 days, to review, monitor and evaluate the recipient's medical condition and medical needs according to the written plan of care during the period in which agency care is being provided. The RN shall evaluate the appropriateness of the relationship between the direct care giver and the recipient, assess the extent to which goals are being met, and determine if the current level of home health services provided to the recipient continues to be appropriate to treat the recipient's medical condition and if the services are medically necessary. The supervising RN shall discuss and review with the recipient the services received by the recipient and discuss the results of the supervisory visit with the LPN, home health aide or personal care worker. The results of each supervisory visit shall be documented in the recipient's medical record.

(c) *Training.* Home health aides shall be trained and tested in accordance with the requirements of s. 146.40, Stats., and ch. DHS 129. Aides shall not be assigned any tasks for which they are not trained, and training and competency in all assigned tasks shall be documented and made part of the provider's records.

(3) PHYSICAL THERAPISTS. Physical therapists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under the contract to the home health agency.

(4) OCCUPATIONAL THERAPISTS. Occupational therapists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under contract to the home health agency.

(5) SPEECH AND LANGUAGE PATHOLOGISTS. Speech and language pathologists may be employed by the home health agency or by an agency under contract to the home health agency, or may be independent providers under contract to the home health agency.

(6) RESPIRATORY CARE SERVICES. (a) A certified home health agency may be certified to provide respiratory care services under s. DHS 107.113 if registered nurses, licensed practical nurses and respiratory therapists employed by or under contract to the agency provide these services and:

1. Are credentialed by the national board on respiratory care; or

2. Know how to perform services under s. DHS 107.113 (1) and have the skills necessary to perform those services. Skills required to perform services listed in s. DHS 107.113 (1) (e) to (f) are required on a case-by-case basis, as appropriate. In no case may a person provide respiratory care before that person has demonstrated competence in all areas under s. DHS 107.113 (1) (a) to (d).

(b) A registered nurse who fulfills the requirements of this subsection shall coordinate the recipient's care.

(c) The department shall review an agency's continued compliance with this subsection.

(7) PRIVATE DUTY NURSING. A home health agency may provide private duty nursing services under s. DHS 107.12 performed by a registered nurse or licensed practical nurse.

(8) COST REPORTS. The department may, when necessary, require home health agencies to report information which is supplementary to information required on medicare cost reports.

(9) DEPARTMENT REVIEW. (a) *Record review.* The department may periodically review the records described in this section and s. DHS 106.02 (9), subject only to restrictions of law. All records shall be made immediately available upon the request of an authorized department representative.

(b) *In-home visits.* As part of the review under par. (a), the department may contact recipients who have received or are receiving MA services from a home health care provider. The provider shall provide any identifying information requested by the department. The department may select the recipients for visits and may visit a recipient with the approval of the recipient or recipient's guardian. The recipient to be visited has the opportu-

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nity to have any person present whom he or she chooses, during the visit by personnel of the department or other governmental investigating agency.

(c) *Investigation of complaints.* The department may investigate any complaint received by it concerning the provision of MA services by a home health care provider. Following the investigation, the department may issue a preliminary final report to the home health care provider in question, except when doing so would jeopardize any other investigation by the department or other state or federal agency.

(10) REQUIREMENTS FOR PROVIDING PRIVATE DUTY NURSING OR RESPIRATORY CARE SERVICES. For certified agencies providing private duty nursing or respiratory care services or both under this section, the following requirements apply:

(a) *Duties of the nurse.* 1. The following nursing services may be performed only by a registered nurse:

a. Making the initial evaluation visit;

b. Initiating the physician's plan of care and necessary revisions;

c. Providing those services that require care of a registered nurse as defined in ch. N 6;

d. Initiating appropriate preventive and rehabilitative procedures;

e. Accepting only those delegated medical acts which the RN is competent to perform based on his or her nursing education, training or experience; and

f. Regularly reevaluating the patient's needs.

2. Nursing services not requiring a registered nurse may be provided by a licensed practical nurse under the supervision of a registered nurse. Licensed practical nurse duties include:

a. Performing nursing care delegated by an RN under s. N 6.03;

b. Assisting the patient in learning appropriate self-care techniques; and

c. Meeting the nursing needs of the recipient according to the written plan of care.

3. Both RNs and LPNs shall:

a. Arrange for or provide health care counseling within the scope of nursing practice to the recipient and recipient's family in meeting needs related to the recipient's condition;

b. Provide coordination of care for the recipient;

c. Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience;

d. Prepare written clinical notes that document the care provided within 24 hours of providing service and incorporate them into the recipient's clinical record within 7 days; and

e. Promptly inform the physician and other personnel participating in the patient's care of changes in the patient's condition and needs.

(b) *Patient rights.* A nurse shall provide a written statement of the rights of the recipient for whom services are provided to the recipient or guardian or any interested party prior to the provision of services. The recipient or guardian shall acknowledge receipt of the statement in writing. The nurse shall promote and protect the exercise of these rights and keep written documentation of compliance with this subsection. Each recipient receiving care shall have the following rights:

1. To be fully informed of all rules and regulations affecting the recipient;

2. To be fully informed of services to be provided by the nurse and of related charges, including any charges for services for which the recipient may be responsible;

3. To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of services, including referral to a health care institution or other agency;

4. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of that refusal;

5. To confidential treatment of personal and medical records and to approve or refuse their release to any individual, except in the case of transfer to a health care facility;

6. To be taught, and have the family or other persons living with the recipient taught, the treatment required, so that the recipient can, to the extent possible, help himself or herself, and the family or other party designated by the recipient can understand and help the recipient;

7. To have one's property treated with respect; and

8. To complain about care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

(c) *Universal precautions.* A nurse shall have the necessary orientation, education and training in epidemiology, modes of transmission and prevention of HIV and other blood-borne or body fluid-borne infections and shall follow universal blood and body-fluid precautions for each recipient for whom services are provided. The nurse shall employ protective measures recommended by the federal centers for disease control (CDC), including those pertaining to medical equipment and supplies, to minimize the risk of infection from HIV and other blood-borne pathogens.

Note: A copy of the CDC recommended universal precautions may be obtained from the Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701.

(d) *Medical record.* The nurse shall maintain a medical record for each recipient. The record shall document the nature and scope of all services provided and shall be systematically organized and readily accessible to authorized department personnel. The medical record shall document the recipient's condition, problems, progress and all services rendered, and shall include:

1. Recipient identification information;

2. Appropriate hospital information, including discharge information, diagnosis, current patient status and post-discharge plan of care;

3. Recipient admission evaluation and assessment;

4. All medical orders, including the physician's written plan of care and all interim physician's orders;

5. A consolidated list of medications, including start and stop dates, dosage, route of administration and frequency. This list shall be reviewed and updated for each nursing visit, if necessary;

6. Progress notes posted as frequently as necessary to clearly and accurately document the recipient's status and services provided. In this paragraph, "progress note" means a written notation, dated and signed by a member of the health team providing covered services, that summarizes facts about care furnished and the recipient's response during a given period of time;

7. Clinical notes written the day service is provided and incorporated into the clinical record within 7 days after the visit or recipient contact. In this paragraph, "clinical note" means a notation of a contact with a recipient that is written and dated by a member of the home health team providing covered services, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition;

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8. Written summaries of the recipient's care provided by the nurse to the physician at least every 62 days; and

9. Written authorizations from the recipient or the recipient's guardian when it is necessary for the nurse to procure medical supplies or equipment needed by the recipient, unless the recipient's care is being provided by an MA-certified home health agency.

(e) *Back-up and emergency procedures.* 1. The recipient shall be informed of the identity of the agency-assigned alternate nurse before the alternate nurse provides services.

2. The nurse shall document a plan for recipient-specific emergency procedures in the event a life-threatening situation or fire occurs or there are severe weather warnings. This plan shall be made available to the recipient and all caregivers prior to initiation of these procedures.

3. The nurse shall take appropriate action and immediately notify the recipient's physician, guardian, if any, and any other responsible person designated in writing by the patient or guardian of any significant accident, injury or adverse change in the recipient's condition.

(f) *Discharge of the recipient.* A recipient shall be discharged from services provided by the nurse upon the recipient's request, upon the decision of the recipient's physician, or if the nurse documents that continuing to provide services to the recipient presents a direct threat to the nurse's health or safety and further documents the refusal of the attending physician to authorized discharge of the recipient with full knowledge and understanding of the threat to the nurse. The nurse shall recommend discharge to the physician and recipient if the recipient does not require services or requires services beyond the nurse's capability. The nurse provider shall issue a notification of discharge to the recipient or guardian, if possible at least 2 calendar weeks prior to cessation of skilled nursing services, and shall, in all circumstances, provide assistance in arranging for the continuity of all medically necessary care prior to discharge.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (intro.), (1) and (2), r. and recr. (3), cr. (4) and (5), Register, April, 1988, No. 388, eff. 7-1-88; emerg. r. and recr. (1) and (2), cr. (6), eff. 7-1-92; r. and recr. (1) and (2), cr. (6) to (10), Register, February, 1993, No. 446, eff. 3-1-93; correction in (intro.) made under s. 13.93 (2m) (b) 7., Stats., Register, October, 2000, No. 538; corrections in (intro.), (2) (a), (c), (6) (a) (intro.), 2., (7) and (9) (a) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 20-039: am. (6) (a) (intro.) Register October 2021 No. 790, eff. 11-1-21; EmR2306: emerg. cr. (1m), eff. 5-1-23; CR 23-045: cr. (1m) Register January 2024 No. 817, eff. 2-1-24.

DHS 105.17 Personal care providers. (1) DEFINITIONS. In this section:

(a) "Client" means an individual who receives personal care services from an entity certified or required to be certified under this section, irrespective of whether that individual is a medicaid recipient.

(ag) "Delegated act" means an act that is delegated to an RN or L.P.N. by a physician, podiatrist, dentist or optometrist.

(am) "Freestanding personal care agency" means an entity described in s. 49.45 (42) (d) 3. e., Stats.

(b) "Legal representative" means a person who is any of the following:

1. A guardian as defined under s. 54.01 (10), Stats.

2. A person appointed as a health care agent under an activated power of attorney for health care under ch. 155, Stats.

3. A person appointed as an agent under a durable power of attorney under s. 243.07, 1989 Stats., executed on or before April 28, 1990.

4. A parent of a minor child.

(c) "Principal" means an administrator, a person with management responsibility for the applicant, an officer or person owning directly or indirectly 5% or more of the shares or other evidences of ownership of a corporate applicant, a partner in a partnership which is an applicant, or the owner of a sole proprietorship which is an applicant.

(1c) REQUIREMENTS. For MA certification, a personal care provider shall be one of the following types of entities and shall meet applicable certification requirements:

(a) A home health agency licensed under s. 50.49, Stats., and ch. DHS 133.

(b) A county department established under s. 46.215, 46.22 or 46.23, Stats.

(d) An independent living center as defined in s. 46.96 (1) (ah), Stats.

(e) A federally recognized American Indian tribe or band in Wisconsin.

(f) A freestanding personal care agency.

(1e) CONTRACTING, PLANNING AND COORDINATION; FIT AND QUALIFIED. A personal care provider shall do all of the following:

(a) Possess the capacity to enter into a legally binding contract.

(b) Present a proposal to the department to provide personal care services that does all of the following:

1. Documents cost-effective provision of services.

2. Documents a quality assurance mechanism and quality assurance activities.

3. Demonstrates that employees possess knowledge of and training and experience with special needs, including independent living needs, of the client group or groups receiving services.

(c) Provide a written plan of operation describing the entire process from referral through delivery of services and follow-up.

(d) Cooperate with other health and social service agencies in the area and with interested community referral groups to avoid duplication of services and to provide coordination of personal care services to clients.

(e) Be fit and qualified. All of the following factors are relevant to a determination by the department whether the applicant is fit and qualified for purposes of this paragraph:

1. Any adverse action against the applicant or any principal by a licensing agency of any state that resulted in denial, suspension, injunction, or revocation of a license to operate a human services or health care agency or facility.

2. Any adverse action against the applicant or any principal initiated by a state or federal agency based on non-compliance that resulted in civil money penalties, termination of a provider agreement, suspension of payments, or the appointment of temporary management of a facility or agency.

3. Any conviction of the applicant or any principal for a crime involving neglect or abuse of patients or of the elderly or involving assaultive behavior or wanton disregard for the health or safety of others, or any act of abuse under s. 940.285 or 940.295, Stats., or similar law in another jurisdiction.

4. Any conviction of the applicant or any principal for a crime related to the delivery of personal care or other health care-related services or items, or for providing personal care or other health care-related services without a license or other form of permission required by law.

5. Any conviction of the applicant or any principal for a crime involving a controlled substance under ch. 961, Stats., or similar law in another jurisdiction.

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6. Any conviction of the applicant or any principal for a crime involving a sexual offense.

7. Any prior financial failure of the applicant or any principal that resulted in bankruptcy or in the closing of a human services or health care agency or facility or the relocation or discharge of such an agency's or facility's patients.

8. Any unsatisfied judgment against the applicant or any principal or any debts that are at least 90 days past due.

(f) Adopt written policies, procedures and documents that outline agency operations.

(g) Adopt a statement detailing the services to be provided.

(h) Oversee the management of the agency.

(i) Appoint an administrator.

(j) Provide for a substitute administrator to act in the absence of the administrator. If it is necessary to immediately terminate an administrator or if the agency loses an administrator for other reasons, employ or name a qualified replacement as soon as possible within 90 days of the vacancy.

(k) Notify the department in writing within 10 days of any appointment or change of the administrator or the substitute administrator.

(L) Notify the department in writing within 10 days of a change in the location of the agency or contact information for the personal care provider.

(1f) PROVISION OF INFORMATION. A county, independent living center or federally recognized American Indian tribe or band personal care provider shall provide, in a format approved by the department, identifying information about the county, independent living center or federally recognized American Indian tribe or band and those agencies and individuals that provide Medicaid personal care services through a contract with the county, independent living center or federally recognized American Indian tribe or band.

(1g) FINANCES; ACCOUNTING; RECORDKEEPING; BILLING. A personal care provider shall do all of the following:

(a) *Cash flow.* Document adequate resources to maintain a cash flow sufficient to cover operating expenses for 60 days.

(b) *Accounting methods.* Document a financial accounting system that complies with generally accepted accounting principles.

(c) *Recordkeeping.* Maintain all of the following records:

1. Written personnel policies.

2. Written job descriptions.

3. A written plan of operations indicating the entire process from making referrals through delivery of services and follow-up.

4. A written statement defining the scope of personal care services provided, including the population being served, service needs and service priorities.

5. A written record of personal care workers' training.

6. Workers' time sheets.

7. Contracts with workers and other agencies.

8. Records of supervisory visits.

(cm) *Electronic visit verification.* The provider is required to capture and retain EVV records.

(d) *Billing.* Bill the medical assistance program for services covered under s. DHS 107.112.

(1k) ADMINISTRATOR AND ADMINISTRATOR QUALIFICATIONS. (a) The administrator of a personal care agency shall meet all of the following requirements:

1. Be at least 21 years of age.

2. Have the ability to fulfill the job requirements, respond to the needs of the clients, and manage the personal care agency.

3. Have an associate degree or higher in a health care-related field from an accredited college, or a bachelor's degree in a field other than in health care from an accredited college and one year experience working in a health care-related field.

4. Have training and experience in health care administration and at least one year of supervisory or administrative experience in home health care or personal care, or a related health program.

5. Be knowledgeable about this chapter and s. DHS 107.112, and take all reasonable steps to ensure that the personal care agency complies with the requirements of this chapter.

6. Be responsible for the overall provision of training and competency of all employees.

(b) Persons who are the administrator of record with the department of a personal care agency on the effective date of this rule shall be exempt from the qualification requirements specified under par. (a).

(1n) PERSONNEL MANAGEMENT. The personal care provider shall document and implement a system of personnel management, if more than one personal care worker is employed or under contract, that includes all of the following:

(a) 1. Evaluate every personal care worker and RN supervisor employed by or under contract with the provider periodically according to the provider's policy for quality of performance and adherence to the provider's policies and this chapter and s. DHS 107.112. Evaluations shall be followed up with appropriate action.

2. Provide orientation and on-going instruction for RN supervisors and personal care workers. Personal care workers shall receive orientation before providing services to a client. The titles of the persons responsible for conducting orientation and training shall be specified in the plan. The plan shall include a system for providing instruction when an evaluation of the RN's or personal care worker's performance or competency indicates additional instruction may be needed. Orientation shall include training on all of the following:

a. Policies and objectives of the provider.

b. Information concerning specific job duties. Training shall be provided for each skill the personal care worker is assigned and shall include a successful demonstration of each skill by the personal care worker to the qualified trainer, under the supervision of the RN supervisor, prior to providing the service to a client independently. Only an RN may train others on a delegated act, as defined in s. N 6.02 (5), and s. N 6.03. The RN or qualified trainer shall document the personal care worker's successful demonstration of each skill and maintain the information in their personnel file.

c. The functions of personnel employed by the provider and how they interrelate and communicate with each other in providing services.

d. Health and safety procedures for working in a home environment.

e. Epidemiology, modes of transmission and prevention of infections and the need for routine use of current infection control measures as recommended by the U.S. centers for disease control and prevention.

f. Responding to medical and non-medical emergencies.

g. Ethics, confidentiality of client information, and client rights.

3. Comply with the caregiver background check requirements under s. 50.065, Stats., and ch. DHS 12, including the disclosure requirements under s. 50.065 (2m), Stats., and s. DHS

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12.115. The provider shall also comply with the caregiver misconduct reporting and investigation requirements under ch. DHS 13.

(b) Employ trained personal care workers as described under sub. (3), or train or arrange and pay for training of employed or subcontracted personal care workers as necessary. No employee or subcontractor may be assigned any duty for which he or she is not trained.

(c) Employ or contract with at least one registered nurse.

(d) 1. Supervise the provision of personal care services. Except as provided in subd. 2., services for all clients shall be supervised by an RN according to the requirements set forth in s. DHS 107.112 (3) (a) and (c). The visit to the client's home by an RN shall be conducted at a time when the personal care worker will be directly observed providing personal care services to the client in the client's home. The RN shall document the results of the visit including the observation of the personal care worker and maintain the information in their personnel file or other designated agency file. When observation of the personal care worker by the RN reveals a failure to follow the client's care plan, the personal care provider shall provide counseling, education or retraining to ensure the personal care worker is adequately trained to complete their job responsibilities.

2. Clients who are not Medicaid recipients may choose to waive the requirements contained in s. DHS 107.112 (3) (c) for the supervisory review of the personal care worker, including a visit to the client's home every 60 days, through a written agreement between the client or the client's legal representative and the personal care agency. The agreement shall specify the requirements being waived by the client or the client's legal representative and the benefits of the requirement and probable consequences of the requirement not applying to the client. The agreement shall be included in the service agreement required s. DHS 105.17 (1w) (c).

(e) Employ or contract with personal care workers to provide personal care services.

(f) In the case of personal care workers who are not employees of the personal care provider, specify all required training, qualifications and services to be performed in a written personal care provider contract between the personal care provider and personal care workers, and maintain a copy of that contract on file.

(fm) Document performance of personal care services by personal care workers by maintaining time sheets of personal care workers which document the types and duration of services provided, by funding source.

(1r) INFECTION CONTROL AND PREVENTION. (a) The personal care provider shall develop and implement written policies for control of communicable diseases that take into consideration control procedures incorporated by reference in ch. DHS 145 and that ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work unless authorized to do so by a physician or physician assistant or advanced practice nurse.

(b) 1. The personal care provider shall ensure that each new employee, before having direct contact with clients, is certified in writing by a physician, physician assistant or registered nurse as having been screened for tuberculosis, and clinically apparent communicable disease that may be transmitted to a client during the normal performance of the employee's duties. The screening shall occur within 90 days before the employee has direct client contact.

2. The personal care provider shall ensure that each continuing employee having direct contact with clients is periodically screened for clinically apparent communicable disease by a physician, physician assistant, or registered nurse based on the likelihood of their exposure to a communicable disease, including tuberculosis. The exposure to a communicable disease may have occurred in the community or in another location.

(c) The personal care provider shall monitor employees' adherence to evidence-based standards of practice as recommended by the U.S. centers for disease control and prevention, or other evidence-based standards of practice, related to protective measures. When monitoring reveals a failure to follow evidence-based standards of practice, the provider shall provide counseling, education, or retraining to ensure staff is adequately trained to complete their job responsibilities.

(d) The personal care provider shall provide equipment and supplies necessary for all staff having direct care contact with the client to minimize the risk of infection.

(1w) CLIENT SERVICES. The personal care provider shall do all of the following:

(a) *Acceptance.* Assess a prospective client's appropriateness to be served by the provider without delay, unless the reason for the delay is justifiable and documented, and accept a client only if there is reasonable expectation that the client's needs can be met by the provider. If the provider accepts the applicant as a client, the provider shall promptly provide services to the individual. If the provider does not accept an applicant as a client, the provider shall inform the applicant of other personal care providers in the area or how to obtain a list of those providers.

(b) *Information to provide to the client.* The provider shall provide, in writing, prior to or at the time of accepting an applicant as a client, each client or the client's legal representative all of the following:

1. The provider's rules and the client's responsibilities under the provider's rules.

2. The procedures indicating the complaint or grievance process which shall include a statement on how the client can make a complaint to the department.

3. A statement of client's rights which shall include all of the following:

a. To be fully informed of these rights and of all of the provider's rules governing client responsibilities.

b. To be fully informed of services available from the provider.

c. To be informed of all changes in services and charges as they occur.

Note: For clients who are Medicaid recipients, personal care services are not subject to recipient cost sharing, per s. 49.45 (18) (b) 11., Stats., and the provider is prohibited from charging the recipient for services in addition to or in lieu of obtaining Medicaid payment, per s. 946.91 (5), Stats.

d. To participate in the planning of services, including referral to a health care institution or other provider and to refuse to participate in experimental research.

dm. To have access to information about the client's health condition to the extent required by law.

Note: Section 146.83, Stats., and federal HIPAA regulations [45 CFR s. 164.524] generally require health care providers to make health care records available for inspection by the patient.

e. To refuse service and to be informed of the consequences of that refusal.

f. To confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the provider, except in the case of transfer to another provider or to a health facility, or as otherwise permitted by law.

g. To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.

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h. To be taught the service required so that the client can, to the extent possible, help himself or herself.

i. To have a person designated by the client taught the service required, so that, to the extent possible, the person designated can understand and help the client.

j. To have one's property treated with respect.

k. To complain about the care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

L. To have the client's legal representative exercise the client's rights when the legal representative is legally authorized to do so.

(c) *Service agreement.* Before services are provided, the personal care provider shall inform the client, orally and in writing, of the extent to which payment may be expected from other sources, the charges for services that will not be covered by other sources and charges that the individual may have to pay.

Note: For clients who are Medicaid recipients, personal care services are not subject to recipient cost sharing, per s. 49.45 (18) (b) 11., Stats., and the provider is prohibited from charging the recipient for services in addition to or in lieu of obtaining Medicaid payment, per s. 946.91 (5), Stats.

(d) *Client records.* Maintain all of the following records, if required in this section or s. DHS 107.112, for each client:

1. The nursing assessment, physician prescription, plan of care, personal care worker's assignment and record of all assignments, and record of registered nurse supervisory visits.

2. The record of all visits by the personal care worker, including observations and assigned activities completed and not completed.

3. Written acknowledgement of receipt by the client of the client's rights and responsibilities, provider rules and policies, and the department statement on how to register a complaint.

4. A copy of the discharge summary.

5. All of the information required under s. DHS 106.02 (9) (e) 2. for each of its clients.

(e) *Client's preference for services.* Give full consideration to a client's preferences for service arrangements and choice of personal care workers.

(f) *Discharge of a client.* 1. A personal care provider may discharge a client only for one or more of the reasons listed in subd. 2., 3., or 6. and only after discussing the reasons for the discharge with the client or the client's legal representative and the client's attending physician, when the physician has ordered personal care services, and providing written notice to the client or client's legal representative within the timelines specified in this paragraph.

2. The personal care provider shall provide written notice to the client or the client's legal representative at least 10 working days in advance of the discharge if the reason for the discharge is either of the following:

a. The provider is unable to provide the personal care services required by the client due to either a change in the client's conditions that is not an emergency, or the provider's documented inability to staff the case.

b. Non-payment for services.

3. The personal care provider shall provide written notice to the client or the client's legal representative at the time of the discharge if the reason for the discharge is the result of any of the following:

a. The safety of the personal care worker or nurse supervisor is compromised, as documented by provider staff.

b. The attending physician orders the discharge of the client for emergency medical reasons.

c. The client no longer needs personal care service as determined by the attending physician.

d. The client is abusing or misusing the personal care benefit as determined by the department or county agency under s. DHS 104.02 (5).

4. A copy of the written notice of discharge shall be placed in the client's medical record.

5. The personal care provider shall include all of the following in the written notice of discharge required under this paragraph:

a. The reason the provider is discharging the client.

b. The assistance the personal care provider is able to provide in arranging for continuity of all necessary personal care services.

c. A notice of the client's right to file a complaint with the department if the client believes the discharge does not comply with any of the provisions of this section and the department's toll-free complaint telephone number and the address and telephone number of the department's division of quality assurance.

Note: A complaint may be filed by writing the Bureau of Health Services, Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701-2969 or by calling the department's toll-free complaint line at 1-800-642-6552 or by filing a complaint at http://dhs.wisconsin.gov/bqaconsumer/HealthCareComplaints.htm.

6. No written notification is necessary for discharge for any of the following reasons:

a. The client dies.

b. The client changes place of residence to a location in an area not served by the provider.

c. The client or the client's legal representative notifies the provider in writing to terminate services.

7. The personal care provider shall complete a written discharge summary within 30 calendar days following discharge of a client or voluntary termination of services by the client or the client's legal representative. The discharge summary shall include a description of the care provided and the reason for discharge. The personal care provider shall place a copy of the discharge summary in the former client's medical record. Upon request, the personal care provider shall provide a copy of the discharge summary to the former client, the client's legal representative, the attending physician, or advanced practice nurse prescriber.

Note: A complaint may be filed by writing the Bureau of Health Services, Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701-2969 or by calling the department's toll-free complaint line at 1-800-642-6552 or by filing a complaint at http://dhs.wisconsin.gov/bqaconsumer/HealthCareComplaints.htm.

(h) *Client grievances and complaints.* Provide and document a grievance mechanism to resolve clients' complaints about personal care services, including a personal care provider's decision not to hire a client's choice of a personal care worker. The procedure shall set forth a procedure for clients to register complaints with the department.

(2) QUALIFICATIONS AND DUTIES OF THE REGISTERED NURSE SUPERVISOR. (a) *Qualifications.* A personal care provider shall employ or contract with an RN supervisor who shall have all of the following qualifications:

1. Current licensure as a registered nurse under s. 441.06, Stats.

2. Training and experience in the provision of personal care services or in a related program.

3. At least one year of supervisory or administrative experience in personal care services or in a related program.

(b) *Duties.* The RN supervisor shall perform all of the following duties:

1. Assess and evaluate the need for services according to the standards of practice contained in s. N 6.03 (1) (a) and (d), and

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make referrals to other services as appropriate. Documentation shall be signed and dated by the RN supervisor who conducted the assessment and evaluation, attesting to its accuracy and truthfulness.

2. Secure written orders from the client's physician. These orders are to be renewed once every 3 months unless the physician specifies that orders covering a period of time up to one year are appropriate, or when the client's needs change, whichever occurs first. Physician orders for personal care services are not required for clients who are not Medicaid recipients unless the personal care service is a delegated act. This provision does not mitigate the RN supervisor's responsibility to follow the standards contained in ch. N 6.

3. Develop a plan of care for the client, giving full consideration to the client's preferences for service arrangements and choice of personal care workers, interpret the plan to the personal care worker, include a copy of the plan in the client's health record, and review the plan at least every 60 days and update it as necessary.

3m. Promptly notify a client's physician or other appropriate medical personnel and legal representative, if any, of any significant changes observed or reported in the client's condition.

4. Develop appropriate time and service reporting mechanisms for personal care workers and instruct the workers on their use.

5. Give the personal care worker written instructions about the services to be performed and arrange for an appropriate person to demonstrate to the personal care worker how to perform the services.

6. Evaluate the competency of the personal care worker to perform the services.

(3) QUALIFICATIONS AND DUTIES OF PERSONAL CARE WORKERS. (a) *Qualifications.* Personal care workers shall have the following qualifications:

1. Be trained under s. DHS 105.17 (1n) (a) 2. and (b) in the provision of personal care services, and in each skill that the personal care worker is assigned.

2. Provide documentation of required training to the personal care provider for the provider's records;

3. Be a person who is not a legally responsible relative of the client under s. 49.90 (1), Stats.

4. Have the skills, education, experience and ability to fulfill the employee's job requirements.

5. Be at least 16 years old.

(b) *Duties.* Personal care workers shall do all of the following:

1. Perform tasks assigned by the RN supervisor.

2. Report in writing to the RN supervisor on each assignment.

3. Promptly report any significant changes observed or reported in the client's condition to the RN supervisor.

4. Confer as required with the RN supervisor regarding the client's progress.

5. Upon coming in contact with blood or other potentially infectious materials including those that are air-borne, non-intact skin, or mucus membranes in caring for clients, practice infection control measures as recommended by the U.S. centers for disease control and prevention.

(4) INSPECTIONS AND INVESTIGATIONS. (a) 1. The department's division of quality assurance may make any inspections and investigations, including complaint investigations, it considers necessary and may review clinical and administrative records, policies and other documents required under this section or s. DHS 107.112.

2. Any interference with or refusal to allow or cooperate with any inspection or investigation under this subsection may be grounds for termination of MA certification.

(b) The department may contact clients of personal care providers as part of an inspection or investigation. The provider shall provide the department a list of names, addresses and other identifying information of current and past clients as may be requested. The department may select the names of the clients to be contacted and may contact these clients upon the client's approval.

(c) Upon determining that a personal care provider is not compliant with one or more certification requirements under this section or s. DHS 107.112, the department shall promptly notify the provider of the specific rule violated, state the facts that constitute the deficiency and specify the date by which the provider is required to correct the deficiency.

(5) MA APPLICATION REQUIREMENTS; FREESTANDING PERSONAL CARE AGENCIES. (a) *Definitions.* In the section, "branch office" means a location or site from which a personal care agency provides services within a portion of the total geographic area served by the personal care agency. "Parent agency" means a personal care agency with one or more branch offices.

(ag) *Application for MA certification.* For MA certification, a freestanding personal care agency shall submit an application on forms provided by the department, and provide all information requested on the forms. The application shall be fully completed and submitted with the applicable nonrefundable fee in an amount established by the department.

(ar) *Multiple locations.* A branch office shall separately apply and be separately certified if the department determines that the branch office, because of the volume of services provided or the distance between the branch office and the parent agency, cannot adequately share supervision and administration of services with the parent agency. Each office the department finds to be necessary shall submit a separate application under this subsection and shall independently satisfy all requirements for certification set forth in this section, except that the requirements under s. DHS 105.17 (1e) (b), (1g) (a) and (b), (1n), and (1w) (h) may be satisfied by policies and practices that are adopted by the entity that owns or controls the agency, and that are applicable to all required offices of the agency. If a branch agency is not separately approved from a parent agency, the parent agency shall be deemed to be in violation of this chapter or s. DHS 107.112 if the branch is in violation.

Note: To obtain a copy of the application forms, send your request to the Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701-2969. The street address is 1 W. Wilson Street in Madison. The e-mail address is: Dhswebmaildqa@wisconsin.gov. The completed application forms should be sent to the same office.

Note: Fees are permitted under s. 49.45 (42) (c), Stats., and set and periodically revised by the Department's Division of Quality Assurance. Fees may vary based on a number of factors including revenues from operations.

(b) *Recommendation for certification.* 1. Following receipt of a complete application for MA certification or for a change in certification when there has been a change in the ownership of a personal care agency, the department shall review the application, and investigate the applicant and principals to determine the applicant's ability to comply with this section and s. DHS 107.112.

2. Within 90 days after receiving a complete application, the department shall either approve or deny the application. Approval will be effective for a 1-year period from the date a complete application was submitted to the department.

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3. The applicant shall submit a written request to the department for an on-site survey within 9 months of the date the application was approved.

4. The applicant shall show that the agency has served at least 5 clients requiring personal care services during the period of the approved application. At the time of the on-site survey, the applicant or its personnel shall demonstrate provision of personal care services to at least 2 clients.

5. If the applicant does not submit a written request for an on-site survey within 9 months of the date the application was approved, the application will no longer be valid.

6. Within 90 days following completion of an on-site survey, the department shall either recommend certification or not recommend certification of the applicant to the department's division of medicaid services.

(c) *Non approval.* The department may not approve certification for an applicant who does not comply with any provision of this chapter, s. DHS 107.112, or ch. 50, Stats., or who is not fit and qualified as specified in DHS 105.17 (1e) (e), or who has failed to pay any fee or any outstanding amounts due to the department.

(d) *Annual reporting and fee.* 1. Every 12 months, on a schedule determined by the department, a certified freestanding personal care agency shall submit an annual report to the department in the form and containing the information that the department requires. The freestanding personal care agency shall submit with the report a fee in an amount determined by the department. If a complete annual report and fee are not timely submitted to the department, the department shall issue a warning to the freestanding personal care agency.

2. The department may terminate certification of a freestanding personal care agency that does not submit a completed report and fee to the department within 60 days after the date established by the department in subd. 1.

Note: Fees are permitted under s. 49.45 (42) (c), Stats., and set and periodically revised by the Department's Division of Quality Assurance. Fees may vary based on a number of factors including revenues from operations.

(6) QUALITY ASSESSMENT AND ASSURANCE COMMITTEE. (a) A personal care agency shall establish a quality assessment and assurance committee for the purpose of identifying and addressing quality of care issues. The committee shall include all of the following members:

1. The administrator.

2. The substitute administrator.

3. The registered nurse supervisor.

4. At least 1 other member of the agency's staff.

(b) The quality assessment and assurance committee shall do all of the following:

1. Meet at least quarterly to identify quality of care issues that require quality assessment and assurance activities.

2. Develop and implement appropriate plans of action to correct identified quality of care issues.

(c) The department may not require disclosure of the records of the quality assessment and assurance committee except to determine compliance with the requirements of this section.

(7) AGENCY CLOSURE. (a) Any personal care agency that intends to close shall provide written notice to each client, the client's legal representative, if any, the client's attending physician and the department at least 30 days before closing.

(b) The personal care agency shall provide assistance to clients in arranging for continuity of necessary services.

History: Cr. Register, April, 1988, No. 388, eff. 7-1-88; emerg. am. (1) (intro.), eff. 7-1-88; am. (1) (intro.), Register, December, 1988, No. 396, eff. 1-1-89; am. (3) (a) 1., Register, February, 1993, No. 446, eff. 3-1-93; correction in (1) (intro.) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528; correction in (1) (intro.) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 08-108: am. (1) (intro.) Register June 2009 No. 642, eff. 7-1-09; CR 09-107: renum. (1) to be (1c), (1e), (1g), (1n), (1r) and (1w) and am., renum. (4) (intro.) to be (4) (a) 1. and am., renum. (4) (a) to (f), (h) and (i) to be (1g) (c) 1. to 8. and am., r. (1) (L), (3) (a) 4. and (4) (g), cr. (1), (1e) (intro.), (e), (1f), (1g) (intro.), (1n) (a) 2., 3., (1r) (title), (a) to (c), (1w) (intro.) to (c), (f), (2) (b) 3m., (3) (b) 5., (4) (a) 2., (b), (c) and (5), am. (2) (a) (intro.) to 2., (b), (3) (a) 1., 3., (b), and (4) (title), r. and recr. (2) (a) 3. Register August 2010 No. 656, eff. 9-1-10; correction in (1) (b) 3. made under s. 13.92 (4) (b) 7., Stats., Register July 2011 No. 667; CR 19-087: cr. (1) (ag), (1e) (f) to (L), (1k), am. (1n) (a) 2. b., (d) 1., r. and recr. (2) (b) 1., am. (2) (b) 2., cr. (3) (a) 4., 5., r. and recr. (5) (b), (c), cr. (6), (7) Register August 2020 No. 776, eff. 9-1-20; correction in (1n) (a) 2. b., (5) (c) made under s. 35.17, Stats., Register August 2020 No. 776; republished to correct an error in transcription in (5) (c) Register December 2020 No. 779; CR 22-026: r. (1c) (c) Register May 2023 No. 809, eff. 6-1-23; EmR2306: emerg. cr. (1g), (cm), eff. 5-1-23; CR 23-045: cr. (1g) (cm) Register January 2024 No. 817, eff. 2-1-24.

DHS 105.19 Nurses in independent practice. (1) QUALIFICATIONS. (a) For MA certification to perform skilled nursing services as a nurse in independent practice providing home health services under s. DHS 107.11 (6) or private duty nursing services under s. DHS 107.12, the nurse shall be:

1. Licensed as a registered nurse pursuant to s. 441.06, Stats.;

2. Licensed as a practical nurse pursuant to s. 441.10, Stats.; or

3. A registered nurse providing supervision of a licensed practical nurse certified under this section.

(b) For MA certification to perform respiratory care services as a provider in independent practice, the provider shall be a nurse described in par. (a) or a respiratory therapist. Any person providing or supervising respiratory care who is not credentialed by the national board on respiratory care shall know how to perform the services under s. DHS 107.113 (1) and shall have the skills necessary to perform those services. Skills required to perform services listed in s. DHS 107.113 (1) (e) to (f) are required on a case-by-case basis, as appropriate. In no case may a person provide respiratory care before that person has demonstrated competence in all areas under s. DHS 107.113 (1) (a) to (d). A registered nurse who fulfills these requirements shall coordinate the recipient's care.

(2) PLAN OF CARE. Nursing services and respiratory care shall be provided in accordance with a written plan of care which the physician reviews and signs at least every 62 days or when the recipient's condition changes, whichever occurs first.

(3) SUPERVISION OF A LICENSED PRACTICAL NURSE. A registered nurse or physician designated by the LPN providing nursing or respiratory care services shall supervise the LPN as often as necessary under the requirements of ss. N 6.03 and 6.04 (2) and shall document the results of supervisory activities. An LPN may provide nursing or respiratory care services delegated by an RN as delegated nursing acts under ss. N 6.03 and 6.04 and guidelines established by the board of nursing.

(4) DUTIES OF THE NURSE. (a) The following nursing services may be performed only by a registered nurse:

1. Making the initial evaluation visit;

2. Initiating the physician's plan of care and necessary revisions;

3. Providing those services that require care of a registered nurse as defined in ch. N 6;

4. Initiating appropriate preventive and rehabilitative procedures;

5. Accepting only those delegated medical acts which the RN is competent to perform based on his or her nursing education, training or experience; and

6. Regularly reevaluating the patient's needs.

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(b) Nursing services not requiring a registered nurse may be provided by a licensed practical nurse under the supervision of a registered nurse. Licensed practical nurse duties include:

1. Performing nursing care delegated by an RN under s. N 6.03;

2. Assisting the patient in learning appropriate self-care techniques; and

3. Meeting the nursing needs of the recipient according to the written plan of care.

(c) Both RNs and LPNs shall:

1. Arrange for or provide health care counseling within the scope of nursing practice to the recipient and recipient's family in meeting needs related to the recipient's condition;

2. Provide coordination of care for the recipient, including ensuring that provision is made for all required hours of care for the recipient;

3. Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience;

4. Prepare written clinical notes that document the care provided within 24 hours of providing service and incorporate them into the recipient's clinical record within 7 days; and

5. Promptly inform the physician and other personnel participating in the patient's care of changes in the patient's condition and needs.

(5) PATIENT RIGHTS. A nurse shall provide a written statement of the rights of the recipient for whom services are provided to the recipient or guardian or any interested party prior to the provision of services. The recipient or guardian shall acknowledge recipient of the statement in writing. The nurse shall promote and protect the exercise of these rights and keep written documentation of compliance with this subsection. Each recipient receiving care shall have the following rights:

(a) To be fully informed of all rules and regulations affecting the recipient;

(b) To be fully informed of all services to be provided by the nurse and of related charges, including any charges for services for which the recipient may be responsible;

(c) To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of services, including referral to a health care institution or other agency;

(d) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of that refusal;

(e) To confidential treatment of personal and medical records and to approve or refuse their release to any individual, except in the case of transfer to a health care facility;

(f) To be taught, and have the family or other persons living with the recipient taught, the treatment required, so that the recipient can, to the extent possible, help himself or herself, and the family or other party designated by the recipient can understand and help the recipient;

(g) To have one's property treated with respect; and

(h) To complain about care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

(6) UNIVERSAL PRECAUTIONS. A nurse shall have the necessary orientation, education and training in epidemiology, modes of transmission and prevention of HIV and other blood-borne or body fluid-borne infections and shall follow universal blood and body-fluid precautions for each recipient for whom services are provided. The nurse shall employ protective measures recommended by the federal centers for disease control (CDC), including those pertaining to medical equipment and supplies, to minimize the risk of infection from HIV and other blood-borne pathogens.

Note: A copy of the CDC recommended universal precautions may be obtained from the Division of Quality Assurance, P.O. Box 2969, Madison, Wisconsin 53701.

(7) MEDICAL RECORD. The nurse shall maintain a medical record for each recipient. The record shall document the nature and scope of all services provided and shall be systematically organized and readily accessible to authorized department personnel. The medical record shall document the recipient's condition, problems, progress and all services rendered, and shall include:

(a) Recipient identification information;

(b) Appropriate hospital information, including discharge information, diagnosis, current patient status and post-discharge plan of care;

(c) Recipient admission evaluation and assessment;

(d) All medical orders, including the written plan of care and all interim physician's orders;

(e) A consolidated list of medications, including start and stop dates, dosage, route of administration and frequency. This list shall be reviewed and updated for each nursing visit, if necessary;

(f) Progress notes posted as frequently as necessary to clearly and accurately document the recipient's status and services provided. In this paragraph, "progress note" means a written notation, dated and signed by a member of the health team providing covered services, that summarizes facts about care furnished and the recipient's response during a given period of time;

(g) Clinical notes written the day service is provided and incorporated into the clinical record within 7 days after the visit or recipient contact. In this paragraph, "clinical note" means a notation of a contact with a recipient that is written and dated by a member of the home health team providing covered services, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition;

(h) Written summaries of the recipient's care provided by the nurse to the physician at least every 62 days; and

(i) Written authorizations from the recipient or the recipient's guardian when it is necessary for the nurse to procure medical supplies or equipment needed by the recipient.

(7m) ELECTRONIC VISIT VERIFICATION. The nurse is required to capture and retain EVV records.

(8) BACK-UP AND EMERGENCY PROCEDURES. (a) A recipient's nurse shall designate an alternate nurse to provide services to the recipient in the event the nurse is temporarily unable to provide services. The recipient shall be informed of the identity of the alternate nurse before the alternate nurse provides services.

(b) The nurse shall document a plan for recipient-specific emergency procedures in the event a life-threatening situation or fire occurs or there are severe weather warnings. This plan shall be made available to the recipient and all caregivers prior to initiation of these procedures.

(c) The nurse shall take appropriate action and immediately notify the recipient's physician, guardian, if any, and any other responsible person designated in writing by the patient or guardian of any significant accident, injury or adverse change in the recipient's condition.

(9) DISCHARGE OF THE RECIPIENT. A recipient shall be discharged from services provided by the nurse upon the recipient's request, upon the decision of the recipient's physician, or if the nurse documents that continuing to provide services to the recip-

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ient presents a direct threat to the nurse's health or safety and further documents the refusal of the attending physician to authorize discharge of the recipient with full knowledge and understanding of the threat to the nurse. The nurse shall recommend discharge to the physician and recipient if the recipient does not require services or requires services beyond the nurse's capability. The nurse provider shall issue a notification of discharge to the recipient or guardian, if possible at least 2 calendar weeks prior to cessation of skilled nursing services, and shall, in all circumstances, provide assistance in arranging for the continuity of all medically necessary care prior to discharge.

(10) DEPARTMENT REVIEW. (a) *Record review.* The department may periodically review the records described in this section and s. DHS 106.02 (9), subject only to restrictions of law. All records shall be made immediately available upon the request of an authorized department representative.

(b) *In-home visits.* As part of the review under par. (a), the department may contact recipients who have received or are receiving MA services from a nurse provider. The nurse provider shall provide any identifying information requested by the department. The department may select the recipients for visits and may visit a recipient with the approval of the recipient or recipient's guardian. The recipient to be visited shall be given the opportunity to have any person present whom he or she chooses during the visit by personnel of the department or other governmental investigating agency.

(c) *Investigation complaints.* The department may investigate any complaint received by it concerning the provision of MA services by a nurse provider. Following the investigation, the department may issue a preliminary final report to the nurse provider in question, except when doing so would jeopardize any other investigation by the department or other state or federal agency.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; 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; corrections in (1) (a) (intro.), (b) and (10) (a) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 20-039: am. (1) (b) Register October 2021 No. 790, eff. 11-1-21; EmR2306: emerg. cr. (7m), eff. 5-1-23; CR 23-045: cr. (7m) Register January 2024 No. 817, eff. 2-1-24.

DHS 105.20 Nurse practitioners. (1) QUALIFICATIONS. For MA certification, a nurse practitioner shall be licensed as a registered nurse pursuant to s. 441.06, Stats., and fulfill one of the following requirements:

(a) If practicing as a pediatric nurse practitioner, be currently certified by the American nurses' association or by the national board of pediatric nurse practitioners and associates;

(b) If practicing as any family nurse practitioner, be currently certified by the American nurses' association; or

(c) If practicing as any other primary care nurse practitioner or as a clinical nurse specialist, be currently certified by the American nurses' association, the national certification board of pediatric nurse practitioners and associates, or the nurses' association of the American college of obstetricians and gynecologists' certification corporation, or have a master's degree in nursing from a school accredited by a program designed to prepare a registered nurse for advanced clinical nurse practice.

(2) PROTOCOLS. A written protocol covering a service or delegated medical act that may be provided and procedures that are to be followed for provision of services by nurse practitioners shall be developed and maintained by the nurse practitioner and the delegating licensed physician according to the requirements of s. N 6.03 (2) and the guidelines set forth by the board of nursing. This protocol shall include, but is not limited to, explicit agreements regarding those delegated medical acts which the nurse practitioner or clinical nurse specialist is delegated by the physician to provide. A protocol shall also include arrangements for communication of the physician's directions, consultation with the physician, assistance with medical emergencies, patient referrals and other provisions relating to medical procedures and treatment.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. Register, January, 1991, No. 421, eff. 2-1-91.

DHS 105.201 Nurse-midwives. For MA certification, a nurse midwife shall be certified as a registered nurse under s. DHS 105.19 (1) and shall be certified as a nurse midwife under ch. N 4.

History: Cr. Register, January, 1991, No. 421, eff. 2-1-91.

DHS 105.21 Hospital IMDS. (1) REQUIREMENTS. For MA certification, a hospital which is an institution for mental disease (IMD) shall:

(a) Meet the requirements of s. DHS 105.07, and;

1. Maintain clinical records on all patients, including records sufficient to permit determination of the degree and intensity of treatment furnished to MA recipients, as specified in 42 CFR 482.61; and

2. Maintain adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as specified in 42 CFR 482.62;

(b) Have a utilization review plan that meets the requirements of 42 CFR 405.1035, 405.1037 and 405.1038;

(c) If participating in the PRO review program, meet the requirements of that program and any other requirements established under the state contract with the PROs;

(d) If providing outpatient psychotherapy, comply with s. DHS 105.22;

(e) If providing outpatient alcohol and other drug abuse services, comply with s. DHS 105.23; and

(f) If providing day treatment services, comply with s. DHS 105.24.

(2) WAIVERS AND VARIANCES. The department shall consider applications for waivers or variances of the requirements in sub. (1) if the requirements and procedures stated in s. DHS 106.11 are followed.

Note: For covered mental health services, see s. DHS 107.13.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction in (1) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1990, No. 414; correction in (2) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.22 Psychotherapy providers. (1) TYPES OF PSYCHOTHERAPY PROVIDERS. For MA certification, a psychotherapy provider shall be one of the following:

(a) A physician meeting the requirements of s. DHS 105.05 (1) who has completed a residency in psychiatry. Proof of residency shall be provided to the department. Proof of residency shall either be board-certification from the American board of psychiatry and neurology or a letter from the hospital in which the residency was completed;

(b) A psychologist licensed under ch. 455, Stats.;

(bm) An advanced practice nurse prescriber who is certified under s. 441.16 (2), Stats., and holds current certification in a psychiatric specialty from the American Nurses Credentialing Center.

(bn) A marriage and family therapist licensed under ss. 457.10, 457.11, and 457.14, Stats., including holding a valid training or temporary license;

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(bo) A professional counselor licensed under ss. 457.12 to 457.14, Stats., including holding a valid training or temporary license;

(bp) An advanced practice social worker certified under s. 457.08 (2), Stats.;

(bq) An independent social worker certified under s. 457.08 (3), Stats.;

(br) A clinical social worker licensed under s. 457.08 (4), Stats.;

(c) An outpatient clinic certified under ch. DHS 35; or

(d) A hospital outpatient mental health clinic located on the hospital's physical premises.

(2) STAFFING OF OUTPATIENT FACILITIES. To provide psychotherapy reimbursable by MA, personnel employed by an outpatient clinic under sub. (1) (c) shall meet applicable requirements under ch. DHS 35. Persons employed by a hospital outpatient mental health clinic under sub. (1) (d) need not be individually certified as providers but may provide psychotherapy services upon the department's issuance of certification to the mental health clinic by which they are employed. A hospital outpatient mental health clinic shall maintain a list of the names of persons employed by the clinic who are performing psychotherapy services for which reimbursement may be claimed under MA. This listing shall document the credentials possessed by the named persons which would qualify them for certification under the standards specified in this subsection and shall include the dates that the named persons began employment.

(3) REIMBURSEMENT FOR OUTPATIENT PSYCHOTHERAPY SERVICES. Reimbursement shall be made to any certified psychotherapy provider whose practice, as described by individual licensure or clinic certification regulations, allows for the delivery of psychotherapy without clinical supervision. For outpatient psychotherapy services delivered by certified providers who are required, under individual licensure or clinic certification regulations, to practice under a clinical supervisor, reimbursement shall be made to the supervising provider. The supervising provider must be MA certified.

Note: For covered mental health services, see s. DHS 107.13.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. Register, September, 1991, No. 429, eff. 10-1-91; corrections in (1) (c), (d) and (2) (b) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 06-080: cr. (1) (bm), am. (1) (c), (2) (a) and (3), r. and recr. (1) (d), r. (2) (b) Register May 2009 No. 641, eff. 6-1-09; correction in (2) made under s. 13.92 (4) (b) 1., Stats., Register May 2009 No. 641; CR 20-039: am. (1) (b), cr. (1) (bn) to (br), am. (3) Register October 2021 No. 790, eff. 11-1-21.

DHS 105.23 Alcohol and other drug abuse (AODA) treatment providers. (1) TYPES OF PROVIDERS. For MA certification, an outpatient alcohol and other drug abuse (AODA) treatment provider shall be:

(a) An outpatient facility operated by a board and certified under ss. DHS 75.49, 75.50, and 75.51;

(b) An outpatient facility or hospital outpatient AODA facility certified under ss. DHS 75.49, 75.50, and 75.51; or

(c) A provider certified under s. DHS 105.05 (1), 105.22 (1) (b), 105.22 (1) (bn), 105.22 (1) (bo), or 105.22 (1) (br). Providers that hold a training or temporary license under s. DHS 105.22 (1) (bn) or (bo) are excluded.

(2) STAFFING REQUIREMENTS. (a) To provide AODA services reimbursable under MA, personnel employed by an outpatient facility under sub. (1) (a) or (b) shall:

1. Meet the requirements in s. DHS 105.22 (1) (b) or 105.05 (1); or

2. Be an AODA counselor certified by the Wisconsin alcoholism and drug abuse counselor certification board and work under the supervision of a provider who is a licensed physician or licensed psychologist and employed by the same facility.

Note: Certification standards of the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board may be obtained by writing the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board, Inc., 416 East Main Street, Waukesha, WI 53186.

(b) The facility shall provide the department with a list of persons employed by the facility who perform AODA services for which reimbursement may be claimed under MA. The listing shall identify the credentials possessed by the named persons which would qualify them for certification under the standards specified in par. (a). A facility, once certified, shall promptly advise the department in writing of the employment or termination of employees who will be or have been providing AODA services under MA.

(3) REIMBURSEMENT FOR AODA SERVICES. Reimbursement for outpatient AODA treatment services shall be as follows:

(a) For the services of any provider employed by or under contract to a certified AODA facility, reimbursement shall be made to the facility; and

(b) For the services of any provider who is a physician or licensed psychologist defined under sub. (1) (c) in private practice, reimbursement shall be to the physician or psychologist.

Note: For covered alcohol and other drug abuse treatment services, see s. DHS 107.13 (3).

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1) (b) and(c) and (2) (a) 1., Register, September, 1991, No. 429, eff. 10-1-91; corrections in (1) (a) and (b) made under s. 13.93 (2m) (b) 7., Stats., Register February 2002 No. 554; corrections in (1) (a) and (b) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 20-039: am. (1) (c) Register October 2021 No. 790, eff. 11-1-21; correction in (1) (c) made under s. 35.17, Stats., Register October 2021 No. 790; correction in (1) (a), (b) made under s. 13.92 (4) (b) 7., Stats., Register September 2022 No. 801.

DHS 105.24 Mental health day treatment or day hospital service providers. (1) REQUIREMENTS. For MA certification, a day treatment or day hospital service provider shall:

(a) Be a medical program certified under s. DHS 61.75; and

(b) Meet the following personnel and staffing requirements:

1. A registered nurse and a registered occupational therapist shall be available to participate in program planning, program implementation and daily program coordination;

2. The day treatment program shall be planned for and directed by designated members of an interdisciplinary team that includes a social worker, a psychologist, an occupational therapist and a registered nurse or a physician, physician's assistant or another appropriate health care professional;

3. A written patient evaluation involving an assessment of the patient's progress by each member of the multidisciplinary team shall be made at least every 60 days; and

4. For the purposes of daily program performance, coordination guidance and evaluation:

a. One qualified professional staff member such as an OTR, masters degree social worker, registered nurse, licensed psychologist or masters degree psychologist for each group, or one certified occupational therapy assistant and one other paraprofessional staff person for each group; and

b. Other appropriate staff, including volunteer staff.

(2) BILLING AND REIMBURSEMENT. (a) Reimbursement for medical day treatment or day hospital services shall be at a rate established and approved by the department.

(b) Reimbursement payable under par. (a) shall be subject to reductions for third party recoupments.

Note: For covered day treatment and day hospital services, see s. DHS 107.13 (4).

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. (1) (a), am. (2) (b), r. (2) (c), Register, September, 1991, No. 429, eff. 10-1-91; correction in

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(1) (a) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 22-043: am. (1) (b) 1. Register May 2023 No. 809, eff. 6-1-23.

DHS 105.25 Alcohol and other drug abuse (AODA) day treatment providers. (1) TYPES OF PROVIDERS. For MA certification, an alcohol and other drug abuse (AODA) day treatment provider shall be certified under ss. DHS 75.52 and 105.23.

(2) STAFFING REQUIREMENTS. (a) An alcohol and drug counselor certified as provided in ss. DHS 75.02 (84) and 75.03 (4) (d) shall be available during all hours in which services are provided to participate in treatment planning and implementation and daily program coordination.

(b) A treatment plan for each participating recipient shall be developed, directed and monitored by designated members of an interdisciplinary treatment team which includes an alcohol and drug counselor II or III, certified as provided in ss. DHS 75.03 (85) and 75.18 (2) (c) and (6) (b), a physician or licensed psychologist, and other health care professionals. The treatment team shall maintain a written record of each recipient's treatment and progress toward meeting the goals described in the recipient's plan of care.

(c) All treatment shall be coordinated and provided by at least one qualified professional staff member who has demonstrated experience in delivering direct treatment to persons with alcohol and other drug abuse problems. Other staff members, such as an AODA counselor I who has filed for certification with the Wisconsin alcoholism and drug counselor certification board, inc., may assist in treatment under the supervision of a qualified professional staff member.

History: Emerg. cr. eff. 3-9-89; cr. Register, December, 1989, No. 408, eff. 1-1-90; corrections in (1), (2) (a) and (b) made under s. 13.93 (2m) (b) 7., Stats., Register February 2002 No. 554; corrections made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; correction in (1), (2) (a), (b) made under s. 13.92 (4) (b) 7., Stats., Register September 2022 No. 801; CR 22-043: am. (2) (a) Register May 2023 No. 809, eff. 6-1-23.

DHS 105.255 Community support programs. (1) GENERAL REQUIREMENTS. For MA certification, a community support program (CSP) service provider shall meet the requirements under ss. DHS 63.06 to 63.17 and this section. The department may waive a requirement in ss. DHS 63.06 to 63.17 under the conditions specified in s. DHS 63.05 if requested by a provider. Certified providers under this section may provide services directly or may contract with other qualified providers to provide all or some of the services described in s. DHS 107.13 (6).

(2) MENTAL HEALTH TECHNICIAN. (a) In this subsection, "mental health technician" means a paraprofessional employee of the CSP who is limited to performing the services set out in s. DHS 63.11 (3) (c) and (4).

(b) Except as provided in par. (c), a mental health technician shall have at least 1,000 hours of supervised work experience with long-term mentally ill persons and meet at least one of the following conditions:

1. Has satisfactorily completed the educational curriculum developed by the department;

2. Is certified by the American occupational therapy association as an occupational therapy assistant;

3. Is a practical nurse (LPN) licensed under s. 441.10, Stats.;

4. Has satisfied the training requirements under s. DHS 133.17 (4) for a home health aide;

5. Is included in the registry of persons under ch. DHS 129 who have completed a nurse's assistant training and testing program or only a testing program; or

6. Has satisfied the requirements under s. DHS 105.17 (3) (a) 1. to provide personal care services and has completed an additional 1000 hours of supervised work experience with long-term mentally ill persons.

(c) A mental health technician providing CSP services who does not meet the requirements of par. (b) shall meet the requirements of s. DHS 63.06 (4) (a) 9. and shall in addition meet the requirements of par. (b) within one year following the effective date of the provider's MA certification or the technician's date of employment by the CSP, whichever is later.

(3) DOCUMENTATION OF EMPLOYEE QUALIFICATIONS. Providers shall maintain current written documentation of employee qualifications required under s. DHS 63.06 (4) and this section.

History: Cr. Register, September, 1990, No. 417, eff. 10-1-90; corrections in (1), (2) (c) and (3) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1999, No. 520; correction in (2) (b) 5. made under s. 13.93 (2m) (b) 7., Stats., October, 2000, No. 538; corrections made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.257 Community-based psychosocial service programs. For MA certification as a community-based psychosocial service program under s. 49.45 (30e), Stats., a provider shall be certified as a comprehensive community services program under ch. DHS 36. The department may waive a requirement in ss. DHS 36.04 to 36.12 under the conditions specified in s. DHS 36.065 if requested by a provider. Certified providers under this section may provide services directly or may contract with other qualified providers to provide all or some of the services described in s. DHS 107.13 (7).

History: Emerg. cr. eff. 7-1-04; CR 04-025: cr. Register October 2004 No. 586, eff. 11-1-04; corrections made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.259 Peer recovery support services. For MA certification under s. 49.45 (30j), Stats., a provider agency shall be certified to operate as one of the following:

(1) A substance use overdose treatment program under subch. III of ch. DHS 72.

(2) A service under ch. DHS 34, 35, 36, 63, 75, or 124, that also provides peer services that meet all requirements described in subch. II of ch. DHS 72, in conjunction with treatment services.

History: CR 24-081: cr. Register September 2025 No. 837, eff. 10-1-25.

DHS 105.26 Chiropractors. For MA certification, chiropractors shall be licensed pursuant to s. 446.02, Stats.

Note: For covered chiropractic services, see s. DHS 107.15.

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

DHS 105.265 Podiatrists. For MA certification, podiatrists shall be licensed under s. 448.63, Stats., and ch. Pod 1 and registered under s. 448.07, Stats., and ch. Pod 4.

History: Cr. Register, January, 1991, No. 421, eff. 2-1-91; corrections made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

DHS 105.27 Physical therapists and assistants. (1) PHYSICAL THERAPISTS. For MA certification, physical therapists shall be licensed pursuant to ss. 448.05 and 448.07, Stats., and ch. PT 1.

(2) PHYSICAL THERAPIST ASSISTANTS. For MA certification, physical therapist assistants shall have graduated from a 2-year college-level program approved by the American physical therapy association, and shall provide their services under the supervision of a physical therapist certified pursuant to sub. (1) and. ss. 448.53, 448.56, and 448.985, Stats. Documentation of supervision shall be maintained and provided to the department upon request. Physical therapist assistants may not bill or be reimbursed

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directly for their services. When performing services, physical therapist assistants are to be submitted as renderer on billing claims.

Note: For covered physical therapy services, see s. DHS 107.16.

Note: The declaration of supervision for non-billing providers' form is available by accessing: https://www.dhs.wisconsin.gov/library/f-01182.htm.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register February 2002 No. 554; CR 22-043: am. (2) Register May 2023 No. 809, eff. 6-1-23.

DHS 105.28 Occupational therapists and assistants. (1) OCCUPATIONAL THERAPISTS. For MA certification, an occupational therapist shall:

(a) Be certified by the American occupational therapy association as an occupational therapist, registered; or

(b) Have graduated from a program in occupational therapy accredited by the council on medical education of the American medical association and the American occupational therapy association, have completed the required field work experience, and have made application to the American occupational therapy association for the certification examination for occupational therapist, registered. Certification under this paragraph shall be valid until 8 weeks after the examination is taken. On passing the examination, the therapist shall obtain certification by the American occupational therapy association in the calendar year in which the examination is taken. An individual certified under this paragraph for medical assistance who fails the examination may be recertified for medical assistance only under the conditions of par. (a).

(2) OCCUPATIONAL THERAPY ASSISTANTS. For MA certification, occupational therapy assistants shall be certified by the American occupational therapy association. Occupational therapy assistants may not bill or be reimbursed directly for their services. When performing services, occupational therapy assistants are to be submitted as renderer on billing claims. Occupational therapy assistants shall provide services under the supervision of an occupational therapist certified under sub. (1) and ss. 448.961, 448.963, and 448.966, Stats. Documentation of supervision shall be maintained and provided to the department upon request.

Note: For covered occupational therapy services, see s. DHS 107.17.

Note: The declaration of supervision for non-billing providers' form is available by accessing: https://www.dhs.wisconsin.gov/library/f-01182.htm.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; CR 22-043: renum. (2) (intro.) to (2) and am., r. (2) (a) to (c) Register May 2023 No. 809, eff. 6-1-23.

DHS 105.29 Speech and hearing clinics. For MA certification, speech and hearing clinics shall be currently accredited by the American speech and hearing association (ASHA) pursuant to the guidelines for "accreditation of professional services programs in speech pathology and audiology" published by ASHA.

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

DHS 105.30 Speech pathologists. For MA certification, speech pathologists shall:

(1) Possess a current certification of clinical competence from the American speech and hearing association;

(2) Have completed the educational requirements and work experience necessary for such a certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate of clinical competence under sub. (1).

Note: For covered speech pathology services, see. s. DHS 107.18.

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

DHS 105.31 Audiologists. For MA certification, audiologists shall:

(1) Possess a certificate of clinical competence from the American speech and hearing association (ASHA);

(2) Have completed the educational requirements and work experience necessary for the certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate under sub. (1).

Note: For covered audiology services, see s. DHS 107.19.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1) and (3), Register, May, 1990, No. 413, eff. 6-1-90.

DHS 105.32 Optometrists. For MA certification, optometrists shall be licensed and registered pursuant to ss. 449.04 and 449.06, Stats.

Note: For covered vision care services, see s. DHS 107.20.

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

DHS 105.33 Opticians. For MA certification, opticians shall practice as described in s. 449.01 (2), Stats.

Note: For covered vision care services, see s. DHS 107.20.

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

DHS 105.34 Rehabilitation agencies. For MA certification on or after January 1, 1988, a rehabilitation agency providing outpatient physical therapy, or speech and language pathology form, or occupational therapy shall be certified to participate in medicare as an outpatient rehabilitation facility under 42 CFR 485.50 to 485.74.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. Register, February, 1988, No. 386, eff. 3-1-88; CR 23-046: am. Register April 2024 No. 820, eff. 5-1-24.

DHS 105.35 Rural health clinics. For MA certification, a rural health clinic shall be:

(1) Certified to participate in medicare;

(2) Licensed as required under all other local and state laws; and

(3) Staffed with persons who are licensed, certified form or registered in accordance with appropriate state laws.

Note: For covered rural health clinic services, see s. DHS 107.29.

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

DHS 105.36 Family planning clinics or agencies. For MA certification, family planning clinics or agencies shall meet the following conditions:

(1) GENERAL. In order to qualify for MA reimbursement, family planning clinics shall certify to the department that:

(a) An MA card has been shown before services are provided;

(b) Services are prescribed by a physician or are provided by a nurse midwife as provided under s. 441.15, Stats.; and

(c) No sterilization procedures are available to persons who are mentally incompetent, institutionalized or under the age of 21.

(2) PRINCIPLES OF OPERATION. (a) Family planning services shall be made available in all of the following conditions:

1. Upon referral from any source or upon the patient's own application.

2. Without regard to race, nationality, religion, family size, marital status, maternity, paternity, disability or age, in conformity with the spirit and intent of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, as amended.

3. With respect for the dignity of the individual.

4. With efficient administrative procedures for registration and delivery of services, avoiding prolonged waiting and multiple

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visits for registration. Patients shall be seen on an appointment basis whenever possible.

(b) Acceptance of family planning service shall be voluntary, and individuals shall not be subjected to coercion either to receive services or to employ or not to employ any particular method of family planning. Acceptance or nonacceptance of family planning services shall not be a prerequisite to eligibility for or receipt of any other service funded by local, state, or federal tax revenue.

(c) A variety of medically approved methods of family planning, including the natural family planning method, shall be available to persons to whom family planning services are offered and provided.

(d) The clinic shall not provide abortion as a method of family planning.

(e) Efforts shall be made to obtain third party payments when available for services provided.

(f) All personal information obtained shall be treated as privileged communication, shall be held confidential, and shall be divulged only upon the recipient's written consent except when necessary to provide services to the individual or to seek reimbursement for the services. The agency director shall ensure that all participating agencies preserve the confidentiality of patient records. Information may be disclosed in summary, statistical or other form which does not identify specific recipients.

(3) ADMINISTRATION. (a) The family planning clinic shall have a governing body which is responsible for the conduct of the staff and the operation of the clinic.

(b) A designated person shall be responsible for the day-to-day operation of the clinic.

(c) Written policies and procedures shall be developed which govern the utilization of staff, services to patients and the general operation of the clinic.

(d) Job descriptions for volunteer and paid staff shall be prepared to assist staff members in the performance of their duties.

(e) Each clinic shall have a record system that includes the following components:

1. Patient records:

a. With pertinent medical and social history;

b. With all patient contacts and outcomes;

c. With accumulated data on supplies, staffing, appointments and other administrative functions;

d. For purposes of following up on patients for medical services or referrals to other community resources; and

e. For purposes of program evaluation;

2. Fiscal records accounting for cash flow; and

3. Organizational records to document staff time, governing body meetings, administrative decisions and fund raising.

(f) Each clinic shall engage in a continuing effort of evaluating, reporting, planning and implementing changes in program operation.

(g) Each clinic shall develop a system of appointments and referrals which is flexible enough to meet community needs.

(h) Each clinic shall make provision for a medical back-up for patients who experience family planning related problems at a time when the clinic staff is unavailable.

(4) STAFFING. (a) Clinic staff, either paid or volunteer, shall perform the following functions:

1. Outreach workers or community health personnel shall have primary responsibility to contact individuals in need of family planning services, initiate family planning counseling, and assist in receiving, successfully using and continuing medical services;

2. The secretary or receptionist shall greet patients at the clinic, arrange for services and perform a variety of necessary clerical duties;

3. The interviewer or counselor shall take social histories, provide family planning information to patients and counsel patients regarding their family planning and related problems;

4. The nurse or clinic aide shall assist the physician in providing medical services to the patient;

5. The physician shall be responsible for providing or exercising supervision over all medical and related services provided to patients; and

6. The clinic coordinator shall oversee the operation of the clinic.

(b) 1. Training programs shall be developed for new staff, and time shall be made available periodically for their training.

2. For existing staff, time shall be made available for staff conferences and for inservice training in new techniques and procedures.

3. For volunteers, time shall be made available for staff to coordinate, train, and supervise them to be an effective, integral part of the clinic.

(c) Paraprofessional personnel may be hired and trained.

(5) PATIENT AND COMMUNITY OUTREACH. Each clinic shall have an active outreach effort aimed at:

(a) Recruiting and retaining patients in the family planning clinic, through:

1. A system of identifying the primary target populations;

2. A method of contacting the target population;

3. Procedures for family planning counseling and motivating appropriate persons to avail themselves of family planning medical services;

4. Assisting individuals in receiving family planning medical services;

5. Activities designed to follow-up potential and actual family planning patients as indicated; and

6. A record system sufficient to support the functions in subds. 1. to 5.;

(b) Meeting all human needs through appropriate and effective referral to other community resources; and

(c) Increasing community awareness and acceptance of the family planning clinic through:

1. The use of mass media;

2. Presentations to community organizations and agencies;

3. Public information campaigns utilizing all channels of communication;

4. Development of formal referral arrangements with community resources; and

5. Involvement of appropriate community residents in the operation of the family planning clinic.

(6) PATIENT EDUCATION AND COUNSELING. At the time the patient is to receive family planning medical services, the following components of social services shall be provided:

(a) An intake interview designed to obtain pertinent information regarding the patient, to explain the conditions under which services are provided and to create the opportunity for a discussion of the patient's problems;

(b) A group or individual information session which includes:

1. Reproductive anatomy and physiology;

2. Methods of contraception, including how they work, side effects and effectiveness;

3. An explanation of applicable medical procedures;

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4. An opportunity for patients to ask questions and discuss their concerns; and

5. An optional discussion of such topics as breast and cervical cancer, venereal disease, human sexuality or vaginopathies; and

(c) An exit interview which is designed to:

1. Clarify any areas of concern or questions regarding medical services;

2. Elicit from the patient evidence of a complete understanding of the use of family planning methods;

3. Effectively inform the patient what procedures are to be followed if problems are experienced;

4. Inform the patient about the clinic's follow-up procedures and possible referral to other community resources; and

5. Arrange for the next visit to the clinic.

(7) MEDICAL SERVICES. (a) All medical and related services shall be provided by or under the supervision and responsibility of a physician.

(b) The following medical services shall be made available:

1. Complete medical and obstetrical history;

2. Physical examination;

3. Laboratory evaluation;

4. Prescription of the family planning method selected by the patient unless medically contraindicated;

5. Instructions on the use of the chosen method, provision of supplies and schedule for revisits; and

6. Referral to inpatient service when necessary to treat complications of contraceptive services provided by the clinic.

(c) Equipment and supplies in the clinic shall be commensurate with the services offered. Sufficient first aid equipment shall be available for use when needed.

(d) Treatment for minor vaginal infections and venereal disease may be made available either by the clinic or through referral.

(8) FACILITIES. The family planning clinic shall be designed to provide comfort and dignity for the patients and to facilitate the work of the staff. A clinic facility shall be adequate for the quantity of services provided, and shall include:

(a) A comfortable waiting room with an area for patient reception, record processing and children's play;

(b) Private interviewing and counseling areas;

(c) A group conference room for staff meetings and patient education;

(d) A work room or laboratory area with sufficient equipment and nearby storage space, none of which is accessible to the patient;

(e) A sufficient number of private and well-equipped examining rooms with proximal dressing areas which ensure the dignity of the patient;

(f) Adequate toilet facilities, preferably near the dressing room; and

(g) Arrangements for routine and restorative facility maintenance.

Note: For covered family planning services, see s. DHS 107.21.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. (2) (e), (7) (b) 6., renum. (2) (f) and (g) to be (2) (e) and (f), (7) (b) 7. to be (7) (b) 6., Register, January, 1997, No. 493, eff. 2-1-97; correction in (1) (b) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528; CR 20-068: am. (2) (a) (intro.), 1. to 3. Register December 2021 No. 792, eff. 1-1-22.

DHS 105.37 Early and periodic screening, diagnosis and treatment (EPSDT) providers. (1) EPSDT HEALTH ASSESSMENT AND EVALUATION SERVICES. (a) *Eligible providers.* The following providers are eligible for certification as providers of EPSDT health assessment and evaluation services:

1. Physicians;

2. Outpatient hospital facilities;

3. Health maintenance organizations;

4. Visiting nurse associations;

5. Clinics operated under a physician's supervision;

6. Local public health agencies;

7. Home health agencies;

8. Rural health clinics;

9. Indian health agencies; and

10. Neighborhood health centers.

(b) *Procedures and personnel requirements.* 1. EPSDT providers shall provide periodic comprehensive child health assessments and evaluations of the general health, growth, development and nutritional status of infants, children and youth. Immunizations shall be administered at the time of the screening if determined medically necessary and appropriate. The results of a health assessment and evaluation shall be explained to the recipient's parent or guardian and to the recipient if appropriate.

2. EPSDT health assessment and evaluation services shall be delivered under the supervision of skilled medical personnel. In this section "skilled medical personnel" means physicians, physician assistants, nurse practitioners, public health nurses or registered nurses. Skilled medical personnel who perform physical assessment screening procedures shall have successfully completed either a formal pediatric assessment or an inservice training course on physical assessments approved by the department. Individual procedures may be completed by paraprofessional staff who are supervised by skilled medical personnel. Registered nurses who perform EPSDT physical assessments shall have satisfactorily completed a curriculum for pediatric physical assessments approved by the department.

3. All conditions uncovered which warrant further care shall be diagnosed or treated or both by the provider, if appropriate, or referred to other appropriate providers. A referral may either be a direct referral to the appropriate health care provider or a referral recommendation submitted through the agency responsible for the patient's case management and advocacy.

4. Health maintenance organizations and prepaid health plans providing EPSDT services shall meet all requirements of 42 CFR 441.60 in addition to the requirements under subds. 1. to 3.

(c) *Records and documentation.* 1. Certified providers of EPSDT screening services shall:

a. Complete the department's EPSDT claim form and an individual health and developmental history for each client; and

b. Maintain a file on each client receiving EPSDT services which includes a copy of the EPSDT claim form, individual health and developmental history and follow-up for necessary diagnosis and treatment services.

2. The EPSDT provider shall release information on the results of the health assessment to appropriate health care providers and health authorities when authorized by the patient or the patient's parent or guardian to do so.

(2) EPSDT CASE MANAGEMENT ACTIVITIES. (a) *Case management reimbursement.* Providers certified under sub. (1) as providers of EPSDT health assessment and evaluation services shall be eligible to receive reimbursement for EPSDT case management in accordance with the limitations contained in the case

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management agreement between the provider and the department.

(b) *Case management plan.* 1. All EPSDT providers who apply to receive reimbursement for EPSDT case management services shall submit to the department a case management plan. The case management plan shall describe the geographic service area, target population, coordination with support activities conducted by the department and other health-related services, case management activities and the method of documenting the activities.

2. The department shall evaluate the adequacy of each provider's case management plan according to the case management requirements of the proposed service area and target population, the extent to which the plan would ensure that children receive the necessary diagnosis and treatment services for conditions detected during EPSDT health examinations, the proposed coordination with the EPSDT central notification system and other health related services, and proposed methods for documenting case management services. Based on the evaluation, the department shall either approve or deny the provider's request for reimbursement of case management activities and shall impose on providers as conditions for reimbursement any personnel, staffing or procedural requirements that it determines are necessary pursuant to 42 CFR 441 Part B.

(c) *Records and documentations.* Providers shall maintain records and documentation required by the department in order to verify appropriate use of funds provided by the department for EPSDT case management activities.

(3) DIAGNOSIS AND TREATMENT SERVICES. Providers of diagnosis and treatment services for EPSDT recipients shall be certified according to the appropriate provisions of this chapter.

Note: For covered EPSDT services, see s. DHS 107.22.

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

DHS 105.38 Ambulance providers. (1) For MA certification, ambulance service providers shall be licensed pursuant to s. 256.15, Stats., and ch. DHS 110, and shall meet ambulance inspection standards of the Wisconsin department of transportation under s. 341.085, Stats., and ch. Trans 309.

(2) An ambulance service provider that also provides air ambulance services shall submit a separate application under s. DHS 105.01 for certification as an air ambulance provider.

Note: For a copy of the application form for an ambulance service provider license, write the EMS Section, Division of Public Health, P.O. Box 2659, Madison, Wisconsin, 53701.

Note: For covered transportation services, see s. DHS 107.23.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; renum. 105.38 to 105.38 (1) and am., cr. (2), Register, November, 1994, No. 467, eff. 12-1-94; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1999, No. 520; correction in (1) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.39 Specialized medical vehicle providers. (1) For MA certification, a specialized medical vehicle provider shall meet the requirements of this section and shall sign the affidavit required under sub. (6) stipulating that the provider is in compliance with the requirements of this section as well as with the requirements of the department of transportation for human service vehicles under ss. 110.05 and 340.01 (23g), Stats., and ch. Trans 301, and shall provide proof of compliance when requested by the department.

(2) VEHICLES. (a) Insurance of not less than $250,000 personal liability for each person, not less than $500,000 personal liability for each occurrence and not less than $10,000 property damage shall be carried on each specialized medical vehicle used to transport a recipient.

(b) Each vehicle shall be inspected and the inspection documented at least every 7 days by an assigned driver or mechanic, to ensure:

1. The proper functioning of the vehicle systems including but not limited to all headlights, emergency flasher lights, turn signal lights, tail lights, brake lights, clearance lights, internal lights, windshield wipers, brakes, front suspension and steering mechanisms, shock absorbers, heater and defroster systems, structural integrity of passenger compartment, air conditioning system, wheelchair locking systems, doors, lifts and ramps, moveable windows and passenger and driver restraint systems;

2. That all brakes, front suspension and steering mechanisms and shock absorbers are functioning correctly;

3. That all tires are properly inflated according to vehicle or tire manufacturers' recommendations and that all tires possess a minimum of 1/8-inch of tread at the point of greatest wear; and

4. That windshields and mirrors are free from cracks or breaks.

(c) The driver inspecting the vehicle shall document all vehicle inspections in writing, noting any deficiencies.

(d) All deficiencies shall be corrected before any recipient is transported in the vehicle. Corrections shall be documented by the driver. Documentation shall be retained for not less than 12 months, except as authorized in writing by the department.

(e) Windows, windshield and mirrors shall be maintained in a clean condition with no obstruction to vision.

(f) Smoking is not permitted in the vehicle.

(g) Police, sheriff's department and ambulance emergency telephone numbers shall be posted on the dash of the vehicle in an easily readable manner. If the vehicle is not equipped with a working two-way radio, sufficient money in suitable denominations shall be carried to enable not less than 3 local telephone calls to be made from a pay telephone.

(h) A provider shall maintain a list showing for each vehicle its registration number, identification number, license number, manufacturer, model, year, passenger capacity, insurance policy number, insurer, types of restraint systems for wheelchairs and whether it is fitted with a wheelchair lift or with a ramp. Attached to the list shall be evidence of compliance with ch. Trans 301.

(3) VEHICLE EQUIPMENT. (a) The vehicle shall be equipped at all times with a flashlight in working condition, a first aid kit and a fire extinguisher. The fire extinguisher shall be periodically serviced as recommended by the local fire department.

(b) The vehicle shall be equipped with a lift or ramp for loading wheelchairs. The vehicle shall also be equipped with passenger restraint devices for each passenger, including restraint devices for recipients in wheelchairs or on cots or stretchers as defined in s. DHS 107.23 (1) (c) 4. Both a recipient and the recipient's wheelchair, cot or stretcher shall be secured.

(c) Provision shall be made for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and the driver in the event of an accident.

(4) DRIVERS. (a) Each driver shall possess a valid regular or commercial operator's license which shall be unrestricted, except that the vision restrictions may be waived if the driver's vision is corrected to an acuity of 20/30 or better by the use of corrective lenses. In this event, the driver shall wear corrective lenses while transporting recipients.

(b) 1. Each driver before driving a vehicle or serving as an attendant shall have received all of the following:

a. Basic Red Cross or equivalent training in first aid and cardiopulmonary resuscitation (CPR);

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b. Specific instructions on care of passengers in seizure; and

c. Specific instructions in the use of all ramps, lift equipment and restraint devices used by the provider.

2. Each driver shall receive refresher training in first aid at least every 3 years and shall maintain CPR certification. A driver who is an emergency medical services practitioner licensed under ch. DHS 110, a licensed practical nurse, a registered nurse or a physician assistant shall be considered to have met these requirements by completion of continuing education which includes first aid and CPR.

(c) The provider shall maintain a current list of all drivers showing the name, license number and any driving violations or license restrictions of each and shall keep that list current.

(5) COMPANY POLICY. Company policies and procedures shall include:

(a) Compliance with state and local laws governing the conduct of businesses, including ch. Trans 301.

(b) Establishment and implementation of scheduling policies that assure timely pick-up and delivery of passengers going to and returning from medical appointments;

(c) Documentation that transportation services for which MA reimbursement is sought are:

1. For medical purposes only;

2. Ordered by the attending provider of medical service; and

3. Provided only to persons who require this transportation because they lack other means of transport, and who are also physically or mentally incapable of using public transportation;

(d) Maintenance of records of services for 5 years, unless otherwise authorized in writing by the department; and

(e) On request of the department, making available for inspection records that document both medical service providers' orders for services and the actual provision of services.

(6) AFFIDAVIT. The provider shall submit to the department a notarized affidavit attesting that the provider meets the requirements listed in this section. The affidavit shall be on a form developed by and available from the department, and shall contain the following:

(a) A statement of the requirements listed in this section;

(b) The date the form is completed by the provider;

(c) The provider's business name, address, telephone number and type of ownership;

(d) The name and signature of the provider or a person authorized to act on behalf of the provider; and

(e) A notarization.

Note: For covered transportation services, see s. DHS 107.23.

(7) DENIAL OF RECERTIFICATION. If a provider violates provisions of this chapter, s. DHS 106.06, 107.23 or any other instruction in MA program manuals, handbooks, bulletins or letters on provision of SMV services 3 times in a 36-month period, the department may deny that provider's request for re-certification.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. (1), (2) (a), (b) (intro.), 1., (3) (a), (b), (4) (a), (5) (a), renum. (2) (b) 2. and 3. to be 3. and 4., cr. (2) (b) 2., (h), (7), r. and recr. (4) (b), (c), Register, November, 1994, No. 467, eff. 12-1-94; reprinted to restore dropped copy in (3), Register, January, 1997, No. 493; emerg. am. (4) (b) 3., eff. 7-3-99; am. (4) (b) 3., Register, December, 1999, No. 528, eff. 1-1-00; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register February 2002 No. 554; CR 03-033: r. (4) (b) 2., renum. (4) (b) 3. to be (4) (b) 2. Register December 2003 No. 576, eff. 1-1-04; corrections in (3) (b), (4) (b) 2. and (7) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; correction in (4) (b) 2. made under s. 13.92 (4) (b) 7., Stats., Register July 2011 No. 667; CR 20-039: am. (4) (b) 2. Register October 2021 No. 790, eff. 11-1-21.

DHS 105.40 Durable medical equipment and medical supply vendors. (1) Except as provided in sub. (2), vendors of durable medical equipment and medical supplies shall be eligible to participate in the MA program.

(2) Orthotists and prosthetists who develop and fit appliances for recipients shall be certified by the American board for certification in orthotics and prosthetics (A.B.C.). Certification shall be a result of successful participation in an A.B.C. examination in prosthetics, orthotics, or both, and shall be for:

(a) Certified prosthetist (C.P.);

(b) Certified orthotist (C.O.); or

(c) Certified prosthetist and orthotist (C.P.O.)

Note: For covered durable medical equipment and medical supply services, see s. DHS 107.24.

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

DHS 105.41 Certification of hearing instrument specialists. For MA certification, hearing instrument specialists shall be licensed pursuant to ss. 459.01 to 459.14, Stats.

Note: For covered hearing aids and supplies, see s. DHS 107.24.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; CR 03-033: am. Register December 2003 No. 576, eff. 1-1-04.

DHS 105.42 Physician office laboratories. (1) REQUIREMENTS. For MA certification, physician office laboratories, except as noted in sub. (2), shall be licensed pursuant to 42 CFR 493 (CLIA).

(2) EXCEPTION. Physician office laboratories servicing no more than 2 physicians, chiropractors or dentists, and not accepting specimens on referral from outside providers, are not required to be licensed under 42 CFR 493 (CLIA). These laboratories, however, shall submit an affidavit to the department declaring that they do not accept outside specimens.

(3) MEDICARE CERTIFICATION REQUIREMENT. Physician office laboratories which accept referrals of 100 or more specimens a year in a specialty shall be certified to participate in medicare in addition to meeting the requirements under sub. (1).

Note: For covered diagnostic testing services, see s. DHS 107.25.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction in (1) and (2) made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

DHS 105.43 Hospital and independent clinical laboratories. For MA certification, a clinical laboratory that is a hospital laboratory or an independent laboratory shall be licensed pursuant to 42 CFR 493 (CLIA). In addition, the laboratory shall be certified to participate in medicare and meet the requirements of 42 CFR 405.1310 to 405.1317.

Note: For covered diagnostic testing services, see s. DHS 107.25.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

DHS 105.44 Portable x-ray providers. For MA certification, a portable x-ray provider shall be directed by a physician or group of physicians, registered pursuant to s. 254.35, Stats., and ch. DHS 157, certified to participate in medicare, and shall meet the requirements of 42 CFR 405.1411 to 405.1416.

Note: For covered diagnostic testing services, see s. DHS 107.25.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528; correction made under s. 13.93 (2m) (b) 7., Stats., Register December 2003 No. 576; correction made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.45 Dialysis facilities. For MA certification, dialysis facilities shall meet the requirements enumerated in ss. DHS 152.05 and 152.08, and shall be certified to participate in medicare.

Note: For covered dialysis services, see s. DHS 107.26.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, November, 1994, No. 467; correction made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

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DHS 105.46 Blood banks. For MA certification, blood banks shall be licensed or registered with the U.S. food and drug administration and shall be approved pursuant to 42 CFR 493 (CLIA).

Note: For covered blood services, see s. DHS 107.27.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.93 (2m) (b) 7., Stats., Register, December, 1999, No. 528.

DHS 105.47 Health maintenance organizations and prepaid health plans. (1) CONTRACTS AND LICENSING. Except as provided in sub. (3), for MA certification, a health maintenance organization or prepaid health plan shall enter into a written contract with the department to provide services to enrolled recipients and shall be licensed by the Wisconsin commissioner of insurance.

(2) REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS. For MA certification, an HMO shall:

(a) Meet the requirements of 42 CFR 434.20 (c);

(b) Make services it provides to individuals eligible under MA accessible to these individuals, within the area served by the organization, to the same extent that the services are made accessible under the MA state plan to individuals eligible for MA who are not enrolled with the organization; and

(c) Make adequate provision against the risk of insolvency, which is satisfactory to the department and which ensures that individuals eligible for benefits under MA are not held liable for debts of the organization in case of the organization's insolvency.

Note: For covered health maintenance organization and prepaid health plan services, see s. DHS 107.28.

(3) CARE ORGANIZATIONS PROVIDING THE FAMILY CARE BENEFIT. A care management organization under contract with the department under s. DHS 10.42 is not required to be licensed by the Wisconsin commissioner of insurance if both of the following apply:

(a) The organization enrolls only individuals who are eligible under s. 46.286, Stats.

(b) The services offered by the organization do not include hospital or physician services.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; cr. (3), Register, October, 2000, No. 538, eff. 11-1-00; correction in (3) (intro.) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.48 Out-of-state providers. (1) When a provider in a state that borders on Wisconsin documents to the department's satisfaction that it is common practice for recipients in a particular area of Wisconsin to go for medical services to the provider's locality in the neighboring state, the provider may be certified as a Wisconsin border status provider, subject to the certification requirements in this chapter and the same rules and contractual agreements that apply to Wisconsin providers, except that nursing homes are not eligible for border status.

(2) Out-of-state independent laboratories, regardless of location, may apply for certification as Wisconsin border status providers.

(2m) Out-of-state providers who meet the definition of a border-status provider as described in s. DHS 101.03 (19) and who provide services to Wisconsin members via telehealth, regardless of provider location, may apply for certification as Wisconsin border-status providers if they are licensed in Wisconsin under applicable Wisconsin statute and administrative code.

(3) Other out-of-state providers who do not meet the requirements of sub. (1) may be reimbursed for non-emergency services provided to a Wisconsin MA recipient upon approval by the department under s. DHS 107.04.

(4) The department may review border status certification of a provider annually. Border status certification may be canceled by the department if it is found to be no longer warranted by medical necessity, volume or other considerations.

(5) (a) A provider certified in another state for services not covered in Wisconsin shall be denied border status certification for these services in the Wisconsin program.

Note: Examples of providers whose services are not covered in Wisconsin are music therapists and art therapists.

(b) A provider denied certification in another state shall be denied certification in Wisconsin, except that a provider denied certification in another state because the provider's services are not MA-covered in that state may be eligible for Wisconsin border status certification if the provider's services are covered in Wisconsin.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. Register, September, 1991, No. 429, eff. 10-1-91; correction in (3) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; CR 22-043: cr. (2m) Register May 2023 No. 809, eff. 6-1-23.

DHS 105.49 Ambulatory surgical centers. For MA certification, an ambulatory surgical center shall be certified to participate in medicare as an ambulatory surgical center under 42 CFR 416.39.

Note: For covered ambulatory surgical center services, see s. DHS 107.30.

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

DHS 105.50 Hospices. For MA certification, a hospice shall be certified to participate in medicare as a hospice under 42 CFR 418.50 to 418.100.

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

DHS 105.51 Case management agency providers. (1) AGENCY. For MA certification, a provider of case management services shall be an agency with state statutory authority to operate one or more community human service programs. A case management agency may be a county or Indian tribal department of community programs, a department of social services, a department of human services, or a county or tribal aging unit. Each applicant agency shall specify each population eligible for case management under s. DHS 107.32 (1) (a) 2. for which it will provide case management services. Each certified agency shall offer all 3 case management components described under s. DHS 107.32 (1) so that a recipient can receive the component or components that meet his or her needs.

(2) EMPLOYED PERSONNEL. (a) To provide case assessment or case planning services reimbursable under MA, persons employed by or under contract to the case management agency under sub. (1) shall:

1. Possess a degree in a human services-related field, possess knowledge regarding the service delivery system, the needs of the recipient group or groups served, the need for integrated services and the resources available or needing to be developed, and have acquired at least one year of supervised experience with the type of recipients with whom he or she will work; or

2. Possess 2 years of supervised experience or an equivalent combination of training and experience.

Note: The knowledge required in subd. 1. is typically gained through supervised experience working with persons in the target population.

(b) To provide ongoing monitoring and service coordination reimbursable under MA, personnel employed by a case management agency under sub. (1) shall possess knowledge regarding the service delivery system, the needs of the recipient group or groups served, the need for integrated services and the resources available or needing to be developed.

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(3) SUFFICIENCY OF AGENCY CERTIFICATION FOR EMPLOYED PERSONNEL. Individuals employed by or under contract to an agency certified to provide case management services under this section may provide case management services upon the department's issuance of certification to the agency. The agency shall maintain a list of the names of individuals employed by or under contract to the agency who are performing case management services for which reimbursement may be claimed under MA. This list shall certify the credentials possessed by the named individuals which qualify them under the standards specified in sub. (2). Upon request, an agency shall promptly advise the department in writing of the employment of persons who will be providing case management services under MA and the termination of employees who have been providing case management services under MA.

(4) CONTRACTED PERSONNEL. Persons under contract with a certified case management agency to provide assessments or case plans shall meet the requirements of sub. (2) (a), and to provide ongoing monitoring and service coordination, shall meet the requirements of sub. (2) (b).

(5) RECORDKEEPING. The case manager under s. DHS 107.32 (1) (d) shall maintain a file for each recipient receiving case management services which includes the following:

(a) The assessment document;

(b) The case plan;

(c) Service contracts;

(d) Financial forms;

(e) Release of information forms;

(f) Case reviews;

(g) A written record of all monitoring and quality assurance activities; and

(h) All pertinent correspondence relating to the recipient's case management.

(6) REIMBURSEMENT. (a) Case management services shall be reimbursed when the services are provided by certified providers or their subcontractors to recipients eligible for case management.

(b) Payment shall be made to certified providers of case management services according to terms of reimbursement established by the department.

(7) COUNTY ELECTION TO PARTICIPATE. (a) The department may not certify a case management agency for a target population unless the county board or tribal government of the area in which the agency will operate has elected to participate in providing benefits under s. DHS 107.32 through providers operating in the county or tribal area. The county board or tribal government may terminate or modify its participation by giving a 30 day written notice to the department. This election is binding on any case management agencies providing services within the affected county or tribal area.

(b) Any case management agency provider requesting certification under this section shall provide written proof of the election of the county or tribal government to participate under this subsection.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88; corrections in (1) (a), (5) (intro.) and (7) (a) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.52 Prenatal care coordination providers.

(1) AGENCY. For MA certification, an agency that provides prenatal care coordination services under s. DHS 107.34 (1) may be any of the following:

(a) A community-based health organization.

(b) A community-based social services agency or organization.

(c) A county, city, or combined city and county public health agency.

(d) A county department of human services under s. 46.23, Stats., or social services under s. 46.215 or 46.22, Stats.

(e) A family planning agency certified under s. DHS 105.36.

(f) A federally qualified health center, as defined in 42 CFR 405.2401 (b).

(gm) A home visiting program under 42 USC 711.

(h) An independent physician association.

(i) A hospital.

(j) A physician's office or clinic.

(m) A rural health clinic certified under s. DHS 105.35.

(n) A tribal agency health center.

(o) A women, infants, and children program under 42 USC 1786.

(2) QUALIFIED PROFESSIONALS. (a) *Definition.* In this subsection, "qualified professional" means any of the following:

1. A nurse practitioner licensed as a registered nurse pursuant to s. 441.06, Stats., and currently certified by the American nurses' association, the national board of pediatric nurse practitioners and associates, or the nurses' association of the American college of obstetricians and gynecologists' certification corporation.

2. A nurse midwife certified under s. DHS 105.201.

3. A public health nurse meeting the qualifications of s. DHS 139.08.

4. A physician licensed under ch. 448, Stats., to practice medicine or osteopathy.

5. A physician assistant certified under ch. 448, Stats.

6. A dietitian certified or eligible for registration by the commission on dietetic registration of the academy of nutrition and dietetics with at least 2 years of community health experience.

7. A registered nurse with at least 2 years of experience in maternity nursing or community health services or a combination of maternity nursing and community health services.

8. An employee with at least a bachelor's degree and 2 years of experience in health promotion, health advocacy, health education, case management or care coordination, child or family social work, community outreach, or child welfare or related field; or

9. A health educator with any of the following:

a. A certified health education specialist credential from the National Commission for Health Education Credentialing.

b. A master's degree in health education and at least 2 years of experience in community health services.

10. A doula with at least 4 years of experience providing care coordination and any of the following:

a. Certification by a department approved doula certification program.

b. Experience providing doula services that is functionally equivalent to the training required under a department approved doula certification program.

11. A licensed midwife under ch. 440 subch. XIII, Stats., or a licensed nurse midwife under s. 441.15, Stats.

12. A licensed clinical social worker certified under s. 457.08 (4), Stats.

(b) *Required qualified professionals.* To be certified to provide prenatal care coordination services that are reimbursable under MA, the prenatal care coordination agency under sub. (1) shall have on staff, either employed, under contract, or in

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a volunteer capacity, at least one qualified professional with all of the following:

1. At least 2 years of experience in coordinating services for at-risk or low-income women.

2. The necessary skills to supervise assessment and ongoing care coordination and monitoring.

3. Education on providing health education and nutrition counseling or at least one year of work experience providing health education and nutrition counseling.

(c) *Duties of a qualified professional.* A qualified professional shall do all of the following:

1. Supervise tasks assigned to care coordinators.

2. Administer or review and sign each comprehensive assessment and assessment update performed.

3. Develop and sign the individualized plan of care based on the needs identified in the assessment.

4. Confer with the care coordinator regarding the member's progress towards goals and outcomes identified in the member's plan of care.

5. Provide health education and nutritional counseling services.

(d) *Division of duties for multiple qualified professionals.* If a prenatal care coordination agency has on staff or under contract more than one qualified professional meeting the requirements of par. (b) 1. to 3., then any duty listed in par. (c) may be assigned to a specific qualified professional.

(2m) QUALIFICATIONS AND DUTIES OF CARE COORDINATORS. (a) *Qualifications.* A care coordinator shall have all of the following qualifications:

1. Be trained under sub. (6) in the provision of prenatal care coordination services, and in each skill that the care coordinator is assigned under sub. (4) (k).

Note: : The reference to skills assigned under sub. (4) (k) was inadvertently left in during rulemaking. The phrase after the comma should have been struck. Corrections will be made in future rulemaking.

2. Provide documentation of required training to the prenatal care agency for the provider's records.

3. Have the skills, education, experience and ability to fulfill the employee's job duties listed in par. (b).

4. Be at least 18 years old.

(b) *Duties.* A care coordinator shall do all of the following:

1. Perform tasks assigned by the qualified professional supervisor.

2. Report in writing to the qualified professional supervisor on each comprehensive assessment and assessment update administered.

3. Confer with the qualified professional supervisor regarding the member's progress towards goals and outcomes identified in the member's plan of care.

(3) SUFFICIENCY OF AGENCY CERTIFICATION. Individuals employed by or under contract with an agency that is certified to provide prenatal care coordination services under this section may provide prenatal care coordination services upon the department's issuance of certification to the agency. The agency shall do all of the following:

(a) At the time of hire or contract, and at least every 3 years thereafter, conduct and document a background check for all care coordinators and qualified professionals following the procedures in s. 50.065, Stats., and ch. DHS 12.

(b) Maintain a list of all persons who provide or supervise the provision of prenatal care coordination services. The list shall include the credentials of each named individual who is qualified to supervise assessment and ongoing care coordination under sub. (2) (b) and (c).

(c) Report in writing to the department the name of any qualified professional hired to provide prenatal care coordination services within 10 business days of the hiring.

(d) Report in writing to the department the termination of any qualified professional who provided prenatal care coordination services within 10 business days of the termination.

(3m) FIT AND QUALIFIED DETERMINATION. (a) In this subsection:

1. "Applicant" means the person seeking MA certification as a prenatal care coordination services provider.

2. "Principal" means an administrator or a person with management responsibility for the agency who owns directly or indirectly 5 percent or more of the shares or other evidences of ownership of a corporate applicant, a partner in a partnership which is an applicant, or the owner of a sole proprietorship which is an applicant.

(b) An applicant may not be certified under this section unless the department determines that the applicant and any principal with the agency are fit and qualified to provide prenatal care coordination services, considering all of the following:

1. Whether the applicant or any principal with the agency have convictions for a crime involving any of the following:

a. Neglect or abuse of patients.

b. Assaultive behavior or wanton disregard for the health and safety of others.

c. Delivery of health care services or items.

d. Misappropriation, theft, or fraud.

2. Whether the applicant or any principal with the agency has a finding of abuse or neglect of a client, or misappropriation of client property under s. 146.40 (4r) (b), Stats.

3. The applicant and any principal with the agency's financial stability, including outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines, that resulted in the applicant or principal's business, corporation, or partnership filing for bankruptcy under chapter 7 or 11 of the United States Bankruptcy Code, 11 USC 701 to 784 or 1101 to 1195.

4. Whether the applicant and any principal with the agency has experience through education or at least one year of continuous work experience in child health and family services.

(4) ADMINISTRATIVE RECORDS AND REQUIRED DOCUMENTATION. To be certified to provide prenatal care coordination services under this section, the prenatal care coordination provider under sub. (1) shall comply with s. DHS 106.02 (9) and shall submit a plan of operation to the department and implement the plan, once certified. The plan of operation shall demonstrate all of the following:

(a) That the provider is located in the area it will serve.

(b) That the provider has a variety of techniques to identify low-income pregnant women.

(c) That, at a minimum, the provider has the name, location and telephone number of all of the following resources in the area to be served:

1. Women, infants, and children (WIC) programs.

2. Maternal and child health services.

3. The county, city, or combined city and county public health agency.

4. Child day care services.

5. Mental health and substance use disorder treatment agencies.

6. The county protective service agency.

7. Domestic abuse agencies.

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8. Translator and interpreter services including services for the hearing-impaired.

9. Family support services.

10. Transportation services.

10g. Food programs.

10r. Housing resources and programs.

11. MA-certified primary care and obstetric providers, including health maintenance organizations participating in the medical assistance program's HMO program.

(dm) That the provider coordinate with other health and social service agencies in the service area, including managed care providers and community resource providers, to avoid duplication of services and to facilitate coordination of prenatal care services to members.

(e) That the agency has contacted in writing MA-certified primary and obstetric care providers in its area and has identified the types of services the prenatal care coordination agency provides. These contacts and this information shall be documented and the documentation retained in the agency's administrative records.

(f) That the agency has the ability and willingness to deliver services in a manner that is sensitive to the particular characteristics of the racial or ethnic group or groups with which it intends to work. Documentation of that ability shall be maintained and kept up-to-date. Documentation shall consist of one or more of the following at all times:

1. Records showing the racial and ethnic composition of the population served in the past.

2. Records showing that the agency has developed, implemented and evaluated programs specifically targeted toward the racial or ethnic group or groups.

3. Records showing that the agency has provided health care services in a geographic area where a significant percentage of the population was the same as the agency's targeted racial or ethnic group or groups.

4. Evidence that the agency's board or administration has a significant amount of representation from the targeted group or groups.

5. Letters of support from minority health service organizations which represent the targeted group or groups.

6. Evidence of the agency's ability to address pertinent cultural issues such as cultural norms and beliefs, language, outreach networking and extended family relationships.

(g) That the agency has the ability to arrange for supportive services provided by other funding sources such as county transportation, county protective services, interpreter services, child care services and housing. This description shall include the methods, techniques and contacts which will be used to offer and provide assistance in accessing those services.

(h) That the provider has the capability to provide ongoing prenatal care coordination monitoring of pregnant MA members and to ensure that all necessary services are obtained.

(i) That the provider has hired or contracted at least one qualified professional meeting the criteria in sub. (2).

(j) The entire service provision process including referrals, service delivery, assessment, care planning, and follow-up activities.

(k) The provider's personnel management and training plan, as required under sub. (6).

(L) The provider's quality assurance procedures and documentation requirements.

(m) That the provider has adequate resources to maintain a cash flow sufficient to cover operating expenses for 60 days.

(5) MEMBER RECORD. The prenatal care coordination agency shall maintain a confidential prenatal care coordination file for each recipient receiving prenatal care coordination services, which includes all of the following items required or produced in connection with provision of covered services under s. DHS 107.34 (1):

(a) Verification of the pregnancy.

(b) Completed assessment.

(c) Care plan.

(d) Completed consent documents for release of information.

(e) A written record of all member-specific prenatal care coordination monitoring which includes the dates of service, description of service provided, the staff person doing the monitoring, the contacts made, the length of time, signature and date, and the results.

(f) Documentation regarding referrals from a prenatal care coordination provider to service providers and follow-up, including all of the following:

1. The name of the referred provider.

2. The reason for referral.

3. The date the referral was made.

4. Any authorizations from the member for release of information.

5. All communication and follow-up on the referral with both the member and the referred provider.

(g) All pertinent correspondence relating to coordination of the recipient's prenatal care.

(6) PERSONNEL MANAGEMENT. The prenatal care coordination agency shall document and implement a personnel management system and training plan that includes all of the following:

(a) The agency's plan to hire, support, and train staff to provide services that are family centered and culturally appropriate.

(b) If more than one qualified professional or care coordinator is employed or under contract with the agency, all of the following:

1. A process for periodically evaluating every care coordinator and qualified professional supervisor employed by or under contract with the agency in accordance with the provider's quality assurance procedures.

2. A process for following up on all evaluations with appropriate action to ensure the employee can competently perform all assigned duties.

(c) A requirement that no employee or subcontractor may be assigned any duty for which they are not trained. The prenatal care coordination agency shall provide or arrange for training of employed or subcontracted care coordinators as necessary.

(d) Procedures for ensuring all qualified professionals and care coordinators receive orientation and ongoing instruction. The procedures shall include:

1. Requirements that orientation and training shall be completed by a qualified professional or care coordinator before they provide services to a member.

2. The names and titles of persons responsible for conducting orientation and training.

3. Dates of the trainings and a description of the course content and length of training.

4. Topics covered in orientation, which shall include training on all of the following, at minimum:

a. The goals, mission, and priorities of the provider.

b. Specific job duties specified in sub. (2m) (b).

c. The functions of care coordinator by provider and how they interrelate and communicate with each other in providing services.

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d. Health and safety procedures for working in a home environment.

e. Responding to medical and non-medical emergencies.

f. Ethics, confidentiality of member information, and member rights.

5. A process for providing instruction when an evaluation of the qualified professional's or care coordinator's performance or competency indicates additional instruction may be needed.

(e) Standards for qualified professional supervision of services rendered by a care coordinator, including the frequency and duration of supervision. When supervision reveals a failure to follow the member's care plan, the prenatal care coordination provider agency or qualified professional shall provide counseling, education or retraining to ensure the care coordinator is adequately trained to complete their job responsibilities. In the case of prenatal care coordinators who are not employees of the prenatal care coordination provider, the plan shall specify all required training, qualifications, and services to be performed in a written care coordinator provider contract between the prenatal care coordination provider and care coordinators, and maintain a copy of that contract on file.

(f) A process for documenting performance of care coordination services by care coordinators by maintaining time sheets of care coordinators which document the types and duration of services provided, by funding source.

(g) A requirement that all prenatal care coordination provider staff or contractors who have or are expected to have regular and direct contact with members complete a minimum of 5 hours of annual training. Annual training shall be related to maternal and child health, case management, or similar social service continuing education, and may be provided via in-service training, conferences, workshops, continuing education, or higher education credits. This requirement shall include all of the following:

1. A process for obtaining required additional training, as identified by the supervising qualified professional.

2. A process for documenting staff completion of ongoing training requirements in the employee's file.

(7) AGENCY CLOSURE OR DISCHARGE OF MEMBER. (a) Any prenatal care coordination agency that intends to close shall provide written notice to each member, the member's legal representative, if any, the member's attending physician and the department at least 30 days before closure.

(b) The prenatal care coordination agency shall provide assistance to members in arranging for continuity of necessary services. This includes, but is not limited, to coordination with other prenatal care coordination providers to ensure necessary services identified in the care plan are sustained or initiated.

History: Cr. Register, June, 1994, No. 462, eff. 7-1-94; CR 03-033: am. (1) (L), (2) (a) (intro.), 1., 6. to 8. Register December 2003 No. 576, eff. 1-1-04; corrections in (1) (intro.), (2) (a) 3., (4) (intro.) and (5) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636; **CR 25-004: am. (1) (intro.), (a) to (f), r. (1) (g), cr. (1) (gm), am. (1) (h) to (j), r. (k), (L), am. (1) (m) to (o), (2) (a) 1. to 8., renum. (2) (a) 9. to (2) (a) 9. (intro.) and am., cr. (2) (a) 9. a., b., 10. to 12., am. (2) (b), cr. (2) (c), (d), (2m), renum. (3) to (3) (intro.) and am., cr. (3) (a) to (d), (3m), am. (4) (intro.), (a), (b), (c) (intro.), 1. to 10., cr. (4) (c) 10g., 10r., r. (4) (d), cr. (4) (dm), am. (4) (e), (f) 1. to 6., (g) to (i), cr. (4) (j) to (m), am. (5) (title), (intro.), (a) to (e), renum. (5) (f) to (5) (f) (intro.) and am., cr. (5) (f) 1. to 5., (6), (7) Register September 2025 No. 837, eff. 10-1-25; correction in (1) (h), (3) (a), (3m) (a) 2., (b) 3., (6) (d) 4. b., (e) made under s. 35.17, Stats., Register September 2025 No. 837.**

DHS 105.525 Child care coordination providers.

(1) PREREQUISITES. For MA certification, an agency that provides child care coordination services under s. DHS 107.345 (1) shall:

(a) Be an agency under s. DHS 105.52 (1) (a) to (d) or (f) to (o) that is certified to provide prenatal care coordination services. An agency providing services to residents of the city of Racine shall also participate in a program to reduce fetal and infant mortality and morbidity under s. 253.16, Stats.

(b) Render services to one of the following groups:

1. Members who are residents of Milwaukee County.

2. Members who are residents of the city of Racine.

(2) QUALIFIED PROFESSIONALS. (a) *Definitions.* In this section, "qualified professional" means any of the following:

1. A professional listed in s. DHS 105.52 (2) (a) 1., 3., 4., 5., 8., 9., or 12.

2. A registered nurse with at least 2 years of experience in pediatric nursing or community health services or a combination of pediatric nursing and community health services.

3. An employee with an Infant Mental Health Endorsement from the Alliance for the Advancement of Infant Mental Health or an affiliated state association.

Note: All states affiliated with the Alliance for the Advancement of Infant Mental Health are listed at https://www.allianceaimh.org/members-of-the-alliance.

(b) *Required qualified professionals.* To be certified to provide child care coordination services that are reimbursable under MA, the child care coordination provider shall have on staff, either employed, under contract, or in a volunteer capacity, at least one qualified professional with all of the following:

1. At least 2 years of experience in coordinating services for at-risk or low income children and families.

2. The necessary skills and relevant education to supervise assessment and ongoing care coordination and monitoring performed by care coordinators.

(c) *Duties.* A qualified professional shall perform all of the duties listed in s. DHS 105.52 (2) (c) 1. to 4.

(3) QUALIFICATIONS AND DUTIES OF CARE COORDINATORS. (a) *Qualifications.* In addition to the qualifications required under s. DHS 105.52 (2m) (a) 3. and 4., a care coordinator shall have a minimum of a high school diploma or GED.

(b) *Duties.* A care coordinator shall perform all of the duties listed in s. DHS 105.52 (2m) (b) 1. to 3.

(4) SUFFICIENCY OF AGENCY CERTIFICATION. Individuals employed by or under contract with a child care coordination agency may provide child care coordination services upon the department's issuance of certification to the child care coordination agency under this section. In order to obtain and maintain certification, the child care coordination agency shall do all of the following:

(a) Comply with the background check provisions in s. DHS 105.52 (3)(a).

(b) Maintain a list of all persons who provide or supervise the provision of child care coordination services. The list shall include the credentials of each named individual who is qualified to supervise assessment and ongoing care coordination under sub. (2) (b) and (c).

(c) Report in writing to the department the name of any qualified professional hired to provide child care coordination services within 10 business days of the hiring.

(d) Report in writing to the department the termination of any qualified professional who provided child care coordination services within 10 business days of the termination.

(5) FIT AND QUALIFIED DETERMINATION. (a) In this subsection:

1. "Applicant" has the meaning provided in s. DHS 105.52 (3m) (a) 1.

2. "Principal" has the meaning provided in s. DHS 105.52 (3m) (a) 2.

(b) An applicant may not be certified under this section unless the department determines that the applicant and any principal with the agency are fit and qualified to provide child care coordi-

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nation services, considering all of the factors listed in s. DHS 105.52 (3m) (b) 1. to 4.

(6) ADMINISTRATIVE RECORDS AND REQUIRED DOCUMENTATION. To be certified to provide child care coordination services under this section, the child care coordination agency shall comply with provider conditions of participation in s. DHS 106.02 (9) and shall submit plan of operation to the department and implement the plan, once certified. The plan of operation shall demonstrate all of the following:

(a) That the agency is located in the area it will serve.

(b) That the agency has a variety of techniques to identify low-income children and families that are appropriate for services under this section.

(c) That the agency will provide the name, location, and telephone number of all of the following resources to individuals in the area to be served:

1. All of the resources identified in s. DHS 105.52 (4) (c) 1. to 10r.

2. MA-certified primary care and pediatric providers, including health maintenance organizations participating in the medical assistance program's HMO program.

(d) That the agency has the ability and willingness to deliver services and maintain documentation as provided in s. DHS 105.52 (4) (f), and to arrange for supportive services as provided in s. DHS 105.52 (4) (g).

(e) That the agency has the capability to provide ongoing child care coordination monitoring for children and families and to ensure that all necessary services are obtained. This includes all of the following:

1. Coordinating with other health and social service agencies in the service area, including managed care providers and community resource providers, to avoid duplication of services and to facilitate coordination of child care services to members.

2. Coordinating with MA-certified primary and pediatric care providers in the service area to communicate the services the child care coordination provider renders, and documenting and retaining these contacts in the provider's administrative records.

(f) That the agency hired or contracted at least one qualified professional meeting the criteria in sub. (2).

(g) The agency's process for referrals, service delivery, assessment, care planning, and follow-up activities.

(h) The agency's personnel management and training plan, as required under sub. (7).

(i) The agency's quality assurance procedures and documentation requirements.

(j) That the agency has adequate resources to maintain a cash flow sufficient to cover operating expenses for 60 days**.**

(7) PERSONNEL MANAGEMENT. The child care coordination agency shall document and implement a personnel management system and training plan, which shall include all of the following:

(a) All of the items required under s. DHS 105.52 (6) (a), (b), and (f).

(b) A requirement that no employee or subcontractor may be assigned any duty for which they are not trained. The child care coordination agency shall provide or arrange for training of employed or subcontracted care coordinators as necessary.

(c) Procedures for ensuring all qualified professionals and care coordinators receive orientation and on-going instruction. The procedures shall include:

1. All of the items required under s. DHS 105.52 (6) (d) 1., 2., 3., and 5.

2. Topics covered in orientation, which shall include training on all of the following, at minimum:

a. All of the topics required under s. DHS 105.52 (6) (d) 4. a., d., e., and f.

b. Specific job duties, specified in s. DHS 105.52 (2m) (b).

c. The functions of the child care coordination provider staff and how they interrelate and communicate with each other in providing services.

3. A process for providing instruction when an evaluation of the qualified professional's or care coordinator's performance or competency indicates additional instruction may be needed.

(d) Standards for qualified professional supervision of services rendered by a care coordinator, including the frequency and duration of supervision. When supervision reveals a failure to follow the member's care plan, the child care coordination provider shall provide counseling, education or retraining to ensure the care coordinator is adequately trained to complete their job responsibilities. In the case of child care coordinators who are not employees of the child care coordination provider, the plan shall specify all required training, qualifications, and services to be performed in a written care coordinator provider contract between the child care coordination provider and care coordinators, and maintain a copy of that contract on file.

(e) Requirements for ongoing training, including all of the following:

1. Training and documentation requirements listed in s. DHS 105.52 (6) (g) 1. and 2.

2. A minimum of 5 hours of annual training for child care coordination provider staff or contractors who have, or are expected to have, regular and direct contact with members. Annual training shall be related to early intervention, education, case management, or similar social service continuing education. Training may be in-service training, conferences, workshops, earning of continuing education credits or earning of higher education credits.

(8) MEMBER RECORD. The child care coordination agency shall maintain a confidential file for each member receiving child care coordination services, which includes all of the following items required or produced in connection with provision of covered services under s. DHS 107.345 (1):

(a) All of the items required under s. DHS 105.52 (5) (b) to (d).

Note: The reference to s. DHS 105.52 (5) (b) to (d) inadvertently omitted a reference to par. (e). Paragraph (a) should read: "All of the items required under s. DHS 105.52 (5) (b) to (e)." This will be corrected in future rulemaking.

(b) Documentation about any care coordination services provided immediately in urgent situations, including documentation regarding the circumstances and reasons for those services being rendered prior to the initial assessment and care plan.

(c) Documentation regarding referrals from a child care coordination provider to service providers including all of the following:

1. The name of the referred provider.

2. The reason for referral.

3. The date the referral was made

4. Any authorizations from the member for release of information.

5. All communication and follow-up on the referral with both the member and the referred provider.

(d) All pertinent correspondence relating to coordination of the member's care.

(9) AGENCY CLOSURE OR DISCHARGE OF MEMBER. Any child care coordination agency that intends to close shall do all of the following:

(a) Provide written notice to each member, the member's legal

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representative, if any, the member's attending physician and the department at least 30 days before closure.

(b) Provide assistance to members in arranging for continuity of necessary services. This includes, but is not limited, to coordination with other child care coordination providers to ensure necessary services identified in the care plan are sustained or initiated.

History: EmR2421: emerg. cr., eff. 1-6-25; CR 25-004: cr. Register September 2025 No. 837, eff. 10-1-25; correction in (4) (c), (d), (7) (d) made under s. 35.17, Stats., renumber (7) (c) 5., (i) to (7) (c) 3., (e) under s. 13.92 (4) (b) 1., Stats, and as renumbered, correction in (7) (e) 1. made under s. 12.92 (4) (b) 7., Stats., and renum. (9) (a) to (9) (a) (intro.) and (a) and, as renumbered, correction in (9) made under s. 35.17, Stats., Register September 2025 No. 837.

DHS 105.53 School-based service providers. (1) ELIGIBLE PROVIDERS. For MA certification, a school-based service provider shall be either a school district under ch. 120, Stats., or a cooperative educational service agency (CESA) under ch. 116, Stats.

(2) SEPARATE CERTIFICATION PROHIBITED. No school district or CESA may be separately certified as a provider of nursing services under ss. DHS 105.19 and 105.20, physical therapy services under s. DHS 105.27, occupational therapy services under s. DHS 105.28, speech and language pathology services under ss. DHS 105.29 and 105.30, audiology services under s. DHS 105.31 or transportation services under s. DHS 105.39.

(3) RECORD-KEEPING REQUIREMENTS. (a) For each recipient of school-based services, the provider shall keep a record containing, at a minimum, all of the following:

1. The recipient's first and last name and date of birth;

2. The prescription or, if referred, the referral for the service;

3. Documentation used to develop the recipient's IEP and to annually revise the IEP; and

4. Annual documentation of the individual's progress toward treatment goals identified in the IEP, changes in the individual's physical or mental status and changes in the treatment plan identified in the IEP.

(b) For each date of service, the provider shall keep a service record within the recipient's record containing all of the following:

1. The date of service;

2. The general type of service provided;

3. A brief description of the specific service provided;

4. The unit of service delivered as defined through handbooks distributed by the department under s. DHS 108.02 (4);

5. A description and the cost of each durable medical equipment item with sufficient detail to allow the MA program to determine the reimbursement rate, when appropriate; and

6. Documentation of whether the procedure was provided in a group or individual setting, when appropriate.

(c) Periodically, at least monthly, the provider shall include in the service record under par. (b) the following:

1. For each service provided, a brief description of the recipient's response to the service and progress toward the treatment goals identified in the IEP; and

2. The service provider's signature.

(d) The provider shall include in the records other information identified by the department in publications in accordance with s. DHS 108.02 (4).

(4) REPORTING REQUIREMENTS. The required annual audit of school district accounts under s. 120.14, Stats., and the audit of CESA receipts and expenditures under s. 115.28 (3m), Stats., shall include evidence, in accordance with instructions distributed by the department under s. DHS 108.02 (4), that requirements for billing and for paying expenses under s. 49.45 (39) (b), Stats., are being met. Sections of those annual audits shall be made available to the department upon request.

(5) REIMBURSEMENT. (a) School-based services shall be reimbursed when the services are provided by certified providers or their contractors to recipients eligible for school-based services.

(b) Payment, based on the cost to provide the service, shall be made to certified providers of school-based services according to terms of reimbursement established by the department and stated in the medicaid state plan under 42 CFR 430.10.

(c) Services provided between July 1, 1995 and June 30, 1996 may be billed through June 30, 1997, to the extent allowed by federal law, notwithstanding s. DHS 106.03 (3) (b) 1.

(6) COORDINATION WITH OTHER MA-CERTIFIED PROVIDERS. (a) *Memorandum of understanding with HMO.* School-based services providers shall have on file a signed copy of a memorandum of understanding with each HMO participating in the medical assistance HMO program when the geographic service area of the HMO coincides with part or all of the geographic service area of the school-based services provider.

(b) *Coordination with fee-for-service providers.* When a recipient receives similar services from both an MA fee-for-service provider and a school-based service provider, the school-based service provider shall document, at least annually, regular contacts with the MA fee-for-service provider, and provide the MA fee-for-service provider with copies of the recipient's IEP and relevant components of the multidisciplinary team evaluation under s. 115.80 (3) and (5), Stats., upon request.

History: Emerg. cr. eff. 6-15-96; cr. Register, January, 1997, No. 497, eff. 2-1-97; CR 03-033: am. (3) (a) 3., 4., (c) 1. and (6) (b) Register December 2003 No. 576, eff. 1-1-04; corrections in (3) (b) 4., (d), (4) and (5) (c) made under s. 13.92 (4) (b) 7., Stats., Register December 2008 No. 636.

DHS 105.54 Qualified complex rehabilitation technology suppliers. (1) CERTIFICATION. For MA certification, complex rehabilitation technology suppliers shall do all of the following:

(a) Be accredited by a department recognized accrediting organization.

(b) Employ at least one complex rehabilitation technology professional.

(c) Have the capability to service and repair all complex rehabilitation technology provided.

(2) CLIENT SERVICES. Complex rehabilitation technology suppliers shall do all of the following:

(a) Require a complex rehabilitation technology professional to be present for evaluation and determination of recipients' complex rehabilitation technology needs.

(b) Provide recipients with written information about how to receive service and repair for complex rehabilitation technology supplied at the time of delivery.

(c) Maintain records of proof of delivery in recipients' files.

(3) REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS. For MA certification, contracts between the department and managed care plans shall require managed care plans to comply with s. 49.45 (9r) (a) 2., Stats., this section, and s. DHS 107.24.

History: CR 20-012: cr. Register October 2021 No. 790, eff. 11-1-21.