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CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE **00–095**

AN ORDER to repeal and recreate chapter HFS 120, relating to the collection, analysis and dissemination of health care information.

Submitted by **DEPARTMENT OF HEALTH AND FAMILY SERVICES**

05–15–00 RECEIVED BY LEGISLATIVE COUNCIL.
06–13–00 REPORT SENT TO AGENCY.

RNS:LR:jal;rv

LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

   Comment Attached YES ☑ NO ☐

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

   Comment Attached YES ☑ NO ☐

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

   Comment Attached YES ☐ NO ☑

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

   Comment Attached YES ☑ NO ☐

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

   Comment Attached YES ☑ NO ☐

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

   Comment Attached YES ☐ NO ☑

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

   Comment Attached YES ☐ NO ☑

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CLEARINGHOUSE RULE 00–095

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated September 1998.]

1. Statutory Authority

Section HFS 120.31 (3) allows for rerelease of individual raw patient data elements to subsequent users with written approval of the department. The department should review this rule for consistency with s. 153.45 (4), Stats. That statute requires the department to prohibit purchasers of data from rereleasing individual data elements of health care data files.

2. Form, Style and Placement in Administrative Code

a. If the rule affects a small business, as defined in s. 227.114 (1) (a), Stats., a regulatory flexibility analysis should be added to the rule.

b. Several titles in the table of contents to ch. HFS 120 do not coincide with the titles in the text. For example, see the titles to ss. HFS 120.05, 120.06, 120.10 and 120.16 and subch. III of ch. HFS 120.

c. Section HFS 120.03 (intro.) should read: "Unless otherwise indicated, in this chapter:". The term "facility" is defined in s. HFS 120.03 (10), but is defined differently elsewhere in the rule. [See s. HFS 120.11 (2).]

d. In s. HFS 120.03 (5), is "normal charges" a commonly understood term?

e. In s. HFS 120.03 (17), "or "IRB"" should be inserted before "means" and "(IRB)" should be deleted from s. HFS 120.31 (2) (a).

f. In the definition of "patient" in s. HFS 120.03 (21), a cross-reference to the statutory definition of "patient" is provided followed by a repetition of the statutory definition. This is not done for other definitions in the rule which have statutorily equivalent definitions. There should be consistency among the definitions in the rule in cross-referencing the statutory definitions.

g. In s. HFS 120.09 (1) (b), the definition of "room and board" should be moved to after the definition of "reportable price increase," to maintain alphabetical order.

h. For consistency with the remainder of the rule, "For the purposes of" should be changed to "In" in s. HFS 120.10 (1).

i. In s. HFS 120.12 (2) (c) 2. a., "this subd. 2. b." should replace "subpar. b."

j. In several places in the rule, what is drafted as introductory material does not end in a colon and lead into the subunits. [See s. 1.03 (8), Manual.] For example, in s. HFS 120.12 (2) (d) 7. and (3) (d) 7., 7. (intro.) should become "7. a." and the subsequent subdivision paragraphs should be "b." and "c."

k. In s. HFS 120.21 (2) (a), "Payer" should replace "Payor" since "payer" is a defined term.

l. There are several references to "medicaid" in the rule. Since "medical assistance" is a defined term, it should replace the references to "medicaid."

4. Adequacy of References to Related Statutes, Rules and Forms

In s. HFS 120.09 (1) (e), a cross-reference to ch. 985, Stats., should be inserted.

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. In the note to the definition of "raw data elements" in s. HFS 120.03 (28), a definition and examples of aggregate information are included. If a definition of aggregate data is needed, this should be provided in the definition section and not in the note to the definition of "raw data elements."

b. In s. HFS 120.04 (3), the term "net expenditures" should be defined or explained.

c. In s. HFS 120.04 (3) (a) 2. and 3., the department specifies the basis for determining assessments on hospitals and ambulatory surgery centers; i.e., gross private-pay patient revenues for hospitals and the number of reported surgical procedures for ambulatory surgery centers. However, subd. 4. does not specify the basis for determining assessments on other providers. Will it be the total amount to be paid by the provider group divided by the number of persons in the provider group?

d. In s. HFS 120.11 (1), the comma after "hospitals" should be changed to "and."

e. In s. HFS 120.14 (1) (c) 2. j., "insureds" should replace "insured's." In subd. 4. a. and b., "the physician's" should replace "their."

f. There are several references in subch. IV to the department's Web site. It would be helpful if a note were inserted at the beginning of the subchapter showing the uniform resource locator (URL) for the Web site.

g. In s. HFS 120.22 (2) (f), the word "elements" should be inserted after the term "raw data" if this is intended to have the same meaning as "raw data elements" in the definition section.

h. In ss. HFS 120.23 (4) (intro.), 120.24 (4) (intro.), 120.25 (4) (intro.) and 120.26 (4) (intro.), the introductory paragraphs should be rephrased so that they are suggestions rather than authorizations. For example, s. HFS 120.23 (4) (intro.) could read: "Some suggestions for using the report are as follows:".

i. In s. HFS 120.23 (4) (b) 1., "important factors consumers should consider when selecting a health care provider" should be replaced with a less directive phrase, such as "important factors consumers might consider when selecting a health care provider."

j. Section HFS 120.24 (2) refers to hospitals that have increased their rates. Does this provision apply only to hospitals that have increased their rates by more than the increase in the Consumer Price Index? [See s. HFS 120.09 (1) (f).] This should be clarified.

k. In s. HFS 120.30 (5) (c) 2. c., do the key identifiers need to be specified? If they are the identifiers that are set forth in s. 153.50 (3) (b), Stats., perhaps these should be specified in the rule.

l. In s. HFS 120.31 (2) (d), this provision seems to preclude the board from meeting more than once a month. It may be better to rephrase this provision as saying that the Independent Review Board shall meet as often as necessary to review policies and requests for custom data or custom analysis of physician office data.

PROPOSED ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
REPEALING AND RECREATING RULES

To repeal and recreate chapter HFS 120, relating to the collection, analysis and dissemination of health care information.

Analysis Prepared by the Department of Health and Family Services

The Department of Health and Family Services is responsible for collecting, analyzing and disseminating a variety of health care data pursuant to ch. 153, Stats. This rulemaking order modifies ch. HFS 120, Wis. Admin. Code, to reflect changes to ch. 153, Stats.

The Office of Health Care Information (OHCI) was established in the Department of Health and Social Services in July 1987, following the enactment of 1987 Wisconsin Act 399 which created ch. 153, Stats., to provide for an office to collect, analyze and disseminate health care information, at first mainly hospital-related information, while maintaining the confidentiality of personal information about patients. The 1993-1995 Budget Act transferred OHCI to the Office of Commissioner of Insurance effective October 1, 1993. Subsequently, 1997 Wisconsin Act 27 transferred OHCI back to what is now called the Department of Health and Family Services in October 1997. The Department then arranged for the rules for operation of OHCI to be renumbered, effective March 1, 1998, from ch. Ins 120 to ch. HFS 120.

Chapter HFS 120 is being proposed to be revised to implement the statutory changes included in 1997 Wisconsin Act 231 and 1999 Wisconsin Act 9. Chapter HFS 120, as it currently exists, primarily addresses the collection and analysis of data from hospitals and ambulatory surgery centers. 1997 Wisconsin Act 231 directed the Department to collect claims data and other health care information from health care providers besides hospitals and freestanding ambulatory surgery centers, including from physicians in their offices and clinics. The rules specify the other providers from whom data will be collected, the data elements to be collected and the manner in which data will be disseminated, and extend to these other providers instructions for data verification and review and comment that apply now only to hospitals and freestanding ambulatory service centers. The rules also provide for assessing the other providers from whom data are collected for the costs of collection, database development and maintenance, generation of data files and standard reports, orientation and training and the expenses of the Board of Health Care Information.

Other changes that have been made in ch. HFS 120 to implement the Act 231 changes to ch. 153, Stats., include the following:

- A waiver process and standards by which a health care provider could, upon request, obtain an exemption from data submission requirements that are burdensome.
- A manner of assessing a fee on health care plans that voluntarily supply health care data to the Department is specified. The assessment fee covers the costs of collection, database development and maintenance and generation of public use data files and standard reports for the health care plans.
- Rules have been added to govern the release of all health care provider-specific and employer-specific information collected. The current rules have only a procedure for releasing physician-specific data.
- Methods have been specified for adjusting health care information for case mix and severity.
- Several provisions have been repealed, including definitions of uniform patient billing form, charge element and uncompensated health care services; the requirement that hospitals and

free standing ambulatory surgery centers use uniform patient billing forms; the requirement that hospitals submit financial data; Board responsibility to determine whether to contract for provision of data processing services for the Department; the requirement that a hospital hold a public hearing before raising its rates; the production by the Department of quarterly and annual reports for the public; certain procedures for data review and verification; and assessment language specific to free standing ambulatory surgery centers.

1999 Wisconsin Act 9, the biennial Budget Bill, further modified language in ch. 153, Stats., insofar as it:

1. Established additional constraints on the type of physician data that can be released in public use data files.
2. Established additional required means of masking the identification of specific patients, employers and health care providers.
3. Established the requirement that compilation and release of custom-designed reports with nonaggregated age, zip code or physician identifiers based on physician data be subject to the review and approval of the independent review board.
4. Prohibited the Department's sale or distribution of physician data that can be linked with public use data files without the approval of the independent review board.
5. Established a separate set of data elements collected from physicians that constitutes "patient-identifiable data."
6. Requires the Department to develop and use a data use agreement.
7. Requires that purchasers of data sign and have notarized Department data use agreements.
8. Prohibits employers from requesting the release of or access to patient-identifiable data.
9. Prohibits the Department from requiring physicians to submit uniform patient billing forms.
10. Prohibits physicians from submitting a variety of data to the Department.
11. Establishes immunity from civil liability for health care providers that mistakenly submit data to the Department in a manner that results in the release of prohibited data elements.
12. Increases by 30-50% the penalties for violation of selected statutory provisions related to confidential data.

The proposed revisions to ch. HFS 120 respond to the major changes made by 1997 Wisconsin Act 231 and 1999 Wisconsin Act 9 to ch. 153, Stats., by reorganizing the chapter into five subchapters that generally correspond to:

- Identifying the purpose and applicability of the chapter;
- Administering the Department's program collecting, analyzing and disseminating data under ch. 153, Stats., and ch. HFS 120;
- Collecting, verifying and adjusting data from each type of health care provider;
- Specifying the source, content, intended distribution and suggested use of regular Department reports based on submitted data; and
- Specifying rules related to the dissemination and use of public use data, ensuring data confidentiality, releasing data, and responding to requests for custom reports and analyses.

The Department's authority to repeal and recreate these rules is found in ss. 153.75 and 227.11 (2) (a), Stats. The rules interpret ss. 153.05 (5), (8) and (13), 153.08 (2), 153.45 (1), (1m), (3) and (5), 153.50 (4) (b), 153.60 (1) and (3), 153.67 and 153.75, Stats.

SECTION 1. Chapter HFS 120 is repealed and recreated to read:

Chapter HFS 120

HEALTH CARE INFORMATION

Subchapter I - General Provisions

Subchapter II - Administration

Subchapter III - Data Collection

Subchapter IV - Standard Reports

Subchapter V - Data Dissemination

Subchapter I — General Provisions

HFS 120.01 Authority and purpose. This chapter is promulgated under the authority of s. 153.75, Stats., to implement ch. 153, Stats. Its purpose is to provide to health care providers, insurers, consumers, governmental agencies and others information concerning health care providers and uncompensated health care services, and provide information to assist in peer review for the purpose of quality assurance.

HFS 120.02 Applicability. This chapter applies to the department, the board on health care information, the independent review board, qualified vendors, health care plans, health care providers licensed in this state and persons requesting data from the department.

HFS 120.03 Definitions. In this chapter: unless otherwise specified see "JAC" p. 5 + 16

(1) "Affirmation statement" means a department document that when signed by a health care provider or an authorized representative of a health care provider submitting data to the department affirms, to the best of the signer's knowledge, all of the following:

(a) Any necessary corrections to data submitted to the department have been made.

(b) The data submitted are complete and accurate.

(2) "Bad debts" means claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

(3) "Board" means the board on health care information established under s. 15.195 (6), Stats.

(4) "Charity care" means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. "Charity care" does not include any of the following:

(a) Care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care.

(b) Contractual adjustments in the provision of health care services below normal billed charges.

(c) Differences between a hospital's charges and payments received for health care services provided to the hospital's employes, to public employes or to prisoners.

(d) Hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy.

(e) Bad debts.

(5) "Contractual adjustment" means the difference between a hospital's normal charges for patient services and the discounted charge or payment received by the hospital from the payer.

(6) "Data profile" means a summary of all submitted data and a listing of all questionable data records and a summary of the number of records received by the department from a health care provider.

(7) "Data submission manual" means the Department's document specifying the procedures for submitting data, including data formats, coding specifications and instructions for editing incorrect data.

(8) "Department" means the department of health and family services.

(9) "Employer coalition" means an organization of employers formed for the purpose of purchasing health care coverage or services as a group.

(10) "Facility" means a hospital, freestanding ambulatory surgery center, inpatient health care facility as defined in s. 50.135 (1), Stats., hospice, community-based residential facility or rural medical center.

(11) "Facility level database" means a database pertaining to a facility, including aggregated utilization, staffing or fiscal data for the facility but not including data on an individual patient or data on an individual health care professional.

(12) "Freestanding ambulatory surgery center" or "center" means any distinct entity that is operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization, that has an agreement with the federal health care financing administration under 42 CFR 416.25 and 416.30 to participate as an ambulatory surgery center, and that meets the conditions set forth in 42 CFR 416.25 to 416.49.

(13) "Health care plan" means an employer coalition or any other insured or self-insured plan providing coverage of health care expenses.

(14) "Health care provider" has the meaning given in s. 146.81 (1), Stats., and includes a freestanding ambulatory surgery center.

(15) "Health care service charge" means the full amount billed for medical services before being reduced by any contractual adjustments or other discounts.

(16) "Hospital" has the meaning specified in s. 50.33 (2), Stats.

(17) "Independent review board" means a department board established under s. 15.195 (9), Stats., for the purpose of reviewing requests to release department data on physician office visits that, if inappropriately released, may jeopardize the privacy of individual patients or health care providers.

(18) "Individual data element" means an item of information from a uniform patient billing form or derived from a uniform patient billing form.

(19) "Medical assistance" means the assistance program operated by the department of health and family services under ss. 49.43 to 49.497, Stats., and chs. HFS 101 to 108.

(20) "Medicare" means the health insurance program operated by the U.S. department of health and human services under 42 USC 1395 to 1395 ccc and 42 CFR ch. IV, subch. B.

(21) "Patient" has the meaning specified in s. 153.01 (7), Stats., namely, a person who receives health care services from a health care provider.

(22) "Payer" means a party responsible for payment of a health care service charge, including an insurer or a federal, state or local government.

Note: Payers often reimburse health care providers a substantially lesser amount than the full charge.

(23) "Person" means any individual, partnership, association or corporation, the state or a political subdivision or agency of the state or of a local unit of government.

(24) "Physician" means a person licensed under ch. 448, Stats., to practice medicine or osteopathy.

(25) "Public program" means any program funded with government funds.

Note: Examples of public programs are primary care under s. 146.93, Stats., Medicare under 42 USC 1395 and 42 CFR subchapter B, Badgercare under s. 49.665, Stats., Family Care under ss. 46.2805 to 46.2895, Stats., and Medical Assistance (Medicaid) under ss. 49.43 to 49.497, Stats., and chs. HFS 101 to 108 and CHAMPUS under 10 USC 1071 to 1103.

(26) "Public use data" means any form of data from the department's comprehensive discharge database or facility level database that does not allow the identification of an individual from the elements released in the data files.

(27) "Qualified vendor" means an entity under contract with a health care provider that will submit data to the department according to formats the department specifies in its data submission manual.

(28) "Raw data elements" means any file, individual record, or any subset thereof, that contains information about an individual health care service provided to a single patient released by the department in public use or custom data files.

Note: 1. Examples of raw data elements are any of the following:

a. The data files hospitals and surgery centers submit to the Department each quarter.

b. The public-use data files the Department produces.

c. Any custom data file produced by the Department that contains individual records representing hospital discharges or surgical cases. Some customers purchase this kind of data when it is more cost-effective than purchasing the complete statewide public-use data files.

d. A computer printout of the individual data elements in individual records representing hospital discharges or surgical cases.

2. Since raw patient data contain individual records, the data differ from a summary, a report, or a table that presents information about a group of hospital discharges or surgical cases. Summaries, reports, and tables are considered aggregate information. Examples of aggregate information are any of the following:

a. A graph or chart.

b. A publication, such as the annual Health Care Data Report.

c. A summary table of diagnostic-related groups and their average charges that a customer produces from a public-use data file.

d. A table of hospitalizations by age group and sex that a customer produces from the Department's interactive Web query system.

(29) "Sign" or "signature" means any combination of words, letters, symbols or characters that is attached to or logically associated with a record and that is used by a person for the purpose

of authenticating a document, including one that has been created in or transformed into an electronic format.

(30) "Subacute care" means goal-oriented, comprehensive, inpatient care designed for an individual who has had an acute illness, injury or exacerbation of a disease process. It is rendered immediately after, or instead of, acute hospitalization to treat one or more specific, active, complex medical conditions or to administer one or more technically complex treatments in the context of a person's underlying long-term conditions and overall situation. Subacute care is generally more intensive than traditional nursing facility care and less intensive than acute inpatient care.

(31) "Trading partner agreement" means a signed, formal arrangement between a health care provider, the department and a qualified vendor providing the transfer of data under this chapter. The agreement specifies the acceptable data formats, the edit review and verification requirements, including procedures for processing confidential patient data and the authorized signatory for the affirmation statement.

(32) "Uncompensated health care services" means charity care and bad debts.

(33) "Uniform patient billing form" means forms consistent with federal data standards for health care payment transactions.

Subchapter II -- Administration

HFS 120.04 Assessments to fund the operations of the health care provider data section and the board. (1) DEFINITION. In this section, "state fiscal year" means the 12-month period beginning July 1 and ending the following June 30.

(2) ESTIMATE OF EXPENDITURES. By October 1 of each year, the department shall estimate the total expenditures for its operation of the health care provider data section and the board for the current state fiscal year from which it shall deduct all of the following:

(a) The estimated total amount of monies related to this chapter the department will receive from user fees, gifts, grants, bequests, devises and federal funds for that state fiscal year.

(b) The unencumbered remaining balances of the total amount of monies received through assessments, user fees, gifts, grants, bequests, devises and federal funds from the prior state fiscal year related to this chapter.

(c) The estimated total amount to be received for purposes of administration of this chapter under s. 20.435 (1) (hi), Stats., during the fiscal year and the unencumbered remaining balance of the amount received for purposes of administration of this chapter under s. 20.435 (1) (dg), Stats., for the fiscal year.

(3) CALCULATION OF ASSESSMENTS. (a) *Health care providers.* 1. The department shall annually assess health care providers a fee in order to fund the operations of the department and the board as authorized in s. 153.60, Stats. The department shall calculate net expenditures and resulting assessments separately for hospitals, as a group, freestanding ambulatory surgery centers, as a group, and each type of health care provider, as a group, based on the collection, analysis and dissemination of information related to each group.

2. The assessment for an individual hospital shall be based on the hospital's proportion of the reported gross private-pay patient revenue for all hospitals for its most recently concluded fiscal year, which is that year ending at least 120 days prior to July 1.

3. The assessment for an individual freestanding ambulatory surgery center shall be based on the freestanding ambulatory surgery center's proportion of the number of reported surgical procedures for all freestanding ambulatory surgery centers for the most recently concluded calendar year.

4. The board shall approve assessment amounts for health care provider classes other than hospitals and freestanding ambulatory surgery centers prior to assessment.

5. No health care provider that is not a facility may be assessed under this section an amount exceeding $75 per year.

(b) *Health care plans.* 1. The department shall, by October 1 of each year, estimate the total amount of expenditures related to the collection, database development and maintenance and generation of public data files and standard reports for health care plans that voluntarily agree to supply data to the department.

2. The department shall divide the expenditure estimate derived in subd. 1. by the total number of enrollees in health care plans that have, by October 1 of each year, notified the department that the health care plan is going to voluntarily supply data to the department under s. HFS 120.15.

3. The department shall annually assess each health care plan that has voluntarily agreed to supply data to the department a fee proportionate to the amount estimated in subd. 1. equivalent to the health care plan's contribution to the total number of enrollees determined under subd. 2.

(4) PAYMENT OF ASSESSMENTS. (a) *Definitions.* In this subsection:

1. "Evidence of being fully retired" means a completed department survey on which the physician certifies that he or she is fully retired and is signed by the physician.

2. "Additional evidence" means a letter from the entity through which medical care was provided by the physician.

(b) *Hospitals and freestanding ambulatory surgery centers.* Each hospital and freestanding ambulatory surgical center shall pay the amount it has been assessed on or before December 1 of each year by check or money order payable as specified in the assessment notice. Payment of the assessment is timely if the assessment is mailed to the address specified in the assessment notice, is postmarked before midnight of December 1 of the year in which the assessment is due, with postage prepaid, and is received not more than 5 days after the prescribed date for making the payment. A payment that fails to satisfy these requirements solely because of a delay or administrative error of the U.S. postal service shall be considered to be timely.

(c) *Individual health care provider classes.* 1. 'All individual health care provider classes.' Each health care provider class other than hospitals and freestanding ambulatory surgical centers shall pay the annual or biennial amount assessed.

2. 'Physicians.' a. A physician providing evidence of being fully retired shall be exempt from paying the assessment of the collection of claims data specified in subd. 1. The department shall

consider physicians providing all medical care free of charge during retirement to be fully retired. The department shall consider physicians who are retired under the patient compensation fund to be fully retired.

b. The department may audit its inpatient and ambulatory surgery databases to corroborate the evidence submitted by physicians. If the department audit indicates that a physician who has submitted evidence of being fully retired is actively practicing, the physician shall submit the claims data assessment, unless the physician provides additional evidence that this care was provided at no charge.

(d) *Health care plans.* Each health care plan voluntarily submitting health care plan data shall pay the amount it has been assessed on or before December 1 of each year by check or money order payable as specified in the assessment notice. Payment of the assessment is timely if the assessment is mailed to the address specified in the assessment notice, is postmarked before midnight of December 1 of the year in which due, with postage prepaid, and is received not more than 5 days after the prescribed date for making the payment. A payment that fails to satisfy these requirements solely because of a delay or administrative error of the U.S. postal service shall be considered to be timely.

HFS 120.05 Communications addressed to the department. (1) FORMAT. Individual health care professionals or the chief executive officer of the facility or the designee of the individual health care professional or the chief executive officer of the facility shall sign all written information or communications submitted by or on behalf of a health care provider to the department.

(2) TIMING. All written communications, including documents, reports and information required to be submitted to the department shall be submitted by 1st class or registered mail or by delivery in person. The date of submission is the day the written communication is postmarked or delivered in person.

Note: Send all communications, except the actual payment of assessments under s. HFS 120.04(4), to the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver them to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

HFS 120.06 Selection of a contractor. (1) DEFINITIONS. In this section:

(a) "Contractor" means a person under contract to the department to collect, process, analyze or store data for any of the purposes of this chapter.

(b) "Major purchaser, payer or provider of health care services" means any of the following:

1. A person, a trust, a multiple employer trust, a multiple employer welfare association, an employe benefit plan administrator or a labor organization that purchases health benefits, which provides health care benefits or services for more than 500 of its full-time equivalent employes, or members in the case of a labor organization, either through an insurer or by means of a self-funded program of benefits.

2. An insurer that writes accident and health insurance and is among the 20 leading insurers for either group or individual accident and health insurance, as specified in the market shares table of the most recent annual Wisconsin insurance report of the state commissioner of insurance. "Major purchaser, payer or provider of health care services" does not include an insurer that writes only disability income insurance.

3. A trust, a multiple employer trust, a multiple employer welfare association or an employe benefit plan administrator, including an insurer, that administers health benefits for more than 29,000 individuals.

4. A person that provides health care services and has 100 or more full-time equivalent employes.

(2) ELIGIBLE CONTRACTORS. If the department designates a contractor for the provision of data processing services for this chapter, including the collection, analysis and dissemination of health care information, the contractor may not be one of the following types of public or private organizations:

(a) A major purchaser, payer or provider of health care services in this state.

(b) A subcontractor of an organization in par. (a).

(c) A subsidiary or affiliate of an organization in par. (a) in which a controlling interest is held and may be exercised by that organization either independently or in concert with any other organization in par. (a).

(d) An association of any of the entities in pars. (a) to (c).

(3) CONFIDENTIALITY. The department may grant the contractor authority to examine confidential materials and perform other specified functions. The contractor shall comply with all confidentiality requirements established under this chapter. The release of confidential information by the contractor without the department's written consent shall constitute grounds for the department to terminate the contract and subjects the contractor to all pertinent penalties and liabilities described in this chapter.

HFS 120.07 Training. The department shall conduct throughout the state a series of training sessions for data submitters to explain its policies and procedures and to provide assistance in implementing the requirements of ch. 153, Stats., and this chapter.

HFS 120.08 Reporting status changes required. A facility shall report to the department any of the following within 45 days after the event occurs:

(1) The opening of a new facility.

(2) The closing of the facility.

(3) The merger of 2 or more facilities.

(4) A change in the name of the facility.

(5) A change of the facility's address.

(6) A change in the identity of the chief executive officer or chief administrative officer of the facility.

(7) A change in the beginning and ending dates of the facility's fiscal year.

Note: Health care providers who are required to send their information directly to the department should use the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

HFS 120.09 Notice of hospital rate increases or charges in excess of rates.

(1) DEFINITIONS. In this section:

(a) "Annualized percentage" means an estimate of the percentage increase in a hospital's gross revenue due to a price increase in charges for patient services for the 12-month period beginning with the effective date of the price increase.

(b) "Room and board" means the charges associated with all services provided to the patient in a private or semi-private room.

(c) "Change in the consumer price index" means the percentage increase or decrease in the consumer price index, as defined in s. 16.004 (8) (e) 1., Stats.

(d) "Charge element" means any service, supply or combination of services or supplies that is specified in the categories for payment under the charge revenue code of the uniform patient billing form.

(e) "Class 1 notice" means the publication of a notice at least once in a newspaper likely to give notice to interested persons in the area where the hospital is located.

(f) "Reportable price increase" means a change in a hospital's prices that will cause the hospital's gross revenue from patient services for the 12-month period following the effective date of the price changes to exceed the change in the consumer price index for the 12-month period ending on December 31 of the preceding year over the 12-month period ending on December 31 of the year prior to the preceding year.

(2) NOTICE REQUIRED. (a) No sooner than 45 calendar days and no later than 30 calendar days before a hospital implements a reportable price increase, it shall publish a class 1 notice of the proposed price increase as provided in this section.

(b) When computing the change in a hospital's gross revenue from patient services for purposes of determining whether a proposed price increase is reportable, a hospital shall include any additional revenue attributable to a price increase, whether reportable or not, within the 12-month period preceding the effective date of the proposed price increase.

(3) CONTENTS OF NOTICE. (a) *Required format.* Each notice under sub. (2) shall include a boldface heading printed in capital letters of at least 18-point type. The text of the notice shall be printed in at least 10-point type. Any numbers printed in the notice shall be expressed as numerals.

(b) *Notice of price increase.* A notice under sub. (2) shall include, at a minimum, all of the following in the following order:

1. A heading entitled, "NOTICE OF PROPOSED HOSPITAL PRICE INCREASE FOR (name of hospital)."

2. The address of the hospital.

3. The beginning and ending dates of the hospital's fiscal year.

4. The total anticipated amount of the price increase, expressed as an annualized percentage.

5. The date the price increase will take effect.

6. The effective date of the hospital's last reportable price increase and the amount of that increase, expressed as an annualized percentage.

7. The name of each charge element listed in table HFS 120.09 for which the hospital proposes to increase the price. A hospital may, but need not, include any charge element for which no price increase is proposed. For each charge element listed, the hospital shall include all of the following information, formatted as follows:

a. Current per unit price.

b. Proposed per unit price.

c. Amount of the price change between subd. 7. a. and b.

d. Percentage of the price change between subd. 7. a. and b.

8. An explanation of the reason for the proposed price increase.

Table HFS 120.09

HOSPITAL CHARGE ELEMENTS

ROOM AND BOARD – PRIVATE
- General classification
- Medical/surgical/gynecology
- Obstetric
- Pediatric
- Psychiatric
- Hospice
- Detoxification
- Oncology
- Other

ROOM AND BOARD – SEMIPRIVATE TWO BED
- General classification
- Medical/surgical/gynecology
- Obstetric
- Pediatric
- Psychiatric
- Hospice
- Detoxification
- Oncology
- Other

NURSERY

- General classification
- Newborn
- Premature
- Neonatal intensive care unit
- Other

INTENSIVE CARE

- General classification
- Surgical
- Medical
- Pediatric
- Psychiatric
- Post-intensive care unit
- Burn care
- Trauma
- Other

CORONARY CARE

- General classification
- Myocardial infarction

INCREMENTAL NURSING CHARGE RATE

- General classification
- Nursery
- Intensive care
- Coronary care

OTHER IMAGING SERVICES

- Mammography, excluding physician fees

EMERGENCY ROOM

- General classification – based on highest volume, excluding physician fees

LABOR ROOM/DELIVERY

- General classification
- Labor
- Delivery
- Circumcision
- Birthing center
- Other

PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS

- General classification
- Electroshock treatment
- Milieu therapy
- Play therapy
- Other

PSYCHIATRIC/PSYCHOLOGICAL SERVICES

- General classification
- Rehabilitation
- Day care
- Night care
- Individual therapy
- Group therapy
- Family therapy

Biofeedback
Testing
Other

(4) AFFIDAVIT OF PUBLICATION. A hospital that publishes any notice under sub. (3) shall require the newspaper in which the notice is published to furnish the hospital with an affidavit of publication attached to a copy of the notice clipped from the paper. The affidavit shall state the name of the newspaper and the date of publication and shall be signed by the editor, publisher, owner or designee of the editor, publisher or owner. Within 14 calendar days after the hospital receives the affidavit of publication, the hospital shall transmit to the department the affidavit and the notice clipped from the newspaper attached.

Note: Health care providers who are required to send their information directly to the department should use the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

HFS 120.10 Liabilities; penalties. (1) DEFINITION. ~~For the purposes of~~ this section, "type of data" means inpatient, ambulatory, fiscal, annual and other health care provider data required to be submitted to the department under this chapter.

(2) CIVIL LIABILITY. In accordance with s. 153.85, Stats., and except as provided in sub. (3), whoever violates the patient confidentiality provisions defined in ss. 153.50 and 153.75(1)(a), Stats., shall be liable to the patient for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation.

(3) IMMUNITY FROM LIABILITY. (a) In accordance with s. 153.86, Stats., and except as provided in par. (b), a health care provider that submits information to the department under this chapter is immune from civil liability for all of the following:

1. Any act or omission of an employe, official or agent of the health care provider that results in the release of a prohibited data element while submitting data to the department.

2. Any act or omission of the department that results in the release of data.

(b) The immunity provided under this subsection does not apply to intentional, wilful or reckless acts or omissions by health care providers.

(4) CRIMINAL PENALTIES. In accordance with s. 153.90 (1), Stats., whoever intentionally violates ss. 153.45(5) or 153.50, Stats., or rules related thereto under subchs. III and V of this chapter may be fined not more than $15,000 or imprisoned for not more than one year in the county jail or both.

(5) FORFEITURES. In accordance with s. 153.90 (2), Stats., whoever violates ch. 153, Stats., or this chapter, except as provided in par. (c), shall forfeit not more than $100 for each violation. Except as stated in s. 153.90 (2), Stats., each day of a violation for each individual type of data the department requires to be submitted constitutes a separate offense.

(a) *Effective date and duration of forfeitures.* 1. 'Forfeiture commencement and duration.' The forfeiture begins on the date the health care provider was in violation, as determined by the department, and is computed for the number of days the health care provider is in violation until the date the health care provider achieves compliance, except that no day in the period between the

date on which a request for a hearing is filed under s. 227.44, Stats., and the date of the conclusion of all administrative and judicial proceedings arising out of a decision under this subsection constitutes a violation.

2. 'Collection of forfeiture.' The department may directly assess forfeitures. If the department determines that a forfeiture should be assessed for a particular violation or for failure to correct the violation, the department shall send a notice of assessment to the alleged violator containing all of the following information:

a. The alleged specific violation of ch. 153, Stats., or this chapter.

b. The amount of the forfeiture per day.

c. The number of days the health care provider was in violation.

d. The total amount due or, if the violation is continuing at the time the notice is sent, a statement specifying how the alleged violator shall calculate the total amount due.

e. The due date of the forfeiture.

f. The right to contest the assessment under s. 227.44, Stats.

3. 'Due date for payment of forfeitures.' All forfeitures shall be paid to the department within 10 calendar days of receipt of notice of assessment or, if the forfeiture is contested under par. (b), within 10 calendar days of receipt of the final decision under administrative review, unless the final administrative decision is appealed and the order stayed by court order under s. 227.52, Stats. Receipt of notice is presumed within 5 days of the date the notice was mailed. The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund.

(b) *Appeals of forfeitures.* A health care provider may contest the department's assessment of a forfeiture by sending, within 10 calendar days after receipt of the department's notification of forfeiture assessment, a written request for hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1), Stats. A request is considered filed when the request is received by the division of hearings and appeals. The division of hearings and appeals shall hold the hearing no later than 30 days after receiving the request for hearing, unless both parties agree to a later date and shall provide at least 10 days prior notification of the date, time and place for the hearing. The hearing examiner shall issue a proposed or final decision within 10 days after the hearing. The decision of the administrator of the division of hearring and appeals shall be the final administrative decision.

Note: A hearing request should be addressed to the division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707, 608-266-3096. Hearing requests may be delivered in person to that office at 5005 University Ave., Room 201, Madison, WI.

(c) *Forfeitures for nonpayment of assessments.* A hospital or freestanding ambulatory surgery center that does not comply with s. HFS 120.04 (4) (b) or health plan that does not comply with s. HFS 120.04 (4) (d) is subject to a forfeiture of $25 for each day after December 31 that the assessment is not paid, subject to a maximum forfeiture equal to the amount of the assessment due or $500, whichever is greater. A forfeiture under this subdivision does not relieve the hospital, association or health care plan from the responsibility of paying the corresponding assessment.

Subchapter III – Data Collection and Submission

HFS 120.11 Common data verification, review and comment procedures. (1) APPLICABILITY. The data verification, review and comment procedures in this section apply to data submitted by hospitals, ambulatory surgery centers as described in ss. HFS 120.12 (5) (c) and (d), (6) (d) and (e) and 120.13 (3) and (4).

(2) DEFINITION. In this section, "facility" means hospitals and freestanding ambulatory surgery centers.

(3) FACILITY DATA VERIFICATION, REVIEW AND COMMENT PROCEDURES. (a) Each facility shall review its collected data for accuracy and completeness before submitting the data to the department.

(b) The department shall check the accuracy and completeness of all submitted data and record all questionable data based on standard edits or the electronic editing features of the department's data submission system.

(c) If the department determines data submitted by the facility to be questionable, and the department has determined that the data cannot be verified or corrected by telephone, the department may return the questionable data to the facility or the facility's qualified vendor with information for revision and resubmission.

(d) The facility shall correct all data errors resulting from the checks performed under this subsection via either the department's or facility's data editing system and complete resubmissions of the corrected data to the department within 10 working days after the facility's receipt of the original data profile.

(e) After the department has made any revisions under par. (d) in the data for a particular facility, the department shall send the facility all of the following:

1. A final data profile under this subsection.

2. An affirmation statement.

(f) The facility shall review the final data profile for accuracy and completeness and shall supply the department within 10 working days after receipt of the original data profile with either of the following:

1. Any corrections to the data.

2. An affirmation statement signed by the chief executive officer or designee indicating that the facility's data are accurate and complete. Facilities submitting affirmation statements to the department electronically shall use a digital signature approved by the department and returned by the facility during the timeframes for data submission specified by the department. A signature on the electronic data affirmation statement represents the signatory's acknowledgment that the data is accurate and the data submitter may no longer submit revised data.

(g) The department may grant an extension for up to 15 calendar days beyond the 10 working days specified in par. (d) if the health care facility adequately justifies to the department the health care facility's need for additional time. Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion or catastrophic computer failure.

(h) If the department discovers data errors after the department's release of the data or if a facility representative notifies the department of data errors after the department's release of the data, the department shall note the data errors as caveats to the completed datasets.

(4) PHYSICIAN VERIFICATION, REVIEW AND COMMENT ON FACILITY-SUBMITTED DATA. During the facility-submitted data verification, review and comment procedures described in sub. (3), the department shall give a physician the opportunity to concurrently review the facility-submitted data associated with the physician's license number.

(a) The department shall notify each physician with a Wisconsin license number identified in the process of the physician's opportunity to review the facility-submitted data associated with their license number.

(b) The department shall notify each identified physician using the physician's last known address on file with the department of regulation and licensing or information provided by the facility that may be more current.

(c) The notice shall include all of the following:

1. A message marked "urgent: dated material."

2. An indication that the physician has 10 working days from the date the notice was postmarked to notify the department that the physician intends to review the requested data before the data is released.

3. A statement informing the physician that the department will not provide further notice of the physician's right to review if the physician chooses not to review the data at that time.

4. Instructions on how the physician may obtain the data.

(d) If a physician files a timely request to review data before release, the department shall promptly send the data to the physician. The department's transmittal shall contain a "permission to change" authorization form that may be duplicated in the event of multiple problems.

1. If the physician wants to dispute the data, the physician shall describe on the form the problem associated with the data and an authorized representative of the facility shall indicate on the form if the facility agrees to the change.

2. The physician shall return the form to the department within 20 working days after the date of the original department transmittal.

3. When the department receives the signed "permission to change" form, the department shall change the data within the facility dataset before its release.

4. If the facility does not agree to the physician's change, the physician may submit his or her written comments on the data to the department within the same 20 working days after the date of the department transmittal. The facility shall also submit its reason for concluding that the submitted data are correct. The department may not change the data submitted by the facility, but shall include both sets of comments with the data released to data requesters.

5. A physician desiring to comment on data he or she submits shall submit his or her comments in a standard electronic word processing format. Comments shall be limited to a maximum of 1000 words. All comments shall be submitted no later than the 20th working day following the department's transmittal.

(e) If the department receives comments from a physician after the release of data, the department shall retain the comments and provide them as part of the documentation released to future data requesters. The department shall note as caveats to the completed data the subsequent discovery of data errors by either the department or the data submitter after the release of data.

HFS 120.12 Data to be submitted by hospitals. (1) UNCOMPENSATED HEALTH CARE PLAN. (a) *Data to be collected.* Hospitals shall provide all of the following data:

1. A set of definitions describing terms used by the hospital throughout the uncompensated health care plan.

2. The procedures the hospital uses to determine a patient's ability to pay for health care services received and to verify financial information from the patient.

3. The hospital's means of informing the public about charity care available at that hospital and a description of the procedure for obtaining the care.

4. The amount of any state loan funds, excluding fund proceeds from the Wisconsin health and educational facilities authority, outstanding with a continuing obligation during the previous year.

(b) *Data submission procedures.* 1. Every hospital shall annually file with the department within 120 calendar days following the close of the hospital's fiscal year the plan required under par. (a).

Note: Health care providers who are required to send their information directly to the department should use the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

2. The department may grant an extension of a deadline specified under subd. 1. only when the hospital adequately justifies to the department the hospital's need for additional time. Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion. A hospital desiring an extension shall submit a request for an extension in writing to the department at least 10 calendar days before the date the data are due. The department may grant an extension for up to 30 calendar days.

(c) *Data verification, review and comment procedures.* 1. Each hospital shall review the plan for accuracy and completeness prior to submitting the plan to the department.

2. The department shall notify a hospital if the plan or any elements of the plan appear to contain questionable data.

3. The hospital shall either verify the accuracy of the plan or send a corrected plan to the department within 10 working days from the date the department notified the hospital of the questionable data.

4. Within the same 10-working day period under subd. 3., the chief executive officer or designee of each hospital shall submit to the department a signed affirmation statement.

a. Hospitals submitting affirmation statements to the department electronically shall use a digital signature approved by the department and returned by the hospital during the timeframes for data submission specified by the department. A signature on the electronic data affirmation statement represents the signatory's acknowledgment that the data is accurate and the data submitter may no longer submit revised data.

b. If the department discovers data errors after the department's release of the data or if a hospital representative notifies the department of data errors after the department's release of the data, the department shall note the data errors as caveats to the completed datasets.

(d) *Data adjustment methods.* There shall be no adjustment methods for uncompensated health care services report data submitted by hospitals.

(e) *Waiver from data submission requirements.* There shall be no waivers from the data submission requirements under this subsection.

(2) HOSPITAL FISCAL SURVEY. (a) *Definition.* In this subsection, "mental health institute" has the meaning given in s. 51.01(12), Stats.

(b) *Data to be collected.* 1. 'General Hospital Data.' Hospitals shall report all of the following financial data to the department in the format specified by the department, in accordance with this subsection and department instructions that are based on guidelines from the July 1998 version of the *Audits of Providers of Health Care Services* published by the American institute of certified public accountants, generally accepted accounting principles and the national annual survey of hospitals conducted by the American hospital association.

a. Gross revenue the hospital derives from services it provides to patients and the sources of that revenue.

b. Deductions from gross revenue the hospital derives from services it provides to patients and the sources of that revenue, including contractual adjustments, charity care and other noncontractual deductions.

c. Net revenue from service to patients.

d. Other revenue.

e. Total revenue.

f. Payroll expenses.

g. Nonpayroll expenses.

h. Total expenses.

i. Expenses for education activities approved by medicare under 42 CFR 412.113 (b) and 412.118 as excerpted from total expenses.

j. Nonoperating gains and losses.

k. Net income.

L. Unrestricted assets.

m. Unrestricted liabilities and fund balances.

n. Restricted hospital funds.

o. Total gross revenue figures for the current and previous fiscal years.

p. Total net revenue figures for the current and previous fiscal years.

q. The dollar difference between gross and net revenue figures for the current and previous fiscal years.

r. The amount of the dollar difference between gross and net revenue figures attributable to a price change, the amount attributable to a utilization change and the amount attributable to any other cause for the current and previous fiscal years.

2. 'Prior year hospital uncompensated care charge data.' The number of patients obtaining uncompensated health care services from the hospital in its most recently completed fiscal year, and the total accrued charges for those services, as determined by all of the following:

a. The number of patients whose accrued charges were attributed to charity care in that fiscal year.

b. The total accrued charges for charity care, based on revenue foregone at full established rates, in that fiscal year.

c. The number of patients whose accrued charges were determined to be a bad debt expense in that fiscal year.

d. The total bad debt expense, as obtained from the hospital's final audited financial statements in that fiscal year.

3. 'Anticipated hospital uncompensated care charge data.' The projected number of patients anticipated to obtain uncompensated health care services from the hospital in its ensuing fiscal year, and the projected charges for those services, as determined by all of the following:

a. The hospital's projected number of patients anticipated to obtain charity care for that fiscal year.

b. The hospital's projected total charges attributed to charity care for that fiscal year.

c. The hospital's projected number of patients anticipated to incur bad debt expenses.

d. The hospital's projected total bad debt expense for that fiscal year.

e. A rationale for the hospital's projections under subdpars. a. to d., considering the hospital's total patients and total accrued charges for the most recently completed fiscal year.

4. 'Hospital uncompensated care obligation data.' If the hospital has a current obligation or obligations under 42 CFR Part 124, the hospital shall report the date or dates the obligation or obligations went into effect, the amount of the total federal assistance believed to be under obligation at the hospital and the date or dates the obligation or obligations will be satisfied.

5. 'Hospitals other than mental health institutes.' a. Each hospital shall submit to the department an extract of the data requested by the department from its final audited financial statements. If the data requested by the department do not appear on the audited financial statements, the hospital shall gather the data from medicare cost reports, notes to the financial statements or other internal hospital financial records. A hospital need not alter the way it otherwise records its financial data in order to comply with this subdivision.

b. If a hospital is jointly operated in connection with a nursing home, a home health agency or other organization, the hospital shall submit the data specified under par. (b) 1. a. to k. for the hospital unit only.

c. If a hospital is jointly operated in connection with a nursing home, a home health agency or other organization, the hospital shall submit the data specified under par. (b) 1. L. to m. for the hospital unit only. If the hospital unit data cannot be separated from the total facility data, the hospital shall report the data for the total facility.

d. County-owned psychiatric or alcohol and other drug abuse hospitals are not required to submit any data specified under par. (b) 1. L. to m.

6. 'Mental health institutes.' a. A mental health institute shall submit to the department an extract of the data requested by the department for a specific fiscal year from the mental health institute's audited or unaudited financial statements. If the audit report is not yet available, the mental health institute may provide unaudited financial statements. If the data requested do not appear on the financial statements, the mental health institute shall gather the data from medicare cost reports, notes to the financial statements or other internal mental health institute financial records.

b. A mental health institute shall submit at least the dollar amounts for the items under par. (b) 1. a. through k. that are available from the state fiscal system.

c. A mental health institute is not required to submit the data specified under par. (b) 1. L. through m.

(c) *Data submission procedures.* 1. A hospital shall submit to the department, no later than 120 calendar days following the close of the hospital's fiscal year, the dollar amounts of the financial data, as specified in paragraph (b).

Note: Health care providers who are required to send their information directly to the department should use the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

2. a. Except as provided in subpar. b., the department may grant an extension of a deadline specified in subd. 1. only when the hospital adequately justifies to the department the hospital's need for additional time. Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion. A hospital desiring an extension shall submit a request in writing

to the department at least 10 calendar days prior to the date that the data are due. The department may grant an extension for up to 30 calendar days.

b. The department may extend the deadline specified in subd. 1. for a mental health institute for up to 90 calendar days upon written request.

(d) *Data verification, review and comment procedures.* 1. Each hospital shall review the data for accuracy and completeness prior to submitting data to the department.

2. The department shall check the accuracy and completeness of all submitted financial data.

3. The department shall notify a hospital if any of the data appear questionable.

4. The hospital shall either verify the accuracy of the data or submit to the department corrected data within 10 working days from the date the department notified the hospital of the questionable data.

5. After the department has made any revisions under subd. 4. in the data for a particular hospital, the department shall send to the hospital a copy of all data variables submitted by that hospital to the department or subsequently corrected by the department.

6. Within the 10 working days specified in subd. 4., the hospital shall review the data for accuracy and completeness and shall supply the department any corrections to the data.

7. Within the same 10-working day period under subd. 6., the chief executive officer or designee of each hospital shall submit to the department a signed affirmation statement.

a. Hospitals submitting affirmation statements to the department electronically shall use a digital signature approved by the department and returned by the hospital during the timeframes for data submission specified by the department. A signature on the electronic data affirmation statement represents the signatory's acknowledgment that the data is accurate and the data submitter may no longer submit revised data.

b. If the department discovers data errors after the department's release of the data or if a hospital representative notifies the department of data errors after the department's release of the data, the department shall note the data errors as caveats to the completed datasets.

(e) *Data adjustment methods*. There shall be no adjustment methods for final audited financial statement data submitted by hospitals.

(f) *Waiver from data submission requirements.* 1. There shall be no waivers from the data submission requirements under this subsection.

2. Hospitals that close, merge or change their reporting fiscal year shall submit a partial final audited financial statement for the applicable partial year.

(3) ANNUAL SURVEY OF HOSPITALS. (a) *Definitions.* In this subsection: 1. "Board" means the certifying body for a medical specialty.

2. "Health maintenance organization" has the meaning specified under s. 609.01 (2), Stats.

(b) *Data to be collected.* Hospitals shall submit to the department, in the format specified by the department, the following data:

1. Type of hospital ownership and tax status.

2. Type of service that best describes the services the hospital provides.

3. Types and status of accreditations, licensure and certifications.

4. Existence of contracts with prepaid health plans, including health maintenance organizations, and other alternative health care payment systems.

5. Provision of selected inpatient, ancillary and other services.

6. Location of services provided.

7. Number of patients using selected services.

8. Number of beds and inpatient utilization for the total facility, including beds set up and staffed, admissions, discharges and days of care.

9. Inpatient utilization by government payers for the total facility.

10. Number of beds and utilization by selected inpatient services.

11. Swing-bed utilization, if applicable, including number of swing beds, admissions and days of care.

12. Use of nursing home services, if applicable, including beds set up and staffed, discharges and days of care.

13. Medical staff information, including availability of contractual arrangements with physicians in a paid capacity, total number of active or associate medical staff by selected specialty and number of board certified medical staff by selected specialty, if applicable.

14. Number of personnel on the hospital's payroll, including hospital personnel, trainees and nursing home personnel by occupational category and by full-time or part-time status.

(c) *Data submission procedures.* 1. A hospital shall submit to the department the data specified in par. (a) according to a schedule specified by the department.

Note: Health care providers who are required to send their information directly to the department should use the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

2. The department may change the due date specified in subd. 1. and if the department does so, the department shall notify each hospital of the change at least 30 days before the data are due.

3. The department may grant an extension of a deadline specified in this paragraph only when the hospital adequately justifies to the department the hospital's need for additional time.

Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion. A hospital desiring an extension shall submit a request for an extension in writing to the department at least 10 calendar days prior to the date that the data are due. The department may grant an extension for up to 30 calendar days.

(d) *Data verification, review and comment procedures.* 1. Each hospital shall review the data for accuracy and completeness prior to submitting the survey to the department.

2. The department shall check the accuracy and completeness of all submitted information.

3. If the department has contacted the hospital and has determined that resubmission of the survey is necessary, the department shall return questionable survey response data to the hospital that submitted the survey with information for revision and resubmission.

4. The hospital shall resubmit the survey returned by the department to the hospital within 10 working days after the hospital's receipt of the questionable survey.

5. After the department has made any revisions under subd. 3. in the information for a particular hospital, the department shall send the hospital a copy of all variables submitted by that hospital to the department or subsequently corrected by the department.

6. The hospital shall review the survey for accuracy and completeness and shall supply the department within the 10 working days specified in subd. 4. after receipt of the questionable survey with any corrections.

7. Within the 10-working day period under subd. 4., the chief executive officer or designee of each hospital shall submit to the department a signed affirmation statement.

a. Hospitals submitting affirmation statements to the department electronically shall use a digital signature approved by the department and returned by the hospital during the timeframes for data submission specified by the department. A signature on the electronic data affirmation statement represents the signatory's acknowledgment that the data is accurate and the data submitter may no longer submit revised data.

b. If the department discovers survey errors after the department's release of the data or if a hospital representative notifies the department of survey errors after the department's release of the data, the department shall note the data errors as caveats to the completed datasets.

(e) *Data adjustment methods.* There shall be no adjustment methods for annual hospital survey data submitted by hospitals.

(f) *Waiver from data submission requirements.* 1. There shall be no waivers from the data submission requirements under this subsection.

2. Hospitals that close, merge or change their reporting fiscal year shall submit a partial final audited financial statement for the applicable partial year.

(4) PUBLISHED NOTICES OF HOSPITAL RATE INCREASES OR CHARGES IN EXCESS OF RATES. (a) *Data to be collected.* Under s. HFS 120.09 (4), hospitals shall submit all newspaper notices and affidavits of publication to the department.

(b) *Data submission procedures*. Under s. HFS 120.09(4), hospitals shall submit a newspaper notice and affidavit of publication to the department within 14 calendar days after the hospital receives the affidavit of publication.

Note: Health care providers who are required to send their information directly to the department should use the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

(c) *Data verification, review and comment procedures*. There shall be no verification, review and comment procedures for published notices submitted by hospitals.

(d) *Data adjustment methods*. There shall be no adjustment methods for published notices submitted by hospitals.

(e) *Waiver from data submission requirements*. There shall be no waivers from the data submission requirements under this subsection.

(5) UNIFORM INPATIENT DISCHARGE DATA. (a) *Data to be collected.* Hospitals shall submit to the department all of the following data for each patient:

1. Federal tax identification number of the hospital.

2. Patient control number.

3. Patient medical record or chart number.

4. Discharge date.

5. Patient zip code.

6. Patient birth date.

7. Patient gender.

8. Admission date.

9. Type of admission.

10. Source of admission.

11. Patient discharge status.

12. Condition codes.

13. Adjusted total charges and components of those charges.

14. Leave days.

15. Primary payer identifier and type.

16. Secondary payer identifier and type.

17. Principal and other diagnosis codes.

18. External cause of injury codes.

19. Principal and other procedure codes.

20. Date of principal procedure.

21. Attending physician license number.

22. Other physician license number, if applicable.

23. Patient race.

24. Patient ethnicity.

25. Type of bill identifying the location of service.

26. Encrypted case identifier.

27. Insured's policy number.

28. Diagnosis present at admission.

(b) *Data submission procedures.* 1. Each hospital shall electronically submit the data elements required under par. (a). The method of submission, data formats and coding specifications shall be defined in the department's data submission manual.

2. Hospitals shall send the data to the department within 30 days of the last day of each calendar quarter using the department's electronic submission system. Calendar quarters shall begin on January 1, April 1, July 1 and October 1 and shall end on March 31, June 30, September 30 and December 31.

3. Upon written request, the department shall provide consultation to a hospital to enable the hospital to submit data according to department specifications.

4. The department may grant an extension of the time limits specified under subd. 2. only when the hospital adequately justifies to the department the hospital's need for additional time. Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion. A hospital desiring an extension shall submit a request for an extension in writing to the department at least 10 calendar days prior to the date that the data are due. The department may grant an extension for up to 30 calendar days.

5. Each hospital shall submit inpatient data electronically with physical specifications, format and record layout in accordance with the department's data submission manual.

6. a. To ensure confidentiality, hospitals using qualified vendors to submit data shall submit a trading partner agreement to the department that has been signed by the qualified vendor.

b. Hospitals shall be accountable for their qualified vendor's failure to submit data in the formats required by the department.

(c) *Data verification, review and comment procedures.* The data verification, review and comment procedures specified in ss. HFS 120.11 (1) to (3) shall apply.

(d) *Physician verification, review and comment on hospital-submitted claims data*. The data verification, review and comment procedures specified in ss. HFS 120.11 (1), (2) and (4) shall apply.

(e) *Data adjustment methods*. The department shall adjust health care charge and mortality information for case mix and severity using commonly acceptable methods and tools designed for administrative claims information to perform adjustments for a class of health care providers.

(f) *Waiver from data submission requirements*. There shall be no waivers from the data submission requirements under this subsection.

(6) AMBULATORY SURGICAL DATA. (a) *Definition*. In this subsection "hospital-affiliated ambulatory surgical center" means an entity that is owned by a hospital and is operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with the federal health care financing administration under 42 CFR 416.25 and 416.30 to participate as an ambulatory surgery center, and meets the conditions set forth in 42 CFR 416.25 to 416.49.

(b) *Data to be collected*. 1. 'Types of procedures reported.' Hospitals shall report to the department information relating to any ambulatory patient surgical procedure within any of the following general types:

a. Operations on the integumentary system.

b. Operations on the musculoskeletal system.

c. Operations on the respiratory system.

d. Operations on the cardiovascular system.

e. Operations on the hemic and lymphatic systems.

f. Operations on the mediastinum and diaphragm.

g. Operations on the digestive system.

h. Operations on the urinary system.

i. Operations on the male genital system.

j. Intersex surgery.

k. Laparoscopy and hysteroscopy.

L. Operations on the female genital system.

m. Maternity care and delivery.

n. Operations on the endocrine system.

o. Operations on the nervous system.

p. Operations on the eye and ocular adnexa.

q. Operations on the auditory system.

2. 'Data elements collected.' Hospitals shall report information on specific ambulatory patient discharges required under subd. 1. from a hospital outpatient department or a hospital-affiliated ambulatory surgical center. The following data elements shall be submitted for each discharge:

a. Federal tax identification number of the hospital.

b. Patient control number.

c. Patient medical record or chart number.

d. Date of principal procedure.

e. Patient zip code.

f. Patient birth date.

g. Patient gender.

h. Adjusted total charges and components of those charges.

i. Primary payer identifier and type.

j. Secondary payer identifier and type.

k. Principal and other diagnosis codes.

L. External cause of injury codes.

m. Principal and other procedure codes.

n. Attending physician license number, if applicable.

o. Other physician license number.

p. Patient race.

q. Patient ethnicity.

r. Type of bill.

s. Encrypted case identifier.

t. Insured's policy number.

(c) *Data submission procedures.* 1. Each hospital shall submit to the department all data described in par. (a). The method of submission shall be defined in the department's data submission manual.

2. Within 30 calendar days after the end of each calendar quarter, each hospital shall submit to the department the surgical data specified in par. (a) for all ambulatory patient discharges using the department's electronic submission system. The department's electronic submission system shall be described in the department's data submission manual. Calendar quarters shall begin on January 1, April 1, July 1 and October 1 and shall end on March 31, June 30, September 30 and December 31.

3. The department may grant an extension of the deadline specified under subd. 2. only when the hospital adequately justifies to the department the hospital's need for additional time. Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion. A hospital desiring an extension shall submit a request for an extension in writing to the department at least 10 calendar days before the date the data are due. The department may grant an extension for up to 30 calendar days.

4. Each hospital shall submit ambulatory patient surgical data electronically with physical specifications, format and record layout in accordance with the department's data submission manual.

5. Upon written request, the department shall provide consultation to a hospital to enable the requesting hospital to submit ambulatory patient surgical data according to the department's specifications.

6. a. To ensure confidentiality, hospitals using qualified vendors to submit data shall submit a trading partner agreement to the department that has been signed by the qualified vendor and the hospital.

b. Hospitals shall be accountable for their qualified vendor's failure to submit data in the formats required by the department.

(d) *Data verification, review and comment procedures.* The data verification, review and comment procedures specified in ss. HFS 120.11 (1) to (3) shall apply.

(e) *Physician verification, review and comment procedures on hospital-submitted ambulatory surgical data.* The data verification, review and comment procedures specified in ss. HFS 120.11 (1), (2) and (4) shall apply.

(f) *Data adjustment methods.* The department shall adjust health care charge information for case mix and severity using commonly acceptable methods and tools designed for administrative claims information to perform adjustments for a class of health care providers.

(g) *Waiver from data submission requirements.* There shall be no waivers from the data submission requirements under this subsection.

HFS 120.13 Data to be submitted by freestanding ambulatory surgery centers. (1) DATA TO BE COLLECTED. (a) *Types of procedures reported.* Freestanding ambulatory surgery centers shall report to the department information relating to any ambulatory patient surgical procedure within any of the following general types:

1. Operations on the integumentary system.

2. Operations on the musculoskeletal system.

3. Operations on the respiratory system.

4. Operations on the cardiovascular system.

5. Operations on the hemic and lymphatic systems.

6. Operations on the mediastinum and diaphragm.

7. Operations on the digestive system.

8. Operations on the urinary system.

9. Operations on the male genital system.

10. Intersex surgery.

11. Laparoscopy and hysteroscopy.

12. Operations on the female genital system.

13. Maternity care and delivery.

14. Operations on the endocrine system.

15. Operations on the nervous system.

16. Operations on the eye and ocular adnexa.

17. Operations on the auditory system.

(b) *Data elements collected.* Freestanding ambulatory surgery centers shall report information on specific ambulatory patient discharges required under par. (a). The center shall submit the following data elements for each discharge:

1. Federal tax number of the freestanding ambulatory surgery center.

2. Patient control number.

3. Patient medical record or chart number.

4. Date of principal procedure.

5. Patient zip code.

6. Patient birth date.

7. Patient gender.

8. Adjusted total charges and components of those charges.

9. Primary payer identifier and type.

10. Secondary payer identifier and type.

11. Principal and other diagnosis codes.

12. External cause of injury codes.

13. Principal and other procedure codes.

14. Attending physician license number, if applicable.

15. Other physician license number.

16. Patient race.

17. Patient ethnicity.

18. Type of bill.

19. Encrypted case identifier.

20. Insured's policy number.

(2) DATA SUBMISSION PROCEDURES. (a) Each freestanding ambulatory surgery center shall electronically submit to the department, as described in the department's data submission manual, all data elements specified in sub. (1) for all ambulatory patient discharges within 30 calendar days after the end of each calendar quarter. Calendar quarters shall begin on January 1, April 1, July 1 and October 1 and shall end on March 31, June 30, September 30 and December 31. The method of submission, data formats and coding specifications shall be defined in the department's data submission manual.

(b) The department may grant an extension of the time limits specified under par. (a) only when the center adequately justifies to the department the center's need for additional time. Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion. A center desiring an extension shall submit a request for an extension in writing to the department at least 10 calendar days prior to the date that the data are due. The department may grant an extension for up to 30 calendar days.

(c) Upon written request, the department shall provide consultation to a freestanding ambulatory surgical center to enable the requesting center to submit ambulatory patient surgical data according to the department's specifications.

(d) 1. To ensure confidentiality, centers using qualified vendors to submit data shall submit a trading partner agreement to the department that has been signed by the qualified vendor and the ambulatory surgery center.

2. Centers shall be accountable for their qualified vendor's failure to submit and edit data in the formats required by the department.

(3) FREESTANDING AMBULATORY SURGERY CENTER DATA VERIFICATION, REVIEW AND COMMENT PROCEDURES. The data verification, review and comment procedures specified in ss. HFS 120.11 (1) to (3) shall apply.

(4) PHYSICIAN VERIFICATION, REVIEW AND COMMENT ON FREESTANDING AMBULATORY SURGERY CENTER-SUBMITTED DATA. The data verification, review and comment procedures specified in ss. HFS 120.11 (1), (2) and (4) shall apply.

(5) DATA ADJUSTMENT METHODS. The department shall adjust health care charge information for case mix and severity using commonly acceptable methods and tools designed for administrative claims information to perform adjustments for a class of health care providers.

(6) WAIVER FROM DATA SUBMISSION REQUIREMENTS. There shall be no waivers from the data submission requirements under this section.

HFS 120.14 Data to be submitted by physician class of provider. (1) CLAIMS DATA. (a) *Data to be collected.* Physicians shall submit all of the following data elements:

1. Patient's birth date.

2. Patient's gender.

3. Patient zip code.

4. Patient condition related to employment.

5. Patient condition related to auto accident.

6. Patient condition related to other accident.

7. Date of current illness, injury or pregnancy.

8. The first date of illness, if patient has had same or similar illness.

9. Primary payer category code.

10. Secondary payer category code.

11. Medical record or chart number.

12. Name of referring physician.

13. Identification number of referring physician.

14. Patient control number.

15. Whether tests were sent to an outside lab.

16. Outside lab charges.

17. Diagnosis or nature of illness or injury.

18. Medicaid resubmission code.

19. Prior authorization number.

20. Dates of service.

21. Place of service.

22. Type of service.

23. Codes for procedures, services or supplies.

24. Modifiers.

25. Charges.

26. Days or units.

27. Encrypted case identifier.

28. Provider employer identification number.

29. Patient account number.

30. Whether the provider accepts assignment.

31. Total charge.

32. Name of facility where services were rendered.

33. Address of facility where services were rendered.

34. Physician's and supplier's billing name.

35. Physician's and supplier's billing address.

36. Billing physician's identification number.

37. Performing physician's identification number.

(b) *Data submission procedures.* 1. Non-exempt physicians shall submit claims information to the department in an electronic format specified in a data submission manual provided by the department. Physicians shall send the information using an internet browser technology, over a secure internet protocol, using authentication and encryption to assure the safe transmission of data to the department. Physicians who submit data through a qualified vendor shall require their vendor to comply with the requirements specified in this paragraph. In addition, qualified vendors shall sign a trading partner agreement.

2. Each physician shall submit his or her monthly data to the department within 30 calendar days following the close of the reporting period. The department shall provide instructions on submission in a data submission manual.

3. The department may grant an extension of the deadline specified under subd. 2. only when the physician adequately justifies to the department the physician's need for additional time. Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion. A physician desiring an extension shall submit a request for an extension in writing to the department at least 10 calendar days prior to the date that the data are due. The department may grant an extension for up to 30 calendar days.

4. a. To ensure confidentiality of the data is maintained, physicians using qualified vendors to submit data shall submit to the department a trading partner agreement.

b. Physicians shall be accountable for their qualified vendor's failure to submit and edit data in the format required by the department.

5. A health care provider that is not a hospital or ambulatory surgery center shall, before submitting information required by the department under this chapter, convert any names of an insured's payer or other insured's payer to a payer category code as specified by the department in it's data submission manual.

6. A health care provider may not submit information that uses any of the following as a patient account number:

a. The patient's social security number or any substantial portion of the patient's social security number.

b. A number that is related to another patient identifying number.

(c) *Data verification, review and comment procedures.* 1. The department shall check the accuracy and completeness of all submitted data.

2. If the physician submits any of the following data elements, the department shall immediately return the information to the physician, or, if the department subsequently discovers the data, the department shall permanently destroy, delete or make non-identifiable the data from its database:

a. The patient's name and street address.

b. The insured's name, street address and telephone number.

c. Any other insured's name, employer or school name and date of birth.

d. The signature of the patient or other authorized signature.

e. The signature of the insured or other authorized signature.

f. The signature of the physician.

g. The patient's account number, after use only as verification of data by the department.

h. The patient's telephone number.

i. The insured's employer's name or school name.

j. Data regarding insured's other than the patient, other than the payer category code under par. (b) 5.

k. The patient's employer's name or school name.

L. The patient's relationship to the insured.

m. The insured's identification number.

n. The insured's policy or group number.

o. The insured's date of birth or sex.

p. The patient's marital, employment or student status.

3. If the data submitted by a physician passes the department's editing processes, the department shall send a data profile to the physician or their qualified vendor indicating what has been sent and an affirmation statement. The physician or their qualified vendor shall review the profile and verify the accuracy of the profile's data.

4. a. If the department determines data submitted by a physician or qualified vendor to be questionable, the department may return the questionable data in a data profile to the physician or their qualified vendor with information for revision and resubmission.

b. The physician or their qualified vendor shall correct all data errors resulting from checks performed under this paragraph via either the department's, physician's or qualified vendor's data editing system and complete resubmissions of the corrected data to the department within 10 working days after the physician's or their qualified vendor's receipt of the data profile.

c. After the department receives data revisions and additional records, the department shall aggregate each physician's data and shall send the physician a copy of the revised data in a final data profile and an affirmation statement.

5. The physician shall review the final data profile for accuracy and completeness and shall supply the department within 10 working days after receipt of the original data profile either of the following:

a. Any additional corrections or additions to the data.

b. A signed affirmation statement. Physicians submitting affirmation statements to the department electronically shall use a digital signature approved by the department and returned by the physician during the timeframes for data submission specified by the department. A physician's signature on the electronic data affirmation statement represents the physician's acknowledgment that the data is accurate and the data submitter may no longer submit revised data.

6. If the department discovers data errors after the department's release of the data or if a physician notifies the department of data errors after the department's release of the data, the department shall note the data errors as caveats to the completed datasets.

7. The department shall include a comment file with each of the physician databases. Physicians desiring to comment on data they submit shall submit their comments in a standard electronic word processing format. Comments shall be limited to a maximum of 1000 words. All comments shall be submitted with the electronic data affirmation statement no later than the 10th working day following the physician's receipt of the data profile.

8. The department may randomly or for cause audit physician-submitted data to verify the reliability and validity of the data.

9. The department may grant an extension for up to 15 calendar days beyond the 10 working days specified in subd. 4. b. if the physician adequately justifies to the department the physician's need for additional time. Adequate justification may include a strike, fire, natural disaster or delay due to data system conversion or catastrophic computer failure.

(d) *Data adjustment methods*. The department shall adjust health care charge and mortality information for case mix and severity using commonly acceptable methods and tools designed for administrative claims information to perform adjustments for physician-submitted data.

(e) *Waiver from data submission requirements*. 1. Physicians practicing anytime during calendar year 1998 and submitting claims data to the department electronically shall continue to submit their practice data to the department electronically.

2. Physicians beginning practice in Wisconsin after calendar year 1998 who have the capacity to submit claims data electronically as evidenced by electronic submission to payers shall submit data to the department electronically.

3. The department may grant up to four 6-month exceptions to the requirements in subd. 1. or 2. to physician practices that request an exception to the submission requirements and submit an affidavit as evidence of lost capacity to submit data electronically.

a. The department shall cancel the exception to the submission requirements after 6 months unless the physician requests another exception in writing.

b. If the department discovers evidence of electronic submission of health care claims data within the exception period, the department shall not grant additional exceptions.

4. The department shall report all exceptions granted by the department under subd. 3. to the board of health care information.

5. The department may grant an exception to the requirements in subd. 1. or 2. to a physician who submits an affidavit of financial hardship and supporting evidence demonstrating financial inability to comply with the requirements.

(2) PHYSICIAN SELF-REPORT. (a) *Data to be collected*. 1. 'Health care plan affiliation and updates.' Physicians shall report new affiliations with health care plans and terminations with health care plans to the department within 30 calendar days of the change.

2. 'Hospital privileges update.' Physicians shall report hospital privilege changes to the department within 30 days of the hospital's granting of the privileges or the discontinuance of the privileges.

(b) *Data submission procedures.* Physicians shall report the information in par. (a) to the department through the department's internet submission system. Physicians without access to the internet shall mail their changes to the department.

Note: For the purposes of par. (b), the Department's address is Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

(c) *Data verification, review and comment procedures.* The department shall, within 15 working days, send an acknowledgement to the reporting physician verifying the self-report and inviting the physician to submit corrected data within 10 working days.

(d) *Data adjustment methods.* There shall be no adjustment methods for data submitted under this subsection.

(e) *Waiver from data submission requirements.* There shall be no waivers from the data submission requirements under this subsection.

(3) PHYSICIAN SURVEY. (a) *Data to be collected.* The department shall collect all of the following types of workforce and practice information:

1. Name of the physician and address or addresses of main practice or employment.

2. Active status information.

3. License or certification status, including date of initial licensure or certification, credential suspensions or revocations.

4. Medical education and training information.

5. Specialty, board certification and recertification information.

6. Teaching focus information, if applicable.

7. Practice information, including practice name, location, phone number, hours spent at location and provision of obstetrical, pediatric or prenatal care.

8. Whether the physician renders services to medicare and medical assistance patients and, if applicable, whether the physician has signed a medicare participation agreement indicating that she or he accepts assignment on all medicare patients.

9. Whether the physician participates in a voluntary partnercare program specified under s. 71.55 (10), Stats., under which assignment is accepted for low-income elderly.

10. Date, state and county of most recent residency.

11. Current names and addresses of facilities at which the physician has been granted privileges.

12. The usual and customary charges for office visits, routine tests and diagnostic workups, preventive measures and frequently occurring procedures, as specified by the department.

13. Health plan affiliations.

(b) *Data submission procedures*. 1. Physicians shall return the survey to the department within 30 days of receiving it. Receipt of data is presumed within 5 days of the date the notice was mailed.

2. The department may grant an extension of a deadline specified in subd. 1. for submission of information only when the physician adequately justifies to the department the physician's need for additional time. Adequate justification may include a labor strike, fire or a natural disaster. A physician desiring an extension shall submit a request for an extension in writing to the department at least 10 calendar days prior to the date that the data are due. The department may grant an extension for up to 30 calendar days. Physicians who have been granted an extension by the department shall submit their data directly to the department.

Note: Physicians who are required to send their information directly to the department should use the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

(c) *Data verification, review and comment procedures*. Physicians shall verify or correct information contained on their survey. The department shall verify questionable information by contacting the applicable physician.

(d) *Data adjustment methods*. There shall be no adjustment methods for data submitted under this subsection.

(e) *Waiver from data submission requirements*. There shall be no waivers from the data submission requirements under this subsection.

HFS 120.15 Data to be submitted by other classes of health care providers. (1) APPLICABILITY. This section applies to all of the following classes of health care providers:

(a) Dentists licensed under ch. 447, Stats.

(b) Chiropractors licensed under ch. 446, Stats.

(c) Podiatrists licensed under ch. 448, Stats.

(2) DATA TO BE COLLECTED. (a) In this subsection, "board" means the certifying body for a medical specialty.

(b) For each of the providers specified in sub. (1), the department shall collect all of the following types of workforce and practice information:

1. Name of the provider and address or addresses of main practice or employment.

2. Date of birth.

3. License or certification status, if applicable, including date of initial licensure or certification, credential suspensions or revocations.

4. Specialty, board certification and recertification information, if applicable.

5. Post-secondary education and training.

6. Whether the provider renders services to medicare and medical assistance patients and, if applicable, whether the provider has signed a medicare participation agreement indicating that she or he accepts assignment on all medicare patients.

7. Whether the provider participates in a voluntary partnercare program specified under s. 71.55 (10), Stats., under which assignment is accepted for low-income elderly.

8. Current names and addresses of facilities at which the provider has been granted privileges, if applicable.

9. The usual and customary charges for office visits, routine tests and preventive measures and frequently occurring procedures, as specified by the department.

10. Participation in health maintenance organizations, preferred provider organizations and independent practice arrangements.

11. Practice name, location, phone number and hours spent at location.

12. Type of degree or certification.

13. Date degree or certification granted.

14. Date, state and county of most recent residency.

(c) If the data specified in par. (b) is not available from the department of regulation and licensing, or is not available for the desired time interval or in the required format, the department shall require the health care provider to submit that information directly to the department or its designee in a format prescribed by the department.

(d) The department shall consult with each applicable health care provider group specified in sub. (1), through a technical advisory committee or trade association, before the department collects data directly from members of that health care provider group.

(3) DATA SUBMISSION PROCEDURES. (a) The department shall require that information specified in sub. (2) be submitted to the department at least once every three years according to a schedule developed by the department. The department may require that the requested information be submitted on an annual or biennial basis according to a schedule developed by the department.

(b) The department may grant an extension of a deadline specified in par. (a) for submission of health care provider information only when the health care provider adequately justifies to the department the health care provider's need for additional time. Adequate justification may include a labor strike, fire or a natural disaster. A health care provider desiring an extension shall submit a request for an extension in writing to the department at least 10 calendar days prior to the date that the data are due. The department may grant an extension for up to 30 calendar days. Health care providers who have been granted an extension by the department shall submit their data directly to the department.

Note: Health care providers who are required to send their information directly to the department should use the following address: Bureau of Health Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to Room 372, 1 W. Wilson Street, Madison, Wisconsin.

(4) DATA VERIFICATION, REVIEW AND COMMENT PROCEDURES. Health care providers specified in sub. (1) shall verify or correct information contained on their survey. The department shall verify questionable data by contacting the applicable health care provider.

(5) DATA ADJUSTMENT METHODS. There shall be no adjustment methods for data submitted under this section.

(6) WAIVER FROM DATA SUBMISSION REQUIREMENTS. There shall be no waivers from the data submission requirements under this section.

Note: With the exception of s. HFS 120.15, under s. 153.90 (2), Stats., and s. 120.10 (3) (b), the Department may assess fines on health care providers that do not submit the data specified in this subchapter on a timely basis. Health care providers may be subject to a fine of $100 per day per type of data that has not been submitted to the Department under this subchapter.

HFS 120.16 Health care plan data. (1) APPLICABILITY. This section applies to health care plans that either voluntarily submit health care plan data directly to the department or submit it to the department through the data collection of other state agencies.

(2) DATA TO BE COLLECTED. The department shall collect all of the following types of data from each participating health care plan or through a designated state agency:

(a) *Financial data*. Information regarding the financial status of the health care plan secured under the authority of the commissioner of insurance.

(b) *Market conduct*. Information regarding the conduct of the health care plan in the marketplace secured under the authority of the commissioner of insurance.

(c) *Quality indicators*. Measures of quality of care provided by the health care plan from the office of the commissioner of insurance.

Note: Quality indicators include Health Plan Employer Data and Information (HEDIS) measures and Consumer Assessment of Health Plans (CAHPS) patient satisfaction measures.

(d) *Grievances and complaints data*. Measures of grievances and complaints filed by enrollees of the health care plan from the office of the commissioner of insurance and the department of employe trust funds.

(3) DATA SUBMISSION PROCEDURES. State agencies specified in sub. (2) shall forward to the department information specified in sub. (2) in electronic files on an annual basis. The information shall be in a format that has been agreed upon by the department and the state agencies.

(4) DATA VERIFICATION, REVIEW AND COMMENT PROCEDURES. Each of the state agencies specified in sub. (2) shall verify that the information provided to the department has been reviewed and meets the agency's standards for release to the public.

(5) DATA ADJUSTMENT METHODS. The department shall include caveats regarding the information the department releases to the public, when needed, to assist consumers in understanding the differences in populations served by the health care plans. Caveats may include references to large populations, such as commercial, medicaid or medicare populations.

Subchapter IV - Standard Reports

HFS 120.20 General provisions. (1) STANDARD REPORTS. The department shall prepare the paper reports listed in this subsection and shall make these paper reports available to the public at a charge that meets the department's cost of printing, copying and mailing a report to the requester. The department shall make electronic copies of the reports available from the department's website at no charge.

(a) Hospital rate increase report.

(b) Patient-level data utilization, charge and quality report.

(c) Guide to Wisconsin hospitals report.

(d) Uncompensated health care services report.

(e) Consumer guide.

(f) Hospital quality indicators.

(2) PROHIBITION ON EARLY RELEASE OF REPORTS. If the department releases drafts of any of the standard reports to health care providers for comment, health care providers or subsequent holders of the drafts may not release these reports or data elements from the reports.

(3) OPEN RECORDS APPLICABILITY. (a) Except as prohibited under par. (b), the data used to compile the reports under this chapter are not subject to inspection, copying or receipt as specified in the open records provisions under s. 19.35 (1), Stats. When the department completes the reports and distributes them to the governor and legislature the reports shall be publicly available.

(b) Data collected under ss. HFS 120.12 to 120.16 shall not be subject to inspection, copying or receipt as specified in the open record provisions under s. 19.35 (1), Stats.

HFS 120.21 Guide to Wisconsin hospitals. (1) DATA SOURCES. The guide to Wisconsin hospitals shall be based on data derived from all of the following sources:

(a) The annual hospital fiscal survey.

(b) The annual survey of hospitals.

(2) CONTENTS. The guide to Wisconsin hospitals shall present descriptive financial, utilization and staffing information about individual Wisconsin hospitals, as well as summary and trend information for selected aggregate data.

(a) *Hospital information*. The guide shall present and interpret all of the following information for all Wisconsin hospitals individually and in the aggregate:

1. Income statement data.

2. Payor source.

3. Hospital type.

4. Average inpatient stay.

5. Number of outpatient visits.

6. Balance sheet data.

7. Occupancy rate.

8. Number and type of beds set up and staffed.

9. Number of discharges.

10. Number of inpatient days.

11. Average census.

12. Number of full-time equivalent staff by occupational category.

13. Type of inpatient service.

14. Type of ancillary or other hospital service.

15. Hospital analysis area.

16. Hospital volume group.

(b) *Explanatory information*. In addition to the information specified under par. (a), the guide shall present all of the following information:

1. A glossary of terms used in the guide.

2. Caveats, data limitations and technical notes associated with the guide.

3. A copy of the department's annual survey of hospitals.

4. A copy of the department's hospital fiscal survey.

(3) REPORT DISSEMINATION. The department shall distribute the paper version of the report at no charge to the governor, the legislature and a board-approved list of individuals and agencies. The department shall make the paper version of the report available for purchase by others. The department shall make available from the department's website an electronic version of the report at no charge.

(4) SUGGESTED USES OF REPORT. The guide may be used in a variety of ways. Examples of how to use the guide include all of the following:

(a) As a tool to evaluate the fiscal health and operating efficiency of hospitals in Wisconsin.

(b) In conjunction with other department data on hospital inpatient discharges and ambulatory surgeries, to evaluate levels of reimbursement or coverage provisions.

(c) In conjunction with other information, to determine patterns of hospital service availability statewide. Service availability patterns, in turn, can help policy-makers and others identify mechanisms that may enhance service accessibility and availability, such as targeting reimbursement incentives or establishing new or additional health service programs.

(d) As a resource document for persons wishing to conduct research or collect information on hospital utilization, services and finances.

HFS 120.22 Utilization, charge and quality reports. (1) DATA SOURCES. The utilization, charge and quality reports shall be based on four broad types of data:

(a) Facility-level data derived from all of the following sources:

1. The annual hospital fiscal survey.

2. The annual survey of hospitals.

(b) Workforce practice information collected under ss. HFS 120.13 (4) and 120.14.

(c) Patient information derived from billing forms submitted by health care providers. Patient information may include any data element contained in billing forms except those that are confidential in nature or that might otherwise allow a patient to be identified. Data elements include patient age, sex, county, diagnoses, procedures, charges and expected payer. Hospital data elements also include source and type of admission and discharge status.

(d) Information collected from the department of regulation and licensing regarding practices, specialties, education and licensing, certification and credential revocation and suspension information of individual health care providers licensed to practice in Wisconsin.

(2) CONTENTS. The utilization, charge and quality reports summarize utilization, charge and quality data on patients treated by health care providers in Wisconsin during the most recent calendar year. The report contains information on services provided to hospital inpatients, the primary reasons for hospitalization, length of stay, expected pay source, discharge status, volume of procedures, charges for services received, and the most common diagnostic conditions. The report also contains selected utilization, charge and quality indicators for individual hospitals and makes comparisons to previous year data, thereby assisting readers in understanding where changes are occurring. The report devoted to outpatient data contains utilization and charge data for patients undergoing selected surgical procedures at hospitals, freestanding ambulatory surgery centers and physician's offices. Some of the specific contents of the reports include the following topics:

(a) A summary of patient-related data and how that data compares to similar data from the previous year.

(b) A reader's guide to the report's data containing an explanation of data sources, terms, concepts and data limitations.

(c) An overview of utilization and charge information in Wisconsin, including an explanation of the difference between patient retail charges and patient discounted charges.

(d) Information on quality indicators.

(e) Information on injury codes.

(f) Tables for individual health care providers providing both raw data and data adjusted for patient severity.

(g) An explanation of how data are adjusted for patient severity.

(h) A list of health care facilities or providers.

(3) REPORT DISSEMINATION. The department shall distribute a paper version of the reports at no charge to the governor, the legislature and a board-approved list of individuals and agencies. The department shall make the paper version report available for purchase by others. The department shall make available from the department's website an electronic version of the report at no charge.

(4) SUGGESTED USES OF REPORT. Comprised of summary data, the report provides either totals or averages. The report can provide health care providers, consumers, researchers and policymakers with a basis for facility and health care provider comparisons, trend analyses, utilization and charge summaries. Examples of information the report may contain include all of the following:

(a) The average charge, adjusted for severity, for selected medical or surgical treatments.

(b) The health care provider's charges for selected services, adjusted for severity.

(c) Possible areas for future research, such as variations among health care providers in utilization or charges.

(d) Quality indicators that can be associated with variations in care delivery, including complication rates, volume of procedures and patient satisfaction.

(e) A description of why charges vary among health care providers.

(f) Trends in health care utilization and charges.

(g) Reasons for physician visits.

HFS 120.23 Consumer guide. (1) DATA SOURCES. The consumer guide shall draw on the following data sources:

(a) Bureau of health information databases, including those related to inpatient stays, ambulatory visits, physician encounters, facility financial and services information and health care provider workforce data.

(b) Databases of other department agencies, including those of the division of health care financing and the bureau of quality assurance.

(c) Databases of other state agencies, including the office of the commissioner of insurance for information related to health plan finances, market conduct, complaints and grievances, and quality indicators.

(d) Other private sector information available through various websites.

(e) Federal databases, including those of the health care financing administration.

(2) CONTENTS. The consumer guide shall contain information on all of the following:

(a) How to find and choose a doctor, hospital, health care plan, nursing home or other health care provider.

(b) How to get health insurance or enroll in medicare, medicaid, badgercare or family care and where to go with health care coverage or payment questions or problems.

(c) Where to learn about specific conditions, illnesses or injuries.

(d) Other websites and related information sources that provide information on health care questions.

(3) REPORT DISSEMINATION. The department shall make available from the department's website an electronic version of the consumer guide at no charge. The department shall distribute a paper, summary version of the consumer guide at no charge to the governor, the legislature and a board-approved list of individuals and agencies. The department shall make the paper, summary version of the consumer guide available for purchase by others.

(4) SUGGESTED USE OF THE CONSUMER GUIDE. Consumers can use the consumer guide to assist them in selecting providers for any of the following health care plans or providers:

(a) *Health care plan.* If available to the department, the following types of data for individual health care plans shall be contained in the consumer guide and may supplement consumers' age, health status, mobility and financial resources as important factors consumers should consider when selecting a health care plan:

1. Health plan costs, such as premium per member.

2. Affiliations of specific physicians, clinics or hospitals.

3. Satisfaction of enrollees with access to providers.

4. Satisfaction of enrollees with service locations.

5. Measures of financial strength, such as profit margins and administrative versus medical costs.

6. Clinical process and outcome measures, such as those required for accreditation by the national committee for quality assurance or participation in the Wisconsin medicaid program.