CR 83-116

CERTIFICATE

STATE OF WISCONSIN)
) SS
DEPARTMENT OF HEALTH AND SOCIAL SERVICES)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Linda Revitiz, Secretary of the Department of Health and Social Services and custodian of the official records of said Department, do hereby certify that the annexed rules relating to certification of health care providers for Medical Assistance reimbursement and the rights and duties of health service providers under the Medical Assistance Program were duly approved and adopted by this Department on November 15, 1985.

I further certify that this copy has been compared by me with the original on file in this Department and that the same is a true copy thereof, and of the whole of such original.

3-1-86

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 15th day of November, 1985.

SEAL:

Linda Reivitz, Secretary
Department of Health and Social SErvices

ORDER OF THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
RENUMBERING AMENDING, REPEALING AND RECREATING, AND CREATING RULES

To amend HSS 106 (title), 106.01 to 106.07, and 106.08 to 106.09; to repeal and recreate HSS 105 and 106.10; to create HSS 106.075 and 106.11, relating to certification of health care providers for Medical Assistance reimbursement and the rights and duties of health service providers under the Medical Assistance Program.

Analysis Prepared by the Department of Health and Social Services

The rules for the Wisconsin Medical Assistance Program (MA), Chapters HSS 101 through 108, Wisconsin Administrative Code, are revised to interpret and implement changes made in ss. 49.43 to 49.497, Stats., and related statutes by Chapters 20, 93 and 317 Laws of 1981 and to accommodate recent change in Federal statutes or regulations including the Omnibus Reconciliation Act of 1981 (P.L. 97-35). Other revisions clarify revised and existing administrative policies and procedures and incorporate proposals for policy change in order to enhance program controls.

Chapter HSS 105 establishes the certification standards and criteria for providers participating in the Wisconsin Medical Assistance Program. Revisions delete much of the federal regulations language and instead require certification by Medicare or incorporate federal regulations by reference. Major areas of change include revisions of the Medicare bid certification requirement for skilled nursing facilities to permit an exemption for non-Medicare certified SNFs if they are already supplying Medicare bids in the area; the deletion of podiatrists as a provider type and the addition of nurse midwives and ambulatory surgical centers; the incorporation of licensing standards established by ch. HSS 133 for home health agencies and ch. HSS 132 for skilled nursing facilities; and exemption of general and psychiatric hospitals providing medical day treatment services from having to comply with JCAH psychiatric accreditation requirements in order to be certified for MA reimbursement.

Chapter HSS 106 defines the rights and responsibilities of providers participating in the Wisconsin Medical Assistance Program. Provider appeal procedures have been revised. A list of services which require collection from a third party carrier prior to billing MA has been added. Language allowing the department to publish reimbursement methodologies in the provider handbooks as well as language recognizing the requirements for copayments has been added. Medicaid sanctions are linked to Medicare, and departmental sanction authority is broadened in relation to negligent or reckless providers.

Pursuant to authority vested in the Department of Health and Social Services by s. 49.45(10), Stats., the Department of Health and Social Services hereby renumbers, amends, repeals and recreates, and creates rules interpreting ss. 49.43 to 49.497, Stats., as follows:

SECTION 1. HSS 105 is repealed and recreated to read:

Chapter HSS 105

MEDICAL ASSISTANCE: PROVIDER CERTIFICATION

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

(2) DEFINITIONS. In this chapter: (a) 1. "Institutional provider" means a provider group or organization which is:

a. Composed of more than one individual performing services; and

b. Licensed or approved by the appropriate state agency or certified for medicare participation, or both.

2. Institutional providers include: hospitals, home health agencies, portable x-ray providers, rehabilitation agencies, independent clinical laboratories, rural health clinics, outpatient mental health clinics, operations by boards authorized under s.51.42, Stats., skilled nursing facilities and intermediate nursing facilities.

(b) "Non-institutional provider" means a provider, eligible for direct reimbursement, who is in single practice rather than group practice, or a provider who, although employed by a provider group, has private patients for whom the provider submits claims to MA.

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

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

(3) GENERAL CONDITIONS FOR PARTICIPATION. In order to be certified by the department to provide specified services for a reasonable period of time as specified by the department, a provider shall:

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

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

(c) Disclose in writing to the department all instances in which the provider, any person in whom the provider has a controlling interest, or any person

having a controlling interest in the provider has been sanctioned by a federal-assisted or state-assisted medical program, since the inception of medicare, medicaid or the title 20 services program;

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

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

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

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

(e) Execute a provider agreement with the department.

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

(a) Institutional providers;

(b) Non-institutional providers;

(c) Provider assistants; and

(d) Group billing providers.

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

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

1. Dental hygienists;

2. Medical record librarians or technicians;

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

4. Nursing aides, assistants and orderlies;

5. Home health aides;

6. Personal care workers;

7. Dieticians;

8. Laboratory technologists;

9. X-ray technicians;

10. Patient activities coordinators;

11. Volunteers; and

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

(b) Providers employed by or under contract to certified institutional providers, including but not limited to physicians, therapists, nurses and provider assistants. These providers shall meet certification standards applicable to their respective provider type.

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

HSS 105.02 REQUIREMENTS FOR MAINTAINING CERTIFICATION. Providers shall comply with the requirements in this section in order to maintain MA certification.

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

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

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

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

(4) MAINTENANCE OF RECORDS. Providers shall prepare and maintain whatever records are necessary to fully disclose the nature and extent of services provided by the provider under the program. Records to be maintained are those

enumerated in subs. (6) and (7). All records shall be retained by providers for a period of not less than 5 years from the date of payment by the department for the services rendered, unless otherwise stated in chs. HSS 101 to 108. In the event a provider's participation in the program is terminated for any reason, all MA-related records shall remain subject to the conditions enumerated in this subsection and sub. (2).

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

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

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

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

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

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

1. Annual budgets;

2. Patient census information, separately:

a. For all patients; and

b. For MA recipients;

3. Annual cost settlement reports for medicare;

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

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

6. Independent accountants' audit reports;

7. Records supporting historical costs of buildings and equipment;

8. Building and equipment depreciation records;

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

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

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

12. Payroll records;

13. Inventory records;

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

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

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

1. Prescriptions which support MA billings;

2. MA patient profiles;

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

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

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

HSS 105.03 PARTICIPATION BY NON-CERTIFIED PERSONS. (1) REIMBURSEMENT FOR EMERGENCY SERVICES. If a resident of Wisconsin or of another state who is not certified by MA in this state provides emergency services to a Wisconsin recipient, that person shall not be reimbursed for those services by MA unless the services are covered services under ch. HSS 107 and:

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

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

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

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

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

HSS 105.04 SUPERVISION OF PROVIDER ASSISTANTS. Provider assistants shall be supervised. Unless otherwise specified under ss. HSS 105.05 to 105.49, supervision shall consist of at least intermittent face-to-face contact between the supervisor and the assistant and a regular review of the assistant's work by the supervisor.

HSS 105.05 CERTIFICATION OF PHYSICIANS AND ASSISTANTS. (1) PHYSICIANS. For MA certification, physicians shall be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 1, 2, 3, 4, 5, and 14.

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

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

HSS 105.06 CERTIFICATION OF DENTISTS. For MA certification, dentists shall be licensed pursuant to s. 447.05, Stats.

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

HSS 105.07 CERTIFICATION OF GENERAL HOSPITALS. For MA certification, hospitals shall be approved pursuant to s. 50.35, Stats. and ch. H 24 [HSS 124], shall either have a medicare provider agreement or be accredited by the joint commission on the accreditation of hospitals (JCAH), and shall have a utilization review plan that meets the requirements of 42 CFR 405.1035. In addition:

(1) Hospitals providing outpatient psychotherapy shall meet the requirements specified in s. HSS 105.22 (1) (2) and (3);

(2) Hospitals providing outpatient alcohol and other drug abuse services shall meet the requirements specified in s. HSS 105.23;

(3) Hospitals providing day treatment services shall meet the requirements specified in s. HSS 105.24;

(4) Hospitals participating in the peer review organization (PRO) review program shall meet the requirements of 42 CFR 405.1035 and any additional requirements established under state contract with the PRO.

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

HSS 105.08 CERTIFICATION OF SKILLED NURSING FACILITIES. For MA certification, skilled nursing facilities shall be licensed pursuant to s. 50.03, Stats., and ch. HSS 132.

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

HSS 105.09 MEDICARE BED REQUIREMENT. (1) MEDICARE BED OBLIGATION. Each county shall have a sufficient number of skilled nursing beds certified by the medicare program pursuant to ss. 49.45 (6m)(g) and 50.02(2), Stats. The number of medicare-certified beds required in each county shall be determined by the department, based on factors including but not limited to the number of persons over 65 in the county and the number of medicare-eligible persons transferred from hospitals to skilled nursing facilities in the county for convalescent stays.

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

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

(c) If the number of medicare-certified beds in a county is reduced so that the county no longer has a sufficient number of medicare-certified beds under sub. (2), the department shall notify each SNF in the county of the number of additional medicare-certified beds needed in the county. The department may not enforce the penalty in par. (a) until 90 days after this notification has been provided.

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

(b) Homes which are certified ICF/MR are exempt from this section.

(c) The department may exempt the skilled nursing facilities in a county from the requirements of this section if it determines that there is adequate accessibility to medicare certified beds for persons residing in the county.

(d) A skilled nursing facility located within a county determined by the department to have an inadequate number of medicare-certified beds may apply to the department for exemption from the requirements of this section. The department may grant an exemption based on but not limited to:

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

2. Availability of an adequate number of medicare-certified beds in an adjacent county or a regional facility.

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

HSS 105.11 CERTIFICATION OF INTERMEDIATE CARE FACILITIES. For MA certification, intermediate care facilities shall be licensed pursuant to s. 50.03, Stats., and ch. HSS 132.

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

HSS 105.12 CERTIFICATION OF ICFs FOR MENTALLY RETARDED PERSONS OR PERSONS WITH RELATED CONDITIONS. For MA certification, institutions for mentally retarded persons or persons with related conditions shall be licensed pursuant to s. 50.03, Stats., and ch. H 34 [HSS 134].

Note: For covered services, see HSS 107.09

HSS 105.15 CERTIFICATION OF PHARMACIES. For MA certification, pharmacies shall meet the requirements for registration and practice enumerated in ss. 450.02 and 450.04, Stats., and chs. Phar 1 to 6.

HSS 105.16 CERTIFICATION OF HOME HEALTH AGENCIES. For MA certification, home health agencies shall be certified to participate in medicare, be licensed pursuant to ch. HSS 133 and meet the requirements of this section as follows:

(1) HOME HEALTH AGENCY SERVICES. For MA certification, a home health agency shall provide at least part-time or intermittent skilled nursing services, home health aide or personal care services, and medical supplies and equipment, on a visiting basis, in a place of residence used as a patient's home. The home health agency or qualified professionals under contract to the home health agency may provide physical therapy, occupational therapy, speech pathology services, home health aide and personal care services. Home health services shall be provided in accordance with orders from the recipient's physician in a written plan of care that the physician reviews every 60 days.

(2) HOME HEALTH AIDES. (a) Assignment and duties. Home health aides shall be assigned to particular patients by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate. Duties shall include but are not limited to the performance of simple procedures as an extension of therapy services, ambulation and exercise, activities of daily living, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and need and completing appropriate records. No more than 25% of the time spent by the aide may be on non-personal care activities.

(b) Supervision. The registered nurse or appropriate professional staff member when other services are provided shall make a supervisory visit to the patient's residence at least once every 60 days, either to observe and assist when the home health aide is present or, when the aide is absent, to assess relationships and determine whether goals are being met.

(3) PERSONAL CARE WORKERS. (a) Personal care workers may be employed by the home health agency or by an agency under contract to the home health agency. Personal care workers shall work under the direction of the home health agency.

(b) Each personal care worker shall be trained in the provision of personal care services. Training shall consist of a minimum of 40 classroom hours, 25 of which shall cover personal and restorative care subjects. Training shall emphasize techniques and aspects of caring for the target population.

(c) The home health agency shall:

1. Provide the personal care worker with the basic materials and equipment to deliver personal care services;

2. Maintain time sheets documenting, by funding source, the types and duration of services provided by the personal care worker;

3. Maintain on file at the home health agency a copy of the written contract between the home health agency and the contracting agency if the home health agency is contracting for personal care workers;

4. Cooperate with other health and social service agencies in the area and with interested community referral groups in an attempt to avoid duplication of services and to provide the best possible coordination of personal care services to area recipients; and

5. Develop an appropriate time and services reporting mechanism for the personal care worker and instruct the personal care worker in the use of the reporting mechanism.

(d) The supervisor shall:

1. Give written instructions, or if necessary a demonstration to the personal care worker, of the services to be performed;

2. Teach or arrange for the teaching of personal care services to family members, if available and appropriate;

3. Confer with the home health agency staff, the personal care worker, the physician and other involved professionals in regard to the recipient's progress;

4. Judge the competency of the personal care worker to perform the personal care services; and

5. Review the plan of care and perform an evaluation of the patient's condition not less frequently than every 60 days. The evaluation shall include at least one visit to the patient's home and a review of the personal care worker's daily record, and discussion with the physician of any need for changes in type or level of care or discontinuance of care. If a change in type or level of care is necessary and cannot be provided by the home health agency or the contracted agency, appropriate referrals shall be made.

(e) The personal care worker may not be a responsible relative under s. 52.01(1)(a), Stats., or a child of the client receiving services.

(f) The personal care worker shall:

1. Perform tasks assigned by the registered nurse for which appropriate training has been received;

2. Record each visit with the recipient on the medical record, including observations made and activities carried out and not carried out;

3. Report in writing to the supervising registered nurse on each assignment;

4. Report promptly to the registered nurse any changes in the recipient's condition; and

5. Confer with the registered nurse regarding the recipient's progress.

Note: For covered home health agency services, see s. HSS 107.11

HSS 105.19 CERTIFICATION OF LICENSED PRACTICAL NURSES. For MA certification, licensed practical nurses shall be licensed pursuant to s. 441.10, Stats.

HSS 105.20 CERTIFICATION OF REGISTERED NURSES. (1) GENERAL. For MA certification, registered nurses shall be registered pursuant to s. 441.06, Stats.

(2) NURSE PRACTITIONERS. (a) In addition to being a registered nurse, a nurse practitioner shall meet the requirements of 42 CFR 481.2 and shall be:

1. Employed by a rural health clinic;

2. Employed by an EPSDT provider under s.HSS 105.37(1) if providing EPSDT health assessment and evaluation services; or

3. A provider of nursing home recertifications under s.HSS 107.09(3)(m)2, consistent with the requirements of s.441.11(4), Stats.

(b) A nurse practitioner shall meet one of the following requirements:

1. Certification as a primary care nurse practitioner by the American nurses' association or by the national board of pediatric nurse practitioners and associates;

2. Satisfactory completion of a formal one-year academic program which prepares registered nurses to perform an expanded role in the delivery of primary care, which includes at least 4 months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or a certificate to persons who successfully complete the program; or

3. Successful completion of a formal education program intended to prepare registered nurses to perform an expanded role in the delivery of primary care, but which does not meet the requirements of subd. 2., and performance of an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding July 1, 1978.

(c) A nurse practitioner shall develop and maintain with a licensed physician a written protocol of services provided and procedures to follow. This protocol shall include but need not be limited to explicit agreements on the expanded primary care services which can be provided by the nurse practitioner. The protocol shall also include arrangements for communication of the physician's directions, consultation with the physician, assistance with medical emergencies, patient referrals, and other agreed-to provisions. In rural health clinics, the written patient care policies shall be considered sufficient evidence of a joint written protocol.

(3) NURSE MIDWIVES. In addition to being a registered nurse, a nurse midwife shall be certified pursuant to ch. N 6.

Note: For covered independent nursing and nurse-midwife services, see s. HSS 107.12.

HSS 105.21 CERTIFICATION OF PSYCHIATRIC HOSPITALS. (1) REQUIREMENTS. For MA certification, psychiatric hospitals shall:

(a) Be approved pursuant to s. 50.35, Stats., and ch. H 24 [HSS 124], and either be certified for participation in medicare or accredited by the joint commission on the accreditation of hospitals (JCAH);

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

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

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

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

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

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

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

HSS 105.22 CERTIFICATION OF PSYCHOTHERAPY PROVIDERS. (1) TYPES OF PSYCHOTHERAPY PROVIDERS. For MA certification, psychotherapy providers shall be one of the following:

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

(b) A psychologist licensed under ch. 455, Stats., who is listed or eligible to be listed in the national register of health services providers in psychology;

(c) A board-operated outpatient facility certified under ss. HSS 61.91 to 61.98; or

(d) An outpatient facility certified under ss. HSS 61.91 to 61.98, which provides MA services under contract to a board.

(2) AGREEMENT WITH BOARD. All providers certified under sub. (1)(a), (b), or (d) shall have a written agreement with a board to be eligible for reimbursement for psychotherapy services.

(3) STAFFING OF OUTPATIENT FACILITIES. (a) To provide psychotherapy reimbursable by MA, personnel employed by an outpatient facility deemed a provider under sub. (1)(d) shall be individually certified and shall work under the supervision of a physician or psychologist who meets the requirements of sub. (1)(a) or (b). Persons employed by a board-operated or hospital outpatient psychotherapy facility need not be individually certified as providers but may provide psychotherapy services upon the department's issuance of certification to the facility by which they are employed. In this case, the facility shall provide a list of the names of persons employed by the facility who are performing psychotherapy services for which reimbursement may be claimed under MA. This listing shall certify the credentials possessed by the named persons which would qualify them for certification under the standards specified in this subsection. A facility, once certified, shall promptly advise the department in writing of the employment or termination of employes who will be or have been providing psychotherapy services under MA.

(b) A person eligible under this subsection to provide psychotherapy services as an employee of a board-operated or hospital outpatient psychotherapy facility shall be one of the following:

1. A person with a master's degree in social work from a graduate school of social work accredited by the council on social work education, with course work emphasis in case work or clinical social work and who is listed in or eligible to be listed in either the national association of social workers (NASW) register of clinical social workers or the national registry of health care providers in clinical social work;

2. A person with a master's degree in psychiatric mental health nursing from a graduate school of nursing accredited by the national league for nursing;

3. A person with any of the following master's degrees and course work emphasis in clinical psychology: counseling and guidance, counseling psychology, clinical psychology, psychology or school psychology, if the person has met the equivalent of the requirements for registration in the national registry of health care providers in clinical social work or in the NASW register of clinical social workers; or

4. A physician meeting the requirements of sub. (1)(a) or a psychologist meeting the requirements of sub. (1)(b).

(c) Providers defined by par. (b)1 to 3 shall also have 3,000 hours of supervised experience in clinical practice subsequent to the acquisition of an acceptable masters degree. In this subsection, "supervised during the 3,000 hour period" means a minimum of one hour a week of face-to-face supervision by another person meeting the minimum qualifications to be a provider.

(4) REIMBURSEMENT FOR OUTPATIENT PSYCHOTHERAPY SERVICES. Outpatient psychotherapy services shall be reimbursed as follows:

(a) For the services of any provider working in a certified outpatient facility, reimbursement shall be to the facility; and

(b) For the services of any provider in private practice who is licensed and certified according to sub. (1)(a) or (b), reimbursement shall be to that provider.

(5) REIMBURSEMENT FOR INPATIENT PSYCHOTHERAPY SERVICES. Reimbursement shall be made to providers defined in sub. (1)(a) and (b) who provide psychotherapy services to a recipient while the recipient is an inpatient in a general or acute care hospital or in a psychiatric facility. Psychotherapy services provided to inpatients in general hospitals or in psychiatric facilities shall be reimbursed as follows:

(a) For the services of a provider who is a physician under sub. (1)(a) or a psychologist under sub. (1)(b) employed by or under contract to an outpatient facility, reimbursement shall be to the facility; and

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

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

HSS 105.23 CERTIFICATION OF ALCOHOL AND OTHER DRUG ABUSE (AODA) TREATMENT PROVIDERS. (1) TYPES OF PROVIDERS. For MA certification, an outpatient alcohol and other drug abuse (AODA) treatment provider shall be:

(a) An outpatient facility operated by a board and certified under ss. HSS 61.50 to 61.68;

(b) An outpatient facility under contract to a board, certified under ss. HSS 61.50 to 61.68; or

(c) A provider under s. HSS 105.05(1) or 105.22(1)(b) who has a written agreement with a board or a facility under sub. (1)(a) or (b), if the recipient being treated is enrolled in an AODA program at the facility.

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

1. Meet the requirements in s. HSS 105.22(3) or 105.05(1); or

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

Note: Certification standards of the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board may be obtained by writing the Wisconsin

Alcoholism and Drug Abuse Counselor Certification Board, Inc., 416 East Main Street, Waukesha, WI 53186.

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

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

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

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

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

HSS 105.24 CERTIFICATION OF DAY TREATMENT OR DAY HOSPITAL SERVICE PROVIDERS.

(1) REQUIREMENTS. For MA certification, a day treatment or day hospital service provider shall:

(a) Be either:

1. A medical program operated by a board and certified under s. HSS 61.75; or

2. A medical program under contract to a board and certified under s. HSS 61.75. ; and

(b) Meet the following personnel and staffing requirements:

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

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

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

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

a. One qualified professional staff member such as an OTR, masters degree social worker, registered nurse, licensed psychologist or masters degree

psychologist for each group, or one certified occupational therapy assistant and one other paraprofessional staff person for each group; and

b. Other appropriate staff, including volunteer staff.

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

(b) Reimbursement payable under par. (a) shall be subject to reductions for third party recoupments. For day treatment or day hospital services provided under MA, the board shall be responsible for 10 percent of the amount reimbursable under par. (a).

(c) Billing submitted for medical day treatment or day hospital services shall verify that the service has been approved by the board, except in the case of billing for services at state-operated facilities.

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

HSS 105.26 CERTIFICATION OF CHIROPRACTORS. For MA certification, chiropractors shall be licensed pursuant to s. 446.02, Stats.

Note: For covered chiropractic services, see s. HSS 107.15.

HSS 105.27 CERTIFICATION OF PHYSICAL THERAPISTS AND ASSISTANTS. (1) PHYSICAL THERAPISTS. For MA certification, physical therapists shall be licensed pursuant to ss. 448.05 and 448.07, Stats., and ch. Med 7.

(2) PHYSICAL THERAPIST ASSISTANTS. For MA certification, physical therapist assistants shall have graduated from a 2-year college-level program approved by the American physical therapy association, and shall provide their services under the direct, immediate, on-premises supervision of a physical therapist certified pursuant to sub. (1). Physical therapist assistants may not bill or be reimbursed directly for their services.

Note: For covered physical therapy services, see s. HSS 107.16

HSS 105.28 CERTIFICATION OF OCCUPATIONAL THERAPISTS AND ASSISTANTS. (1) OCCUPATIONAL THERAPISTS. For MA certification, an occupational therapist shall:

(a) Be certified by the American occupational therapy association as an occupational therapist, registered; or

(b) Have graduated from a program in occupational therapy accredited by the council on medical education of the American medical association and the American occupational therapy association, have completed the required field work experience, and have made application to the American occupational therapy association for the certification examination for occupational therapist, registered. Certification under this paragraph shall be valid until 8 weeks after the examination is taken. On passing the examination, the therapist shall obtain certification by the American occupational therapy association in the calendar year in which the examination is taken. An individual certified under this paragraph for medical assistance who fails the examination may be recertified for medical assistance only under the conditions of par. (a).

(2) OCCUPATIONAL THERAPY ASSISTANTS. For MA certification, occupational therapy assistants shall be certified by the American occupational therapy association. Occupational therapy assistants may not bill or be reimbursed directly for their services. Occupational therapy assistants shall provide services under the direct, immediate on-premises supervision of an occupational therapist certified under sub. (1), except that they may provide services under the general supervision of an occupational therapist certified under sub. (1) under the following circumstances:

(a) The occupational therapy assistant is performing services which are for the purpose of providing activities of daily living skills;

(b) The occupational therapy assistant's supervisor visits the recipient on a bi-weekly basis or after every 5 visits by the occupational therapy assistant to the recipient, whichever is greater; and

(c) The occupational therapy assistant and his or her supervisor meet to discuss treatment of the recipient after every 5 contacts between the occupational therapy assistant and the recipient.

Note: For covered occupational therapy services, see s. HSS 107.17

HSS 105.29 CERTIFICATION OF SPEECH AND HEARING CLINICS. For MA certification, speech and hearing clinics shall be currently accredited by the American speech and hearing association (ASHA) pursuant to the guidelines for "accreditation of professional services programs in speech pathology and audiology" published by ASHA.

HSS105.30 CERTIFICATION OF SPEECH PATHOLOGISTS. For MA certification, speech pathologists shall:

(1) Possess a current certification of clinical competence from the American speech and hearing association;

(2) Have completed the educational requirements and work experience necessary for such a certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate of clinical competence under sub. (1).

Note: For covered speech pathology services, see s. HSS 107.18

HSS 105.31 CERTIFICATION OF AUDIOLOGISTS. For MA certification, audiologists shall:

(1) Possess a certificate of clinical competence from, and current membership in, the American speech and hearing association (ASHA);

(2) Have completed the educational requirements and work experience necessary for the certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate.

Note: For covered audiology services, see s. HSS 107.19.

HSS 105.32 CERTIFICATION OF OPTOMETRISTS. For MA certification, optometrists shall be licensed and registered pursuant to ss. 449.04 and 449.06, Stats.

Note: For covered vision care services, see s. HSS 107.20.

HSS 105.33 CERTIFICATION OF OPTICIANS. For MA certification, opticians shall practice as described in s. 449.01(2), Stats.

Note: For covered vision care services, see s. HSS 107.20.

HSS 105.34 CERTIFICATION OF REHABILITATION AGENCIES. For MA certification, rehabilitation agencies providing outpatient physical therapy or speech pathology shall be certified to participate in medicare and shall meet the requirements of 42 CFR 405.1702 to 405.1726.

HSS 105.35 CERTIFICATION OF RURAL HEALTH CLINICS. For MA certification, a rural health clinic shall be:

(1) Certified to participate in medicare;

(2) Licensed as required under all other local and state laws; and

(3) Staffed with persons who are licensed, certified, or registered in accordance with appropriate state laws.

Note: For covered rural health clinic services, see s. HSS 107.29.

HSS 105.36 CERTIFICATION OF FAMILY PLANNING CLINICS OR AGENCIES. For MA certification, family planning clinics or agencies shall meet the following conditions:

(1) GENERAL. In order to qualify for MA reimbursement, family planning clinics shall certify to the department that:

(a) An MA card has been shown before services are provided;

(b) Services are prescribed by a physician or are provided by a nurse midwife as provided under s.411.15, Stats.; and

(c) No sterilization procedures are available to persons who are mentally incompetent, institutionalized or under the age of 21.

(2) PRINCIPLES OF OPERATION. (a) Family planning services shall be made available:

1. Upon referral from any source or upon the patient's own application;

2. Without regard to race, nationality, religion, family size, marital status, maternity, paternity, handicap or age, in conformity with the spirit and intent of the civil rights act of 1964, as amended, and the rehabilitation act of 1973, as amended;

3. With respect for the dignity of the individual; and

4. With efficient administrative procedures for registration and delivery of services, avoiding prolonged waiting and multiple visits for registration. Patients shall be seen on an appointment basis whenever possible.

(b) Acceptance of family planning service shall be voluntary, and individuals shall not be subjected to coercion either to receive services or to employ or not to employ any particular method of family planning. Acceptance or nonacceptance of family planning services shall not be a prerequisite to eligibility for or receipt of any other service funded by local, state, or federal tax revenue.

(c) A variety of medically approved methods of family planning, including the natural family planning method, shall be available to persons to whom family planning services are offered and provided.

(d) The clinic shall not provide abortion as a method of family planning.

(e) Diagnostic and treatment services for infertility shall be provided for in the family planning clinic. If these services are not available, the clinic shall make referrals to an appropriate, certified provider of these services.

(f) Efforts shall be made to obtain third party payments when available for services provided.

(g) All personal information obtained shall be treated as privileged communication, shall be held confidential, and shall be divulged only upon the recipient's written consent except when necessary to provide services to the individual or to seek reimbursement for the services. The agency director shall ensure that all participating agencies preserve the confidentiality of patient records. Information may be disclosed in summary, statistical, or other form which does not identify specific recipients.

(3) ADMINISTRATION. (a) The family planning clinic shall have a governing body which is responsible for the conduct of the staff and the operation of the clinic.

(b) A designated person shall be responsible for the day-to-day operation of the clinic.

(c) Written policies and procedures shall be developed which govern the utilization of staff, services to patients and the general operation of the clinic.

(d) Job descriptions for volunteer and paid staff shall be prepared to assist staff members in the performance of their duties.

(e) Each clinic shall have a record system that includes the following components:

1. Patient records:

a. With pertinent medical and social history;

b. With all patient contacts and outcomes;

c. With accumulated data on supplies, staffing, appointments and other administrative functions;

d. For purposes of following up on patients for medical services or referrals to other community resources; and

e. For purposes of program evaluation;

2. Fiscal records accounting for cash flow; and

3. Organizational records to document staff time, governing body meetings, administrative decisions and fund raising.

(f) Each clinic shall engage in a continuing effort of evaluating, reporting, planning and implementing changes in program operation.

(g) Each clinic shall develop a system of appointments and referrals which is flexible enough to meet community needs.

(h) Each clinic shall make provision for a medical back-up for patients who experience family planning related problems at a time when the clinic staff is unavailable.

(4) STAFFING. (a) Clinic staff, either paid or volunteer, shall perform the following functions:

1. Outreach workers or community health personnel shall have primary responsibility to contact individuals in need of family planning services, initiate family planning counseling, and assist in receiving, successfully using and continuing medical services;

2. The secretary or receptionist shall greet patients at the clinic, arrange for services and perform a variety of necessary clerical duties;

3. The interviewer or counselor shall take social histories, provide family planning information to patients and counsel patients regarding their family planning and related problems;

4. The nurse or clinic aide shall assist the physician in providing medical services to the patient;

5. The physician shall be responsible for providing or exercising supervision over all medical and related services provided to patients; and

6. The clinic coordinator shall oversee the operation of the clinic.

(b) 1. Training programs shall be developed for new staff, and time shall be made available periodically for their training.

2. For existing staff, time shall be made available for staff conferences and for inservice training in new techniques and procedures.

3. For volunteers, time shall be made available for staff to coordinate, train, and supervise them to be an effective, integral part of the clinic.

(c) Paraprofessional personnel may be hired and trained.

(5) PATIENT AND COMMUNITY OUTREACH. Each clinic shall have an active outreach effort aimed at:

(a) Recruiting and retaining patients in the family planning clinic, through:

1. A system of identifying the primary target populations;

2. A method of contacting the target population;

3. Procedures for family planning counseling and motivating appropriate persons to avail themselves of family planning medical services;

4. Assisting individuals in receiving family planning medical services;

5. Activities designed to follow-up potential and actual family planning patients as indicated; and

6. A record system sufficient to support the functions in subds. 1 to 5.

(b) Meeting all human needs through appropriate and effective referral to other community resources; and

(c) Increasing community awareness and acceptance of the family planning clinic through:

1. The use of mass media;

2. Presentations to community organizations and agencies;

3. Public information campaigns utilizing all channels of communication;

4. Development of formal referral arrangements with community resources; and

5. Involvement of appropriate community residents in the operation of the family planning clinic.

(6) PATIENT EDUCATION AND COUNSELING. At the time the patient is to receive family planning medical services, the following components of social services shall be provided:

(a) An intake interview designed to obtain pertinent information regarding the patient, to explain the conditions under which services are provided and to create the opportunity for a discussion of the patient's problems;

(b) A group or individual information session which includes:

1. Reproductive anatomy and physiology;

2. Methods of contraception, including how they work, side effects and effectiveness;

3. An explanation of applicable medical procedures;

4. An opportunity for patients to ask questions and discuss their concerns; and

5. An optional discussion of such topics as breast and cervical cancer, venereal disease, human sexuality or vaginopathies; and

(c) An exit interview which is designed to:

1. Clarify any areas of concern or questions regarding medical services;

2. Elicit from the patient evidence of a complete understanding of the use of family planning methods;

3. Effectively inform the patient what procedures are to be followed if problems are experienced;

4. Inform the patient about the clinic's follow-up procedures and possible referral to other community resources; and

5. Arrange for the next visit to the clinic.

(7) MEDICAL SERVICES. (a) All medical and related services shall be provided by or under the supervision and responsibility of a physician.

(b) The following medical services shall be made available:

1. Complete medical and obstetrical history;

2. Physical examination;

3. Laboratory evaluation;

4. Prescription of the family planning method selected by the patient unless medically contraindicated;

5. Instructions on the use of the chosen method, provision of supplies and schedule for revisits;

6. Infertility screening and diagnosis; and

7. Referral to inpatient service when necessary to treat complications of contraceptive services provided by the clinic.

(c) Equipment and supplies in the clinic shall be commensurate with the services offered. Sufficient first aid equipment shall be available for use when needed.

(d) Treatment for minor vaginal infections and venereal disease may be made available either by the clinic or through referral.

(8) FACILITIES. The family planning clinic shall be designed to provide comfort and dignity for the patients and to facilitate the work of the staff. A clinic facility shall be adequate for the quantity of services provided, and shall include:

(a) A comfortable waiting room with an area for patient reception, record processing and children's play;

(b) Private interviewing and counseling areas;

(c) A group conference room for staff meetings and patient education;

(d) A work room or laboratory area with sufficient equipment and nearby storage space, none of which is accessible to the patient;

(e) A sufficient number of private and well-equipped examining rooms with proximal dressing areas which ensure the dignity of the patient;

(f) Adequate toilet facilities, preferably near the dressing room; and

(g) Arrangements for routine and restorative facility maintenance.

Note: For covered family planning services, see s. HSS 107.21

HSS 105.37 CERTIFICATION OF EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROVIDERS. (1) EPSDT HEALTH ASSESSMENT AND EVALUATION SERVICES. (a) Eligible providers. The following providers are eligible for certification as providers of EPSDT health assessment and evaluation services:

1. Physicians;

2. Outpatient hospital facilities;

3. Health maintenance organizations;

4. Visiting nurse associations;

5. Clinics operated under a physician's supervision;

6. Local public health agencies;

7. Home health agencies;

8. Rural health clinics;

9. Indian health agencies; and

10. Neighborhood health centers.

(b) Procedures and personnel requirements. 1. EPSDT providers shall provide periodic comprehensive child health assessments and evaluations of the general health, growth, development and nutritional status of infants, children and youth. Immunizations shall be administered at the time of the screening if determined medically necessary and appropriate. The results of a health assessment and evaluation shall be explained to the recipient's parent or guardian and to the recipient if appropriate.

2. EPSDT health assessment and evaluation services shall be delivered under the supervision of skilled medical personnel. In this section "skilled medical personnel" means physicians, physician assistants, nurse practitioners, public

health nurses or registered nurses. Skilled medical personnel who perform physical assessment screening procedures shall have successfully completed either a formal pediatric assessment or an inservice training course on physical assessments approved by the department. Individual procedures may be completed by paraprofessional staff who are supervised by skilled medical personnel. Registered nurses who perform EPSDT physical assessments shall have satisfactorily completed a curriculum for pediatric physical assessments approved by the department.

3. All conditions uncovered which warrant further care shall be diagnosed or treated or both by the provider, if appropriate, or referred to other appropriate providers. A referral may either be a direct referral to the appropriate health care provider or a referral recommendation submitted through the agency responsible for the patient's case management and advocacy.

4. Health maintenance organizations and prepaid health plans providing EPSDT services shall meet all requirements of 42 CFR 441.60 in addition to the requirements under subds. 1 to 3.

(c) Records and documentation. 1. Certified providers of EPSDT screening services shall:

a. Complete the department's EPSDT claim form and an individual health and developmental history for each client; and

b. Maintain a file on each client receiving EPSDT services which includes a copy of the EPSDT claim form, individual health and developmental history and follow-up for necessary diagnosis and treatment services.

2. The EPSDT provider shall release information on the results of the health assessment to appropriate health care providers and health authorities when authorized by the patient or the patient's parent or guardian to do so.

(2) EPSDT CASE MANAGEMENT ACTIVITIES. (a) Case management reimbursement. Providers certified under sub. (1) as providers of EPSDT health assessment and evaluation services shall be eligible to receive reimbursement for EPSDT case management in accordance with the limitations contained in the case management agreement between the provider and the department.

(b) Case management plan. 1. All EPSDT providers who apply to receive reimbursement for EPSDT case management services shall submit to the department a case management plan. The case management plan shall describe the geographic service area, target population, coordination with support activities conducted by the department and other health-related services, case management activities and the method of documenting the activities.

2. The department shall evaluate the adequacy of each provider's case management plan according to the case management requirements of the proposed service area and target population, the extent to which the plan would ensure that children receive the necessary diagnosis and treatment services for conditions detected during EPSDT health examinations, the proposed coordination with the EPSDT central notification system and other health related services, and proposed methods for documenting case management services.

Based on the evaluation, the department shall either approve or deny the provider's request for reimbursement of case management activities and shall impose on providers as conditions for reimbursement any personnel, staffing or procedural requirements that it determines are necessary pursuant to 42 CFR 441 Part B.

(c) Records and documentations. Providers shall maintain records and documentation required by the department in order to verify appropriate use of funds provided by the department for EPSDT case management activities.

(3) DIAGNOSIS AND TREATMENT SERVICES. Providers of diagnosis and treatment services for EPSDT recipients shall be certified according to the appropriate provisions of this chapter.

Note: For covered EPSDT services, see s. HSS 107.22.

HSS 105.38 CERTIFICATION OF AMBULANCE PROVIDERS. For MA certification, ambulance service providers shall be licensed pursuant to s. 146.50, Stats. and ch. H 20 [HSS 110], and shall meet ambulance inspection standards adopted by the Wisconsin department of transportation under s. 341.085, Stats., and found in ch. Trans 157.

Note: Copies of licensure applications for ambulance service providers can be obtained from the Emergency Services Section, Division of Health, P.O. Box 309, Madison, Wisconsin, 53701. For covered transportation services, see s.HSS 107.23.

HSS 105.39 CERTIFICATION OF SPECIALIZED MEDICAL VEHICLE PROVIDERS. (1) For MA certification, specialized medical vehicle providers shall meet the requirements of this section and shall sign the affidavit required under sub. (6) stipulating that they are in compliance with the requirements of this section.

(2) VEHICLES. (a) Insurance of not less than $100,000 personal liability for each person and not less than $300,000 personal liability for each occurrence shall be carried on all vehicles used in transporting recipients.

(b) Vehicle inspections shall be performed at least every 7 days, by an assigned driver, to ensure:

1. The proper functioning of all headlights, emergency flasher lights, turn signal lights, tail lights, brake lights, clearance lights, windshield wipers, brakes, front suspension and steering mechanisms, shock absorbers, heater and defroster systems, doors and ramps, moveable windows and passenger and driver restraint systems;

2. That all tires are properly inflated according to vehicle or tire manufacturers' recommendations and that all tires possess a minimum of 1/8 inch of tread at the point of greatest wear; and

3. That windshields and mirrors are free from cracks or breaks.

(c) The driver inspecting the vehicle shall document all vehicle inspections in writing, noting any deficiencies.

(d) All deficiencies shall be corrected before any recipient is transported in the vehicle. Corrections shall be documented by the driver. Documentation shall be retained for not less than 12 months, except as authorized in writing by the department.

(e) Windows, windshield and mirrors shall be maintained in a clean condition with no obstruction to vision.

(f) Smoking is not permitted in the vehicle.

(g) Police, sheriff's department and ambulance emergency telephone numbers shall be posted on the dash of the vehicle in an easily readable manner. If the vehicle is not equipped with a working two-way radio, sufficient money in suitable denominations shall be carried to enable not less than 3 local telephone calls to be made from a pay telephone.

(3) VEHICLE EQUIPMENT. (a) The vehicle shall be equipped at all times with a jack and lug wrench, a flashlight in working condition, a first aid kit containing 2 rolls of sterile gauze, sterile gauze compression bandages equal in number to the passenger-carrying capacity of the vehicle, one roll of adhesive tape and one tourniquet, and a fire extinguisher. The fire extinguisher shall be periodically serviced as recommended by the local fire department.

(b) The vehicle shall be equipped with passenger restraint devices, including restraint devices for wheelchairbound recipients if these recipients are carried, and these devices shall be used. Wheelchair restraints shall secure both the passenger and the wheelchair.

(c) Provision shall be made for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and the driver in the event of an accident.

(4) DRIVERS. (a) Each driver shall possess a valid Wisconsin chauffeur's license which shall be unrestricted, except that the vision restrictions may be waived if the driver's vision is corrected to an acuity of 20/30 or better by the use of eyeglasses. In this event, the driver shall wear corrective eyeglasses while transporting recipients.

(b) All drivers shall hold a current card issued as proof of successful completion of the American red cross basic course in first aid, or equivalent.

(c) Within 30 days of the date of employment or the date the specialized transportation service is certified as a provider, all drivers shall receive specific instruction on care and handling of epileptics in seizure. Drivers who attest in writing that they have had prior training in the care and handling of seizure victims shall be considered to have met this requirement.

(5) COMPANY POLICY. Company policies and procedures shall include:

(a) Compliance with all applicable state and local laws governing the conduct of company business;

(b) Establishment and implementation of scheduling policies that assure timely pick-up and delivery of passengers going to and returning from medical appointments;

(c) Documentation that transportation services for which MA reimbursement is sought are:

1. For medical purposes only;

2. Ordered by the attending provider of medical service; and

3. Provided only to persons who require this transportation because they lack other means of transport, and who are also physically or mentally incapable of using public transportation;

(d) Maintenance of records of services for 5 years, unless otherwise authorized in writing by the department; and

(e) On request of the department, making available for inspection records that document both medical service providers' orders for services and the actual provision of services.

(6) AFFIDAVIT. The provider shall submit to the department a notarized affidavit attesting that the provider meets the requirements listed in this section. The affidavit shall be on a form developed by and available from the department, and shall contain the following:

(a) A statement of the requirements listed in this section;

(b) The date the form is completed by the provider;

(c) The provider's business name, address, telephone number and type of ownership;

(d) The name and signature of the provider or a person authorized to act on behalf of the provider; and

(e) A notarization.

Note: For covered transportation services, see s. HSS 107.23

HSS 105.40 CERTIFICATION OF DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY VENDORS.

(1) Except as provided in sub. (2), vendors of durable medical equipment and medical supplies shall be eligible to participate in the MA program.

(2) Orthotists and prosthetists who develop and fit appliances for recipients shall be certified by the American board for certification in orthotics and prosthetics (A.B.C.). Certification shall be a result of successful participation in an A.B.C. examination in prosthetics, orthotics, or both, and shall be for:

(a) Certified prosthetist (C.P.);

(b) Certified orthotist (C.O.); or

(c) Certified prosthetist and orthotist (C.P.O.)

Note: For covered durable medical equipment and medical supply services, see s. HSS 107.24.

HSS 105.41 CERTIFICATION OF HEARING AID DEALERS. For MA certification, hearing aid dealers shall be licensed pursuant to s. 459.05, Stats.

Note: For covered hearing aids and supplies, see s. HSS 107.24.

HSS 105.42 CERTIFICATION OF PHYSICIAN OFFICE LABORATORIES. (1) REQUIREMENTS. For MA certification, physician office laboratories, except as noted in sub. (2), shall be licensed pursuant to s. 143.15, Stats., and ch. HSS 165.

(2) EXCEPTION. Physician office laboratories servicing no more than 2 physicians, chiropractors or dentists, and not accepting specimens on referral from outside providers, are not required to be licensed under s. 143.15, Stats., or to meet ch. HSS 165 standards. These laboratories, however, shall submit an affidavit to the department declaring that they do not accept outside specimens.

(3) MEDICARE CERTIFICATION REQUIREMENT. Physician office laboratories which accept referrals of 100 or more specimens a year in a specialty shall be certified to participate in medicare in addition to meeting the requirements under sub. (1).

Note: For covered diagnostic testing services, see s. HSS 107.25

HSS 105.43 CERTIFICATION OF HOSPITAL AND INDEPENDENT CLINICAL LABORATORIES. For MA certification, a clinical laboratory that is a hospital laboratory or an independent laboratory shall be licensed pursuant to s. 143.15, Stats., and ch. HSS 165. In addition, the laboratory shall be certified to participate in medicare and meet the requirements of 42 CFR 405.1310 to 405.1317.

Note: For covered diagnostic testing services, see s. HSS 107.25.

HSS 105.44 CERTIFICATION OF PORTABLE X-RAY PROVIDERS. For MA certification, a portable x-ray provider shall be directed by a physician or group of physicians, registered pursuant to s. 140.54, Stats., and ch. HSS 157, certified to participate in medicare, and shall meet the requirements of 42 CFR 405.1411 to 405.1416.

Note: For covered diagnostic testing services, see s. HSS 107.25

HSS 105.45 CERTIFICATION OF DIALYSIS FACILITIES. For MA certification, dialysis facilities shall meet the requirements enumerated in ss H 52.05 and 52.06 [HSS 152.07 and 152.08], and shall be certified to participate in medicare.

Note: For covered dialysis services, see s. HSS 107.26.

HSS 105.46 CERTIFICATION OF BLOOD BANKS. For MA certification, blood banks shall be licensed or registered with the U.S. food and drug administration and shall be approved pursuant to s. 143.15, Stats., and s. HSS 165.05.

Note: For covered blood services, see s. HSS 107.27.

HSS 105.47 CERTIFICATION OF HEALTH MAINTENANCE ORGANIZATIONS AND PREPAID HEALTH PLANS. (1) CONTRACTS AND LICENSING. For MA certification, a health maintenance organization or prepaid health plan shall enter into a written contract with the department to provide services to enrolled recipients and shall be licensed by the Wisconsin commissioner of insurance.

(2) REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS. For MA certification, an HMO shall:

(a) Meet the requirements of 42 CFR 434.20 (c);

(b) Make services it provides to individuals eligible under MA accessible to these individuals, within the area served by the organization, to the same extent that the services are made accessible under the MA state plan to individuals eligible for MA who are not enrolled with the organization; and

(c) Make adequate provision against the risk of insolvency, which is satisfactory to the department and which ensures that individuals eligible for benefits under MA are not held liable for debts of the organization in case of the organization's insolvency.

Note: For covered health maintenance organization and prepaid health plan services, see s. HSS 107.28.

HSS 105.48 CERTIFICATION OF OUT-OF-STATE PROVIDERS. (1) BORDER STATUS

(a) Border status certification. 1. Providers enumerated in subds. 2 to 5 whose normal practice includes providing service to Wisconsin recipients may be certified as Wisconsin border status providers if they meet the requirements for certification outlined in this chapter. Certified border status providers shall be subject to the same rules and contractual agreements as Wisconsin providers.

2. Hospitals in Ironwood and Iron Mountain, Michigan, and in Winona and Red Wing, Minnesota may apply for certification as Wisconsin border status providers of inpatient and outpatient services. Hospitals in other communities listed in subd. 4 are eligible for border status certification only as hospital outpatient service providers.

3. Out-of-state independent laboratories, regardless of location, may apply for certification as Wisconsin border status providers.

4. Non-hospital and non-nursing home providers located in the following communities may apply for certification as Wisconsin border status providers:

IOWA	ILLINOIS	MINNESOTA	MICHIGAN
Dubuque	Antioch	Duluth	Bessemer
Guttenberg	Durland	Hastings	Crystal Falls
Lansing	East Dubuque	Kingsdale	Iron Mountain
McGregor	Freeport	LaCrescent	Iron River
	Galena	Lake City	Ironwood
	Harvard	Markville	Kingsford
	Hebron	Minneapolis	Marenisco
	Richmond	Red Wing	Menominee
	Rockford	Rochester	Norway
	South Beloit	Rush City	Wakefield
	Stockton	St. Paul	Watersmeet
	Warren	Stillwater	
	Woodstock	Taylor Falls	
		Wabasha	
		Winona	
		Wrenshall	

5. Out-of-state providers at locations other than those in subd. 4 may apply to the department for border status certification, except that out-of-state nursing homes are not eligible for border status. Requests for border status shall be considered by the department on a case-by-case basis.

(b) Review of border status certification. The department may review border status certification annually. Border status certification may be cancelled by the department if it is found to be no longer warranted by medical necessity, volume or other considerations.

(2) LIMITATION ON CERTIFICATION OF OUT-OF-STATE PROVIDERS. (a) Providers certified in another state whose services are not covered in Wisconsin shall be denied border status certification in the Wisconsin program.

Note: Examples of provider types whose services are not covered in Wisconsin are music therapists and art therapists.

(b) Providers denied certification in another state shall be denied certification in Wisconsin, except that providers denied certification in another state because their services are not MA-covered in that state may be eligible for Wisconsin border status certification if their services are covered in Wisconsin.

HSS 105.49 CERTIFICATION OF AMBULATORY SURGICAL CENTERS. For MA certification, ambulatory surgical centers shall meet the requirements for participation in medicare as stated in 42 CFR 416.39.

Note: For covered ambulatory surgical center services, see s. HSS 107.30

SECTION 2. HSS 106 (title) and 106.01 to 106.07 are amended to read:

Chapter HSS 106

MEDICAL ASSISTANCE: PROVIDER RIGHTS AND RESPONSIBILITIES

HSS 106.01 INTRODUCTION. In addition to ~~other~~ provisions of ~~this rule~~ chs. HSS 105 and 107 relating to individual provider types~~,~~ ~~or~~ and the manner by which specified services are to be provided and paid for under ~~the program,~~ medical assistance (MA), the participation of all providers certified under

~~section~~ ch. HSS ~~105.01~~ 105 to provide or claim reimbursement for services under the program shall be subject to the conditions set forth ~~under~~ in this chapter.

HSS 106.02 GENERAL REQUIREMENTS FOR PROVISION OF SERVICES. ~~.--(1)-REIMBURSABILITY-OF-SERVICES.--(a)-Certification-requirements.-An-individual-or entity-may-claim-reimbursement-for-covered-services-as-defined-in-chapter-HSS 107-when-the-individual-or-entity-providing-such-service-is-properly-licensed or-is-otherwise-qualified,-and-is-certified-under-section-HSS-105.01-to participate-as-a-provider-in-the-program.-Services-defined-under-chapter-HSS 107-as-covered-shall-be-reimbursable-only-if:~~ Providers shall comply with the following general conditions for participation as providers in the MA program:

(1) CERTIFICATION. A provider shall be certified under ch. HSS 105.

(2) COVERED SERVICES. A provider shall be reimbursed only for covered services specified in ch. HSS 107.

~~1.~~ (3) RECIPIENT ELIGIBLE ON DATE OF SERVICE. A provider shall be reimbursed for a service only if the recipient of the service was eligible to receive ~~medical-assistance~~ MA benefits on the date ~~such~~ the service was provided.

~~2.~~ (4) COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS. A provider shall be reimbursed only if the provider complies with applicable state and federal procedural requirements relating to the delivery of the service. ~~and;~~

~~3.~~ (5) APPROPRIATE AND MEDICALLY NECESSARY SERVICES. A provider shall be reimbursed only for ~~the service~~ services ~~provided was~~ that are appropriate and medically necessary for the condition of the recipient.

~~(1)(b)~~ (6) PROVISION OF NON-COVERED SERVICES. If a provider determines that, to assure quality health care to a recipient, it is necessary to provide a non-covered service, nothing in this ~~rule~~ chapter shall preclude the provider from furnishing ~~such~~ the service, if before rendering the service~~,~~ the provider advises the recipient that ~~it~~ the service is not covered under the program~~,~~ and that, if provided, the recipient~~,~~ ~~and not the program, shall be~~ is responsible for payment ~~for the non-covered service~~.

(7) SERVICES TO RECIPIENTS WITH A PRIMARY PROVIDER. A provider other than the designated primary provider may not claim reimbursement for a service to an individual whose freedom to choose a provider has been restricted under s. HSS 104.03 or 104.05 as indicated on the recipient's MA identification card unless the service was rendered pursuant to a written referral from the recipient's designated primary provider or the service was rendered in an emergency. If rendered in an emergency, the provider seeking reimbursement shall submit to the fiscal agent a written description of the nature of the emergency along with the service claim.

~~(2)~~ (8) REFUSAL TO PROVIDE MA SERVICES. ~~Provider~~ A provider ~~shall not be~~ is not required to provide services to a recipient if the recipient refuses or fails to present a currently valid ~~medical assistance~~ MA identification card. If a recipient fails, refuses~~,~~ or is unable to produce a currently valid identification card, the provider may contact the fiscal agent to confirm the

current eligibility of the recipient. The department shall require its fiscal agent to install and maintain adequate toll-free telephone service to enable providers to verify the eligibility of recipients to receive benefits under the program.

~~(3)~~ (9) RECORDS. (a) A provider shall prepare and maintain all records specified under ~~section~~ s. HSS 105.02~~(4)~~(6) and the relevant paragraphs of ~~section~~ s. HSS 105.02~~(5)~~(7) ~~for purposes of maintaining the provider's certification and~~ to fully disclose the nature and scope of services provided under the program.

(b) All ~~such~~ records under par. (a) shall be retained by the provider for a period of not less than 5 years, or 6 years in the case of rural health clinics. ~~The 5 year period, or 6 years in the case of rural health clinics,~~ This period shall commence on the date on which the provider received payment from the program for the service to which the records relate. ~~(b)~~ Termination of a provider's participation ~~in the program~~ shall not terminate the provider's responsibility to retain the ~~subject~~ records unless an alternative arrangement for retention and maintenance has been established by the provider and approved by the department.

(c) The secretary of the department shall designate persons authorized to ~~request~~ have access to, inspect, audit, ~~or~~ review or reproduce the ~~required records~~ records required to be maintained under this subsection. ~~Persons so~~ These ~~authorized~~ persons shall be issued credentials, including photographic identification, verifying the ~~person's~~ authorization.

(d) ~~Upon the~~ On request of an authorized person and ~~upon~~ on presentation of the authorized person's credentials, ~~providers~~ a provider shall permit ~~such persons at all reasonable times~~ access to the records requested. Access for purposes of this section shall include the opportunity to inspect, review, audit and~~/or~~ reproduce the subject records. All costs of reproduction of records shall be borne by the department. The department ~~shall~~ may not use or disclose data or information relating to recipients and contained in a provider's records except for purposes directly related to the administration of the program.

~~(4)~~ (10) NONDISCRIMINATION. Providers shall~~, in providing health care services to recipients,~~ comply with the civil rights act of 1964, 42 USC 1000d et. seq., ~~regulations promulgated thereunder~~ and ~~section~~ s. 504 of the ~~federal~~ rehabilitation act of 1973~~.~~, as amended. Accordingly, providers may not exclude, deny or refuse to provide health care services to recipients on the grounds of race, color, gender, age, national origin or handicap, nor may they discriminate in their employment practices.

HSS 106.03 MANNER OF PREPARING AND SUBMITTING CLAIMS FOR REIMBURSEMENT. (1) FORMAT. A provider shall ~~utilize~~ use claim forms prescribed and furnished by the department~~.~~, ~~In lieu of using such claim forms,~~ except that a provider may ~~utilize~~ use magnetic tape billing if the ~~format and content of such magnetic tape meets department specifications, and the provider receives the department's prior written approval.~~ tape is prepared by a tape billing service approved by the department. In this section, "tape billing service" means a provider or an entity under contract to a provider which provides magnetic tape billing for one or more providers. A tape billing service shall be

approved in writing by the department based on the tape billing service's ability to meet format and content specifications required for the applicable provider types. The department shall, upon request, provide a ~~provider with~~ written format and content specifications required for magnetic tape billings and shall advise the provider or tape billing service of procedures required to obtain departmental approval of magnetic tape billing. The accuracy and completeness of tape billings shall be the sole responsibility of the provider.

(2) CONTENT. A provider shall make all reasonable attempts to ensure that the information contained on the provider's claim forms is complete and accurate. ~~Providers preparing claims~~ In the preparation of claims, providers shall ~~utilize~~ use, where applicable, diagnosis and procedure codes specified by the department for identifying the services that are the subject of the claim. The department shall inform affected providers of the name and source of the designated diagnosis and procedure ~~and diagnosis~~ codes. Every claim submitted shall be signed by the provider~~,~~ or by the provider's authorized agent.

(3) TIMELINESS. A claim may not be submitted until the recipient has received the service which is the subject of the claim. A claim shall be submitted to the fiscal agent within ~~one year~~ 12 months of the date ~~such~~ the service was provided. Payment ~~shall~~ may not be made for any claim submitted after that ~~one year~~ 12-month period, except where the provider demonstrates to the satisfaction of the department that ~~unusual circumstances or~~ circumstances beyond the provider's control prevented timely submission of the claim.

(4) HEALTH CARE SERVICES REQUIRING PRIOR AUTHORIZATION. ~~Claims~~ No payment may be made on a claim for service requiring prior authorization ~~shall be denied where~~ if written prior authorization was not ~~obtained before~~ requested and received by the provider prior to the date of service delivery~~.~~, except that claims that would ordinarily be rejected due to lack of the provider's timely receipt of prior authorization may be paid under the following circumstances:

(a) Where the provider's initial request for prior authorization was denied and the denial was either rescinded in writing by the department or overruled by an administrative or judicial order; ~~rendered pursuant to the recipient's petition for administrative review of the department's denial of prior authorization.~~

(b) Where the service requiring prior authorization was provided ~~within a period of retroactive eligibility, i.e.,~~ before the recipient became eligible, and the provider applies to and receives from the department retroactive authorization for the service~~.~~; or

(c) Where time is of the essence in providing a service which requires prior authorization, and verbal authorization is obtained by the provider from the department's medical consultant or designee. To ensure payment on claims for verbally-authorized services, the provider shall retain records which show the time and date of the authorization and the identity of the individual who gave the authorization, and shall follow-up with a written authorization request form attaching documentation pertinent to the verbal authorization.

(5) PROVIDERS ELIGIBLE TO RECEIVE PAYMENT ON CLAIMS. (a) Eligible providers. Payment for a service shall be made directly to the provider furnishing the service or to the provider organization which provides or arranges for the availability of ~~such~~ the service on a prepayment basis, except that payment may be made:

1. To the employer of an individual provider if ~~such~~ the provider is required as a condition of employment to turn over fees derived from ~~such~~ the service to the employer or to a facility; or

2. To a facility if a service was provided in ~~such~~ a hospital, clinic or other facility, and there exists a contractual agreement between the individual provider and ~~such~~ the facility, under which the facility prepares and submits the claim for reimbursement for the service provided by the individual provider.

(b) Facility contracting with providers. An employer or facility submitting claims for services provided by a provider in its employ or under contract as provided ~~for~~ in ~~paragraph~~ par. (a) ~~above must~~ shall apply for and receive certification from the department to submit claims and receive payment on behalf of the ~~performing~~ provider performing the services. Any claim submitted by an employer or facility so authorized ~~must~~ shall identify the provider number of the individual provider who actually provided the service or item that is the subject of ~~such~~ the claim.

(c) Prohibited payments. No payment which under ~~paragraph~~ par. (a) (intro.) ~~must be~~ is made directly to an individual provider or provider organization

~~providing the service,~~ may be made to anyone else under a reassignment or power of attorney except to an employer or facility ~~as defined in subparagraphs 1 and 2 of paragraph (a)],~~ under par. (a)1 or 2, but nothing in this paragraph shall be construed:

1. To prevent ~~the~~ making ~~of such a~~ the payment in accordance with an assignment from the person or institution providing the service ~~involved~~ if ~~such~~ the service is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction~~,~~; or

2. To preclude an agent of ~~such~~ the provider from receiving any payment if~~,~~ ~~and only if,~~ ~~such~~ the agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for services in connection with the billing or collection of payments due ~~such~~ the person or institution under the program is unrelated, directly or indirectly, to the amount of ~~such~~ payments or the claims ~~therefore~~ for them, and is not dependent upon the actual collection of ~~any such~~ the payment.

(6) ASSIGNMENT OF MEDICARE PART B BENEFITS. A provider providing a covered service to a ~~recipient eligible to receive Part B Benefits under Medicare (Title XVIII)~~ dual entitlee~~,~~ shall accept assignment of the recipient's part B medicare benefits~~,~~ if the service provided is, in whole or in part, reimbursable under medicare part B coverage. All services provided to dual entitlees which are reimbursable under medicare part B shall be billed to medicare. In this subsection, "dual entitlee" means an MA recipient who is also eligible to receive part B benefits under medicare.

(7) THIRD PARTY LIABILITY FOR COST OF SERVICES. (a) Identification. The department shall make reasonable efforts to identify third party resources legally liable to contribute in whole or in part to the cost of services provided a recipient under the program. ~~For purposes of this section, "third party" means an individual, institution, corporation, public or private agency that is liable to pay all or part of the cost of injury, disease or disability of an applicant for a recipient of medical assistance~~

(b) Availability of information. If the department identifies a third-party insurer ~~(either public or private)~~ that provides health or accident coverage for a recipient, ~~such~~ the insurance coverage shall be identified in a code on the recipient's ~~medical assistance~~ MA card. The department shall prepare and distribute to ~~a provider~~ providers code conversion information which indicates whether other insurance coverage is available, and instructions regarding procedures for third-party recovery including any exceptions to the billing standards set forth in pars. (c) to (e).

(c) Collection from third-party insurer. If the existence of a third party source of insurance is identified, ~~the~~ a provider of any of the following services shall, before submitting an MA claim, seek to obtain payment from that third party, ~~payment~~ for the service:

1. Services of physicians if surgery, surgical assistance, anesthesiology, or hospital visits to inpatients are included in the items billed;

2. All hospital services, whether inpatient or outpatient;

3. Services by all types of mental health providers, including but not limited to, counseling and chemical abuse treatment;

4. All therapy when rendered to hospital inpatients; and

5. If the recipient is covered by the civilian health and medical program of the uniformed services (CHAMPUS), all services except the following:

a. Periodic routine examinations and general physical examinations such as for school entry and EPSDT screening;

b. Vision care, except that surgical procedures and pin hole glasses shall be billed to CHAMPUS; and

c. Dental care, except that any service which is treatment of oral infection or removal of broken teeth shall be billed to CHAMPUS.

(d) Denial from third-party insurer. If the third party denies coverage for all or a portion of the cost of the service, the provider may then submit a claim to MA for the unpaid amount. The provider shall retain all evidence of claims for reimbursement, settlement or denials resulting from claims submitted to third-party payers of health care.

(e) Provider's choice for billing. If third-party coverage is indicated on the recipient's MA identification card and the third party billing is not

required by par. (c) or as a medicare-covered service, the provider has the option of billing either MA or the indicated third party, but not both, for the services provided, as follows:

1. If the provider elects to bill the third party, a claim may not be submitted to MA until the third party pays part of or denies the original claim; and

2. If the provider elects to submit a claim to MA, no claim may be submitted to the third party.

(f) Duplicate payment. In the event a provider receives a payment from MA and from a third party for the same service, the provider shall, within 30 days of receipt of the second payment, refund to MA the lesser of the MA payment or the third-party payment.

HSS 106.04 PAYMENT OF CLAIMS FOR REIMBURSEMENT. (1) TIMELINESS. (a) Timeliness of payment. The department shall reimburse a provider for a properly provided covered service~~,~~ according to the provider payment schedule entitled "terms of provider reimbursement," found in the appropriate MA provider handbook distributed by the department. ~~Payment shall issue on a claim for a covered service, properly completed and submitted by the provider, within 30 days of receipt of such claim.~~ The department shall issue payment on claims for covered services, properly completed and submitted by the provider, in a timely manner. Payment shall be issued on at least 95% of these claims within 30 days of claim receipt, on at least 99% of these claims within 90 days of claim receipt, and on 100% of these claims within 180 days of receipt. The department may not consider the amount of the claim in processing claims under this subsection.

(b) Exceptions. The department may exceed claims payment limits under par. (a) for any of the following reasons:

1. If a claim for payment under medicare has been filed in a timely manner, the department may pay a MA claim relating to the same services within 6 months after the department or the provider receives notice of the disposition of the medicare claims;

2. The department may make payments at any time in accordance with a court order, or to carry out hearing decisions or department corrective actions taken to resolve a dispute; or

3. The department may issue payments in accordance with waiver provisions if it has obtained a waiver from the federal health care financing administration under 42 CFR 447.45(e).

(2) COST SHARING. (a) General policy. Pursuant to s. 49.45(18), Stats., the department shall establish copayment rates and deductible amounts for medical services covered under MA. Recipients shall provide the copayment amount or coinsurance to the provider or pay for medical services up to the deductible amount as appropriate. Providers are not entitled to reimbursement from MA for the copayment, coinsurance or deductible amounts for which a recipient is liable.

(b) Exempted recipients and services. Providers may not collect copayments, co-insurance or deductible amounts for the following recipients and services:

1. Recipients who are nursing home residents;

2. Recipients who are members of a health maintenance organization or other prepaid health plan for services provided by the HMO or PHP;

3. A service to any recipient who is under age 18;

4. Services furnished to pregnant women if the services relate to the pregnancy or to any medical condition which may complicate the pregnancy, when it can be determined from the claim submitted that the recipient was pregnant;

5. Emergency hospital and ambulance services and emergency services related to the relief of dental pain;

6. Family planning services and related supplies;

7. Transportation services by a specialized medical vehicle;

8. Transportation services provided through or paid for by a county social services department;

9. Home health services or nursing services if a home health agency is not available;

10. Laboratory and x-ray services prescribed by a physician; and

11. Physician office visits over 6 visits per recipient, per physician, per calendar year;

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

(d) Limitation on copayments for outpatient psychotherapy. Providers may not collect copayments from a recipient for outpatient psychotherapy services received over 15 hours or $500, whichever comes first, during one calendar year.

(e) Limitation on copayments for occupational, physical and speech therapy. Providers may not collect copayments from a recipient for occupational, physical or speech therapy services over 30 hours or $1,500 for any one therapy, whichever comes first, during one calendar year.

(f) Liability for refunding erroneous copayment. In the event that medical services are covered by a third party and the recipient makes a copayment to the provider, the department is not responsible for refunding the copayment amount to the recipient.

(3) NON-LIABILITY OF RECIPIENTS. A provider shall accept payments made by the department in accordance with ~~subsection~~ sub. (1) ~~above~~ as payment in full for services provided a recipient. A provider ~~shall~~ may not attempt to impose an ~~additional~~ unauthorized charge or receive payment from a recipient, relative or other person for services provided, or ~~to~~ impose direct charges upon a recipient in lieu of obtaining payment under the program, except under any of the following conditions:

(a) A service desired, needed or requested by a recipient is not covered under the program or a prior authorization request is denied, and the recipient is advised of this fact before receiving ~~such services~~ the service;

(b) ~~If~~ An applicant is determined to be eligible retroactively under s. 49.46(1)(b), Stats., and a provider has ~~bills~~ billed the applicant directly for services rendered during the retroactive period, in which case the provider shall, upon notification of the recipient's retroactive eligibility, submit claims under this section for covered services provided during the retroactive period. Upon receipt of payment from the program for ~~such~~ the services, the provider shall reimburse in full the recipient or other person who has made prior payment to the provider. A provider shall not be required to reimburse the recipient or other person in excess of the amount reimbursed by the program; or

(c) A recipient in a nursing home ~~resident~~ chooses a private room in the nursing home and the provisions of s. HSS 107.09(3)(k) are met.

(4) RELEASE OF BILLING INFORMATION BY PROVIDERS. (a) Restrictions. A provider may not release information to a recipient or to a recipient's attorney relating to charges which have been billed or which will be billed to MA for the cost of care of a recipient without notifying the department, unless any real or potential third-party payer liability has been assigned to the provider.

(b) Provider liability. If a provider releases information relating to the cost of care of a recipient or beneficiary contrary to par. (a), and the recipient or beneficiary receives payment from a liable third-party payer, the provider shall repay to the department any MA benefit payment it has received for the charges in question. The provider may then assert a claim against the recipient or beneficiary for the amount of the MA benefit repaid to the department.

Note: See the Wisconsin Medical Assistance Provider Handbook for specific information on procedures to be followed in the release of billing information.

~~(3)~~ (5) RETURN OF OVERPAYMENT. If a provider receives a payment under the program to which the provider ~~was~~ is not entitled or in an amount greater than that to which the provider ~~was~~ is entitled, the provider shall promptly return to the department the amount of ~~such~~ the erroneous or excess payment. In lieu of returning ~~such~~ the overpayment, a provider may notify the department in writing of the nature, source and amount of the overpayment and request that the excess payment be deducted from future amounts ~~owing~~ owed the provider under the program. The department shall honor ~~such a~~ the request if the provider is actively participating in the program and is claiming and receiving reimbursement in amounts sufficient to allow recovery of the overpayment within a reasonable period of time, as agreed to by the department and the provider.

~~(4)~~ (6) REQUEST FOR CLAIM PAYMENT ADJUSTMENT. If a provider contests the propriety of the amount of payment received from the department for services claimed, the provider shall notify the fiscal agent of its concerns, request-

ing reconsideration and payment adjustment. All requests for claims payment adjustment shall be made within 90 days from the date of payment on the original claim. The fiscal agent shall within ~~30~~ 45 days of receipt of ~~such~~ the request respond in writing, and advise what, if any, payment adjustment will be made. The fiscal agent's response shall identify the basis for approval or denial of the payment adjustment requested by the provider. This action shall constitute final departmental action with respect to payment of the ~~claim(s)~~ claim in question.

~~(5)~~ (7) DEPARTMENTAL RECOUPMENT OF EXCESS PAYMENTS. (a) Recoupment methods. If the department finds that a provider has received payment under the program to which the provider ~~was~~ is not entitled or in an amount greater than that to which the provider ~~was~~ is entitled, the department may recover the amount of ~~such~~ the improper or excess payment by any of the following methods:

1. By offset or appropriate adjustment against other amounts ~~owing~~ owed the provider for covered services;

2. If the amount ~~owing~~ owed the provider at the time of the department's finding is insufficient to recover in whole the amount of the improper or excessive payment, by offset or credit against amounts determined to be ~~owing~~ owed the provider for subsequent services provided under the program; or

3. By requiring the provider to pay directly to the department the amount of the excess or erroneous payment.

(b) Written notice. No recovery by offset, adjustment, or demand for payments ~~shall~~ may be made by the department under ~~paragraph~~ par. (a), except as provided under par. (c), unless the department gives the provider prior written notice of its intent to recover the amount determined to have been erroneously or improperly paid. The notice shall set forth the amount of the intended recovery, shall identify the claim or claims in question or the basis for recovery, and shall summarize the basis for the department's finding that the provider has received amounts to which the provider ~~was~~ is not entitled or in excess of that to which the provider ~~was~~ is entitled, and shall call to the provider's attention the right to appeal the intended action under par. (d).

(c) Exception. The department ~~shall not be required to~~ need not provide prior written notice under ~~paragraph~~ par. (b) ~~above where~~ when the payment was made as a result of a computer processing or clerical error or ~~where~~ when the provider has requested or authorized the recovery to be made. In ~~such case~~ either of these cases the department or its fiscal agent shall provide written notice of any payment adjustments made on the next remittance ~~advice~~ issued the provider. ~~Such~~ This notice shall specify the amount of the adjustment made and the claim or claims which were the subject of the adjustments.

(d) Request for hearing on recovery action. If the provider chooses to contest the propriety of a proposed recovery, the provider shall, within 20 days after receipt of the department's notice of intent to recover, request a hearing on the matter. Such a request shall be in writing and shall briefly identify the basis for contesting the proposed recovery. Receipt of a timely request for hearing shall preclude the department from making the proposed

recovery ~~proposed~~ while the hearing proceeding is pending. ~~The department shall schedule a hearing on the contested recovery within 20 days of receipt of provider's request for hearing.~~ If a timely request for hearing is not received, the department may recover from current or future obligations of the program to the provider ~~that~~ the amount specified in the notice of intent to recover. All hearings on ~~contested recoveries~~ recovery actions by the department pursuant to s. 49.45(2)(a)10, Stats., shall be ~~held~~ in accordance with the provisions of ch. 227, Stats. ~~All notices under this section shall be in writing and shall be conclusively presumed to have been received within 5 days after evidence of mailing.~~

(e) Request for hearing on payment adjustments. If the provider contests the propriety of adjustments made under ~~paragraph~~ par. (c) ~~above~~, the provider shall, within 30 days of receipt of the remittance, request in writing a hearing on the matter. ~~Such~~ This written request shall be accompanied by a copy of the remittance reflecting the adjustment and by a brief summary statement of the basis for contesting the adjustment. ~~The department shall schedule a hearing on the contested adjustment within 20 days of receipt of the provider's request for hearing.~~ All hearings on contested adjustments shall be held in accordance with the provisions of ch. 227, Stats.

~~(6)~~ (8) SUPPORTING DOCUMENTATION. The department may refuse to make payment and may recover previous payments made~~,~~ on claims where the provider has failed or refused to prepare~~,~~ and maintain records or provide authorized department personnel access to records required under ~~section~~ s. HSS 105.02~~(4)~~ (6) or ~~(5)~~ (7) for purposes of disclosing and substantiating the nature, scope and necessity of services which are the subject of the claims.

~~(7)~~ (9) GOOD FAITH PAYMENT. A claim denied for recipient eligibility reasons may qualify for a good faith payment if the service provided was provided in good faith to a recipient with an ~~medical assistance~~ MA identification card which the provider saw on the date of service and which was apparently valid for the date of service.

HSS 106.05 VOLUNTARY TERMINATION OF PROGRAM PARTICIPATION. (1) PROVIDERS OTHER THAN NURSING HOMES. (a) Termination notice. Any provider other than a skilled nursing facility or intermediate care facility may at any time terminate participation in the program. A provider electing to terminate program participation shall ~~within 30 days~~ at least 30 days before the termination date notify the department in writing of ~~such election~~ that decision and of the effective date of termination from the program.

(b) Reimbursement. A provider may not claim reimbursement for services provided recipients on or after the effective date specified in the termination notice. If the provider's notice of termination fails to specify an effective date, the provider's certification to provide and claim reimbursement for services under the program shall be terminated on the date on which notice of termination is received by the department.

(2) SKILLED NURSING AND INTERMEDIATE CARE FACILITIES. (a) Termination notice. A provider certified under ~~section~~ ch. HSS ~~105.01~~ 105 ~~of this rule~~ as a skilled nursing facility or intermediate care facility may terminate participation in the program upon advance written notice ~~of not less than 30~~

~~days,~~ to the department and to the facility's resident recipients or their legal guardians in accordance with s. 50.03(14)(e), Stats. ~~Such~~ The notice shall specify the effective date of the facility's termination of program participation.

(b) Reimbursement. A skilled nursing facility or intermediate care facility electing to terminate program participation may claim and receive reimbursement for services for a period of not more than 30 days ~~after and including~~ beginning on the effective termination date. Services furnished during the 30-day period shall be reimbursable provided that:

1. The recipient was not admitted to the facility after the date on which written notice of program termination was given the department; and

2. The facility ~~can demonstrate~~ demonstrates to the satisfaction of the department that it has made reasonable efforts to facilitate the orderly transfer of affected resident recipients to another appropriate facility.

(3) RECORD RETENTION. Voluntary termination of a provider's program participation under this section ~~shall~~ does not ~~serve to terminate~~ end the provider's responsibility to retain and provide access to records as required under ~~section~~ s. HSS 106.02~~(3)~~(9) unless an alternative arrangement for retention, maintenance and access has been established by the provider and approved in writing by the department.

HSS 106.06 INVOLUNTARY TERMINATION OR SUSPENSION FROM PROGRAM PARTICIPATION. The department may suspend or terminate the certification of any person, partnership, corporation, association, agency, institution or other entity participating as a health care provider under the program, if the suspension or termination will not deny recipients access to MA services and if after reasonable notice and opportunity for a hearing the department finds that:

(1) NON-COMPLIANCE WITH MA REQUIREMENTS. The provider has repeatedly and knowingly failed or refused to comply with federal or state statutes, rules or regulations applicable to the delivery of, or billing for, services under the program;

(2) REFUSAL TO COMPLY WITH PROVIDER AGREEMENT. The provider has repeatedly and knowingly failed or refused to comply with the terms and conditions of its provider agreement;

(3) IMPROPER ACTIVITIES. (a) The provider has prescribed, provided, or claimed reimbursement for services under the program which were:

~~(a)~~ 1. Inappropriate;

~~(b)~~ 2. Unnecessary or in excess of the ~~recipient~~ recipient's needs;

~~(c)~~ 3. Detrimental to the health and safety of the recipient; or

~~(d)~~ 4. Of grossly inferior quality.

(b) Findings precipitating ~~departmental~~ action by the department under this ~~section~~ subsection shall be based ~~upon~~ on the written findings of a peer review committee established by the department or a PRO under contract to the department ~~for the purpose of~~ to review and ~~evaluation of~~ evaluate health care services provided under the program. The findings shall be presumptive evidence that the provider has engaged in improper activities under this subsection;

(4) SUSPENSION OR REVOCATION. The licensure, certification, authorization, or other official entitlement required ~~under state or federal law~~ as a prerequisite to the provider's certification to participate in the program has been suspended, restricted, terminated, expired or revoked~~,~~;

(5) PUBLIC HEALTH IN JEOPARDY. A provider's licensure, certification, authorization or other official entitlement has been suspended, terminated, expired or revoked under state or federal law following a determination that the health, safety or welfare of the public is in jeopardy;

(6) MEDICARE SANCTIONS. (a) The provider is excluded or terminated from the medicare program or otherwise sanctioned by the medicare program because of fraud or abuse of the medicare program under 42 CFR 420.101 or 474.10.

(b) The provider is suspended from the medicare program for conviction of a medicare program-related crime under 42 CFR 420.122.

(c) The provider is a party convicted of a crime, ineligible to participate in the medicare program and the health care financing administration directs the department to suspend the provider;

~~(5)~~ (7) SERVICE DURING PERIOD OF NONCERTIFICATION. The provider has provided a service to a recipient during a period in which provider's licensure, certification, authorization, or other entitlement to provide the service was terminated, suspended, expired~~,~~ or revoked~~.~~;

~~(6)~~ (8) CRIMINAL CONVICTION. The provider has been convicted of a criminal offense related to ~~the provision of~~ providing or claiming reimbursement for services under medicare ~~(title XVIII, social security act),~~ or under this or any other state's ~~medical assistance~~ MA program. ~~For purposes of~~ In this ~~section,~~ subsection, "convicted" means that a judgment of conviction has been entered by a federal, state or local court, irrespective of whether an appeal from that judgment is pending~~.~~;

~~(7)~~ (9) FALSE STATEMENTS. The provider knowingly made or caused to be made a false statement or misrepresentation of material fact in connection with provider's application for certification or recertification~~.~~;

~~(8)~~ (10) FAILURE TO REPORT STATUS CHANGE. The provider has concealed, failed or refused to disclose any material change in licensure, certification, authorization, or ownership which if known to the department would have precluded the provider from ~~certification.~~ being certified;

~~(9)~~ (11) CONCEALMENT OF OUTSIDE CONTROLLING INTERESTS. The provider at the time of application for certification under ~~section HSS 105.01~~ ch. HSS 105 or after receiving ~~such~~ that certification knowingly misrepresented, concealed or failed to disclose to the department full and complete information as to the identity of each person holding an ownership or ~~control~~ controlling interest~~.~~ in the provider;

~~(10)~~ (12) CONCEALMENT OF PROVIDER'S CONTROLLING INTERESTS. The provider at the time of application for certification under ~~section HSS 105.01~~ ch. HSS 105 or after receiving ~~such~~ that certification knowingly misrepresented, concealed or failed to disclose to the department an ownership or ~~control~~ controlling interest the provider held in a corporation, partnership, sole proprietorship or other entity certified under the program~~.~~;

~~(11)~~ (13) FALSE STATEMENTS CONCERNING THE NATURE AND SCOPE OF SERVICES. The provider ~~has~~ made or caused to be made false statements or misrepresentation of material facts in records required under ~~section~~ s. HSS 105.02 ~~(3),~~ (4), ~~or (5)~~ (6), or (7) and maintained by the provider for purposes of identifying the nature and scope of services provided under the program~~.~~;

(14) FALSE STATEMENTS CONCERNING THE COSTS OF SERVICES. The provider has knowingly made or caused to be made false statements or has misrepresented material facts in connection with the provider's usual and customary charges submitted to the department as a claim for reimbursement;

~~(12)~~ (15) FALSE STATEMENTS CONCERNING COST REPORTS. The provider has knowingly made or caused to be made false statements or misrepresentation of material facts in cost reports relating to the provider's costs, expenditures or usual and customary charges submitted to the department for the purpose of establishing reimbursement rates under the program~~.~~;

~~(13)~~ (16) FAILURE TO KEEP RECORDS. The provider has failed or refused to prepare, maintain or make available for inspection, audit or copy by persons authorized by the department, records necessary to fully disclose the nature, ~~and~~ scope and need of services provided recipients~~.~~;

~~(14)~~ (17) FALSE STATEMENT ON CLAIM. The provider has knowingly made or caused to be made a false statement or misrepresentation of a material fact in a claim~~.~~;

~~(15)~~ (18) OBSTRUCTION OF INVESTIGATION. The provider has intentionally by act of omission or commission obstructed an investigation or audit being conducted by authorized departmental personnel pursuant to s. 49.45(3)(g), Stats~~.~~;

~~(16)~~ (19) PAYMENT FOR REFERRAL. The provider has offered or paid to another person, or solicited or received from another person, any remuneration in cash or in kind in consideration for a referral of a recipient for the purpose of procuring the opportunity to provide covered services to the recipient, payment for which may be made in whole or in part under the program~~.~~;

(20) FAILURE TO REQUEST COPAYMENTS. The provider has failed to request from recipients the required copayment, deductible or coinsurance amount applicable to the service provided to recipients after having received a written statement from the department noting the provider's repeated failure to request required copayments, deductible or coinsurance amounts and indicating the intent to impose a sanction if the provider continues to fail to make these requests;

Note: See s. 49.45(18), Stats., and s. HSS 106.04(2) for requirements on copayments, deductibles and coinsurance amounts.

~~(17)~~ (21) CHARGING RECIPIENT. The provider has, in addition to claiming reimbursement for services provided a recipient, imposed a charge on the recipient for ~~such~~ the services or has attempted to ~~procure~~ obtain payment

from the recipient in lieu of claiming reimbursement through the program contrary to provisions of s. HSS 106.04~~(2)~~ (3)~~.~~;

~~(18)~~ (22) RACIAL OR ETHNIC DISCRIMINATION. The provider has refused to provide or has denied services to recipients on the basis of the recipient's race, color or national origin in violation of the civil rights act of 1964~~.~~, as amended, 42 USC 200d, et. seq., and the implementing regulations, 45 CFR Part 80;

~~(19)~~ (23) HANDICAPPED DISCRIMINATION. The provider has refused to provide or has denied services to a handicapped recipient solely on the basis of handicap, ~~in-violation-of-section~~ thereby violating s. 504 of the rehabilitation act of 1973~~.~~, as amended, 29 USC 794;

~~(20)~~ (24) FUNDS MISMANAGEMENT. A provider providing skilled nursing or intermediate care services has failed to or has refused to establish and maintain an accounting system which ~~insures~~ ensures full and complete accounting of ~~its-resident-receipients~~[1] the personal funds of residents who are recipients~~.~~, or has engaged in, caused, or condoned serious mismanagement or misappropriation of ~~such~~ the funds~~.~~;

Note: See s. HSS 107.09(3)(i) for requirements concerning accounting for the personal funds of nursing home residents.

~~(21)~~ (25) REFUSAL TO REPAY ERRONEOUS PAYMENTS. The provider has failed to repay or has refused to repay amounts that have been determined to be owed the department either under ~~section~~ s. HSS 106.04~~(5)~~ (7) or pursuant to a judgment of a court of competent jurisdiction, as a result of erroneous or improper payments made to the provider under the program~~.~~;

(26) FAULTY SUBMISSION OF CLAIMS, FAILURE TO HEED MA BILLING STANDARDS, OR SUBMISSION OF INACCURATE BILLING INFORMATION. The provider has created substantial extraordinary processing costs by submitting MA claims for services that the provider knows, or should have known, are not reimbursable by MA, MA claims which fail to provide correct or complete information necessary for timely and accurate claims processing and payment in accordance with proper billing instructions published by the department or the fiscal agent, or MA claims which include procedure codes or procedure descriptions that are inconsistent with the nature, level or amount of health care provided to the recipient, and, in addition, the provider has failed to reimburse the department for extraordinary processing costs attributable to these practices;

~~(22)~~ (27) REFUSAL TO PURGE CONTEMPT ORDER. The provider failed or refused to purge a contempt order issued under s. 885.12, Stats., as a result of the provider's refusal to obey a subpoena under s. 49.45(3)(h)1, Stats~~.~~;

~~(23)~~ (28) OTHER TERMINATION REASONS. The provider, ~~or~~ a person with management responsibility for the provider, ~~or~~ an officer or person owning directly or indirectly 5% or more of the shares or other evidences of ownership of a corporate provider, ~~or~~ a partner in a partnership which is a provider, or the owner of a sole proprietorship which is a provider, was ~~either~~:

(a) Terminated from participation in the program within the preceding 5 years~~.~~;

(b) A person with management responsibility for a provider previously terminated under this section, or a person who was employed by a previously

terminated provider at the time during which the act or acts occurred which served as the basis for the termination of the provider's program participation and knowingly caused, concealed, performed or condoned those acts~~,~~;

(c) An officer of~~,~~ or person owning, either directly or indirectly, 5% of the stock or other evidences of ownership in~~,~~ a corporate provider previously terminated at the time during which the act or acts occurred which served as the basis for the termination~~,~~;

(d) An owner of a sole proprietorship~~,~~ or a partner in a partnership~~,~~ that was terminated as a provider under this section, and the person was the owner or a partner at the time during which the act or acts occurred which served as the basis for ~~such~~ the termination~~,~~;

(e) Convicted of a criminal offense related to the provision of services or claiming of reimbursement for services under medicare or under this or any other state's medical assistance program. In this subsection "convicted" means that a judgment of conviction has been entered by a federal, state or local court, irrespective of whether an appeal from the judgment is pending; or

(f) Excluded, terminated, suspended or otherwise sanctioned by medicare or by this or any other state's medical assistance program;

(29) BILLING FOR SERVICES OF A NON-CERTIFIED PROVIDER. The provider submitted claims for services provided by an individual whose MA certification had been terminated or suspended, and the submitting provider had knowledge of the individual's termination or suspension; or

(30) BUSINESS TRANSFER LIABILITY. The provider has failed to comply with the requirements of s.49.45(20), Stats. regarding liability for repayment of overpayments in cases of business transfer.

HSS 106.07 EFFECTS OF SUSPENSION OR INVOLUNTARY TERMINATION. ~~(1) CULPABILITY OF MANAGER. Upon the termination of a provider provider's certification under section s. HSS 106.06, a person with direct management responsibility for said the provider at the time of the occurrence which served as the basis for such the termination may be barred from future participation as a provider for a period not to exceed 5 years.~~

~~--(2) CULPABILITY OF OFFICERS AND OWNERS OF A CORPORATION. Upon termination of a corporate provider under section s. HSS 106.06, officers and persons owning directly or indirectly 5% or more of the stock or other evidences of ownership in the corporation at the time of the occurrence which served as the basis for such the termination, may be barred from future participation as a provider for a period of not to exceed 5 years.~~

~~--(3) CULPABILITY OF A SOLE PROPRIETOR OR PARTNER. Upon the termination of a sole proprietorship or partnership provider under section s. HSS 106.06, an owner or partner in partnership at the time of the occurrence which served as the basis for the termination, may be barred from participation as a provider for a period not to exceed 5 years.~~

(1) LENGTH OF SUSPENSION OR INVOLUNTARY TERMINATION. In determining the period for which a party identified in this chapter is to be disqualified from participation in the program, the department shall consider the following factors:

(a) The number and nature of the program violations and other related offenses;

(b) The nature and extent of any adverse impact on recipients caused by the violations;

(c) The amount of any damages;

(d) Any mitigating circumstances; and

(e) Any other pertinent facts which have direct bearing on the nature and seriousness of the program violations or related offenses.

(2) MEDICARE OR OTHER STATE MEDICAL ASSISTANCE SANCTIONS. Notwithstanding any other provision in this chapter, a party identified in this chapter who is suspended, excluded or terminated under the medicare program or under the medical assistance program of another state shall be barred from participation as a provider during the term of the suspension, exclusion or termination.

~~(4)~~ (3) REFERRAL TO LICENSING AGENCIES. The secretary shall notify the appropriate state licensing agency of the suspension or termination by MA of any provider licensed by the agency~~,~~ and of the act or acts which served as the basis for the provider's suspension or termination.

(4) OTHER POSSIBLE SANCTIONS. In addition or as an alternative to the suspension or termination of a provider's certification, the secretary may impose any or all of the following sanctions against a provider who has been found to have engaged in the conduct described in s. HSS 106.06:

(a) Referral to the appropriate state regulatory agency;

(b) Referral to the appropriate peer review mechanism;

(c) Transfer to a provider agreement of limited duration not to exceed 12 months; or

(d) Transfer to a provider agreement which stipulates specific conditions of participation.

SECTION 3. HSS 106.075 is created to read:

HSS 106.075 DEPARTMENTAL DISCRETION TO PURSUE MONETARY RECOVERY. Nothing in this chapter shall preclude the department from pursuing monetary recovery from a provider at the same time action is initiated to impose sanctions provided for under this chapter.

SECTION 4. HSS 106.08 to 106.09 are amended to read:

HSS 106.08 WITHHOLDING PAYMENT OF CLAIMS. (1) WHEN TERMINATION ACTION IS INITIATED. ~~Where~~ When termination action is initiated against a provider by the department under ~~subsection (7), (11), (12), (13), (14), or (21) of~~

~~section HSS 106.06,~~ s. HSS 106.06(6), (8), (9), (13), (14), (15), (16), (17) or (25), the department may withhold issuance of payments on the provider's claims while proceedings are pending on ~~such~~ the action, except that if a final administrative decision by the hearing officer has not been issued within ~~90~~ 150 days of the initiation of ~~such~~ the action and the delay has not been caused by the subject provider, payment may no longer be withheld and shall be issued to the provider. If the final decision of the hearing officer approves the department action, payments that have been withheld under this subsection shall be permanently denied the provider.

(2) WITHHOLDING CLAIMS DURING SANCTION PERIOD. (a) Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association for any health care provided under MA, except for health care provided prior to the suspension or termination.

(b) No clinic, group, corporation, or other association which is a provider of services may submit any claim for payment for any health care provided by an individual provider within that organization who has been suspended or terminated from participation in MA, except for health care provided prior to the suspension or termination.

(c) The department may recover any payments made in violation of this subsection. Knowing submission of these claims shall be a grounds for administrative sanctions against the submitting provider.

HSS 106.09 PRE-PAYMENT REVIEW OF CLAIMS. (1) HEALTH CARE REVIEW COMMITTEES. The department shall establish committees of qualified ~~professional~~ health

~~personnel~~ care professionals to evaluate and review the appropriateness~~,~~ ~~and~~ quality and quantity of services furnished recipients. ~~Such committees shall perform health care services evaluation and review within the meaning of s. 146.37, Stats.~~

(2) REFERRAL OF ABERRANT PRACTICES. If the department has cause to suspect that a provider is prescribing or providing services which are not necessary for recipients, ~~or which~~ are in excess of the medical needs of recipients, or ~~which are~~ do not ~~in conformity with~~ conform to applicable professional practice standards, the department ~~may~~ shall, before issuing payment for the claims, refer ~~such~~ the claims to the appropriate health care review committee established under sub. (1). The committee shall review and evaluate the medical necessity, appropriateness and propriety of the services ~~of the claims~~ for which payment is claimed. ~~Denial or issuance of~~ The decision to deny or issue the payment for the claims shall take into consideration the findings and recommendation of the committee.

(3) WITHDRAWAL OF REVIEW COMMITTEE MEMBERS FOR CONFLICT OF INTEREST. No individual member of a health care review committee established under sub. (1) may participate in a review and evaluation contemplated in sub. (2) if the individual has been directly involved in the treatment of recipients who are the subject of the claims under review or if the individual is financially or contractually related to the provider under review or if the individual is employed by the provider under review.

(4) PROVIDER NOTIFICATION OF PREPAYMENT REVIEW. A provider shall be notified by the department of the institution of the pre-payment review process under

sub. (2). ~~Claims which undergo pre-payment review shall be evaluated by the committee, and payment~~ Payment shall be issued or denied, following review by a health care review committee, within 60 days of the date on which the claims were submitted to the fiscal agent by the provider.

(5) APPLICATION OF SANCTION. If a health care review committee established under sub. (1) finds that a provider has ~~engaged in the delivery of~~ delivered services ~~which~~ that are inappropriate or not medically necessary, the department may require the provider to request and receive from the department authorization ~~for~~ prior to the delivery of ~~service~~ any service under the program.

SECTION 5. HSS 106.10 is repealed and recreated to read:

HSS 106.10 PROCEDURE, PLEADINGS AND PRACTICE. (1) SCOPE. The provisions of this section shall govern the following administrative actions by the department:

(a) Decertification or suspension of a provider from the medical assistance program pursuant to s. 49.45(2)(a)12, Stats;

(b) Imposition of additional sanctions for non-compliance with the terms of provider agreements under s.49.45(2)(a)9, Stats. or certification criteria established under s.49.45(2)(a)11, Stats., pursuant to s.49.45(2)(a)13, Stats; and

(c) Any action or inaction for which due process is otherwise required by law.

(2) DUE PROCESS. The department shall assure due process in implementing any action described in sub. (1) by providing written notice, a fair hearing and written decision pursuant to s.49.45(2)(a)14, Stats., or as otherwise required by law. In addition to any provisions of this section, the procedures implementing a fair hearing and a written decision shall comply with the provisions of ch. 227, Stats.

(3) WRITTEN NOTICE. The department shall begin actions described under sub. (1) by serving upon the provider written notice of the intended action or written notice of the action. Notice of intended action described under sub. (1)(a) and (b) shall include the following:

(a) A brief and plain statement specifying the nature of and identifying the statute, regulation, or rule giving the department the authority to initiate the action;

(b) A short and plain statement identifying the nature of the transactions, occurrences or events which served as the basis for initiating the action; and

(c) A statement advising the provider of the right to a hearing and the procedure for requesting a hearing.

(4) REQUEST FOR HEARING. A provider desiring to contest a departmental action or inaction under sub. (1) may request a hearing on any matter contested. The request shall be in writing and shall:

(a) Be served upon the department's office of administrative hearings unless otherwise directed by the secretary;

(b) For requests for hearings on actions or intended actions by the department, be served within 20 days of the date of service of the department's notice of intended action or notice of action;

(c) For requests for hearings on inactions by the department, be served within 60 days from the date the provider first became aware of, or should have become aware of with the exercise of reasonable diligence, the cause of the appeal;

(d) Contain a brief and plain statement identifying every matter or issue contested; and

(e) Contain a brief and plain statement of any new matter which the provider believes constitutes a defense or mitigating factor with respect to non-compliance alleged in the notice of action.

Note: Hearing requests should be sent to the Office of Administrative Hearings, P.O. Box 7875, Madison, WI 53707.

(5) PRIOR HEARING REQUIREMENT; EXCEPTION. (a) Except as provided in s.HSS 106.08(1), if no request for hearing has been timely filed, no action described in sub. (1)(a) and (b) shall be taken by the department until 20 days after the notice of intended action has been served unless conditions under par. (b) are met. Except as provided in s.HSS 106.08(1), if a request for a hearing has been timely filed, no action described in sub. (1)(a)

and (b) shall be taken by the department until all provider appeal rights have become exhausted, unless conditions under par. (b) are met.

(b) Actions described under sub. (1)(a) and (b) may be taken against a provider without a prior hearing when the action is initiated on the basis of the department's finding that:

1. The health or safety of a recipient is in imminent danger as a result of the provider's failure to comply with applicable state or federal law relating to the provision of health care services;

2. The licensure, certification, authorization or other official entitlement required under state or federal law as a prerequisite to the provider's certification has been suspended, terminated or revoked; or

3. Federal financial participation is unavailable for payments issued to the provider because the provider has been excluded, terminated, suspended or otherwise sanctioned by medicare or by this or any other state's medical assistance program.

(c) Any action initiated under par. (b) which is based on findings described in par. (b) 2 or 3 may be retroactively enforced to coincide with the period for which federal financial participation is unavailable.

(6) FINAL DECISION. (a) If payment of claims to the provider is being withheld by the department under s.HSS 106.08(1), a final decision shall be made by the department within 150 days of receipt of the hearing request.

(b) The hearing examiner's decision shall be the final decision of the department for contested actions under sub. (1)(a) and (b).

(7) EFFECT OF FAILURE TO APPEAR AT HEARING. (a) If the department fails to appear on the date set for a hearing on a contested action under sub. (1)(a) or (b), the hearing examiner may enter an order dismissing the department's action, pursuant to the motion of the provider or on its own motion.

(b) If the department fails to appear on the date set for a hearing on a contested action under sub. (1)(c), the hearing examiner may enter an order granting the relief sought by the provider upon due proof of facts which show the provider's entitlement to the relief.

(c) If the provider fails to appear on the date set for a hearing on a contested action under sub. (1)(a) or (b), the hearing examiner may enter an order dismissing the provider's appeal upon due proof of facts which show the department's entitlement to the remedy or relief sought in the action.

(d) If the provider fails to appear on the date set for a hearing on a contested action under sub. (1)(c) the hearing examiner may enter an order dismissing the provider's appeal, pursuant to the motion of the department or on its own motion.

(e) The department's office of administrative hearing may by order reopen a default arising from a failure of either party to appear on the date set for hearing. The order may be issued upon motion or petition duly made and

good cause shown. The motion shall be made within 20 days after the date of the hearing examiner's default order.

SECTION 6. HSS 106.11 is created to read:

106.11 WAIVERS AND VARIANCES. The department shall consider applications for a waiver or variance of any rule in chs. HSS 101 to 108 provided that the following requirements and procedures are followed:

(a) Requirements for a waiver or variance. A waiver or variance may be granted if the department finds that the waiver or variance will not adversely affect the health, safety or welfare of any recipient and that:

1. Strict enforcement of a requirement would result in unreasonable hardship on the provider or on a recipient; or

2. An alternative to a rule, including a new concept, method, procedures or technique, new equipment, new personnel qualifications or the implementation of a pilot project is in the interests of better care or management.

(b) Application for a waiver or variance. 1. A request for a waiver or variance may be made at any time. All applications for waiver or variance shall be made in writing to the department, specifying the following:

a. The rule from which the waiver or variance is requested;

b. The time period for which the waiver or variance is requested;

c. If the request is for a variance, the specific alternative action which the provider proposes;

d. The reasons for the request; and

e. Justification that par. (a) would be satisfied.

Note: Waiver or variance requests should be sent to the Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701.

2. The department may require additional information from the provider prior to acting on the request. If the department requires more information, the 90-day period under subd. 3 for department review and approval or denial of the request shall be extended by 60 days from receipt by the department of the additional information.

3. The department shall grant or deny each request for waiver or variance in writing. A notice of denial shall contain the reasons for denial. If a notice of denial is not issued within 90 days after the receipt of a complete request, the waiver or variance shall be automatically approved.

4. The terms of a requested variance may be modified upon written agreement between the department and a provider. The department may impose any conditions on the granting of a waiver or variance which it considers necessary. The department may limit the duration of any waiver or variance.

5. The department may revoke a waiver or variance if:

a. It is determined that the waiver or variance is adversely affecting the health, safety, or welfare of recipients;

b. The provider has failed to comply with the variance as granted;

c. The applicant notifies the department in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or

d. Revocation of the waiver or variance is required by a change in law.

The repeal and rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.026(1), Stats.

Department of Health and Social Services

Dated: November 15, 1985

By _____
Linda Reivitz, Secretary

SEAL:

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES
1 West Wilson Street, Madison, Wisconsin 53702

Anthony S. Earl
Governor

Linda Reivitz
Secretary

Mailing Address:
Post Office Box 7850
Madison, WI 53707

November 15, 1985

Mr. Orlan Prestegard
Revisor of Statutes
30 on the Square - 9th Floor
Madison, Wisconsin 53702

Dear Mr. Prestegard:

As provided in s. 227.023, Stats., there is hereby submitted a certified copy of HSS 105 and 106, administrative rules relating to the certification of health care providers for Medical Assistance reimbursement and the rights and duties of health service providers under the Medical Assistance Program.

These rules are also being submitted to the Secretary of State as required by s. 227.023, Stats.

Sincerely,

Linda Reivitz
SECRETARY

Enclosure