CR 92-41

RULES CERTIFICATE

STATE OF WISCONSIN)
) SS
DEPT. OF INDUSTRY,)
LABOR & HUMAN RELATIONS)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Carol Skornicka, Secretary of the Department of Industry, Labor and Human Relations, and custodian of the official records of said department, do hereby certify that the annexed rule(s) relating to Health Service Fee Dispute Resolution Process (Subject) were duly approved and adopted by this department on May 13, 1992 (Date).

I further certify that said 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.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the department at 7:30 a.m. in the city of Madison, this 13th day of May A.D. 19 92.

Carol Skornicka
Secretary

RECEIVED
MAY 13 1992
9:00 am
Revisor of Statutes
Bureau

7-1-92

DILHR-ADM-6056(N.04/80)

ORDER OF ADOPTION

Pursuant to authority vested in the Department of Industry, Labor and Human Relations by section(s) 102.16 (2), Stats., the Department of Industry, Labor and Human Relations [X] creates; [ ] amends; [ ] repeals and recreates; [ ] repeals and adopts rules of Wisconsin Administrative Code chapter (s):

Ind 80.72 (Number) Health Service Fee Dispute Resolution Process (Title)

The attached rules shall take effect on July 1, 1992 _____ pursuant to section 227.22, Stats.

Adopted at Madison, Wisconsin, this date: May 13, 1992

DEPARTMENT OF INDUSTRY, ~~LABOR~~ AND HUMAN RELATIONS

Secretary

RECEIVED

MAY 13 1992

Revisor of Statutes Bureau

ADM-6055 (R.01/87)

State of Wisconsin \ Department of Industry, Labor and Human Relations

RULES in FINAL DRAFT FORM

Rule No.: Ind 80.72

Relating to: Health Service Fee Dispute Resolution Process

Ind 80.72 HEALTH SERVICE FEE DISPUTE RESOLUTION PROCESS. (1) PURPOSE. The purpose of this section is to establish the procedures and requirements for resolving a dispute under s. 102.16(2), Stats., between a health service provider and an insurer or self-insured employer over the reasonableness of a fee charged by the health service provider relating to the examination or treatment of an injured worker, and to specify the standards that health service fee data bases must meet for certification by the department.

(2) DEFINITIONS. In this section:

(a) "ADA" means American dental association.

(b) "Applicant" means the person requesting certification of a data base.

(c) "Certified" means approved by the department for use in determining the reasonableness of fees.

(d) "CPT code" means the American medical association's 1992 physicians' current procedural terminology.

Note: this volume is on file in the offices of the secretary of state and the revisor of statutes, and in the worker's compensation division of the department, GEF I, room 161, 201 E. Washington Ave., Madison, Wisconsin. Copies can be obtained from local textbook stores or from the american medical association, order department: OP054192, P.O. Box 10950, Chicago, IL 60601.

(e) "Data base" means a list of fees for procedures compiled and sorted by CPT code, ICD-9-CM code, ADA code, DRG code, or other similar coding which is systematically collected, assembled, and updated, and which does not include procedures charged under medicare.

(f) "DRG" means a diagnostic related group established by the federal health care financing administration.

(g) "Dispute" means a disagreement between a health service provider and an insurer or self-insured employer over the reasonableness of a fee charged by a health service provider where the insurer or self-insured employer refuses to pay part or all of the fee.

(h) "Fee" or "health service fee" means the amount charged for a procedure by a health service provider.

(i) "Formula amount" means the mean fee for a procedure plus 1.5 standard deviations from that mean as shown by data from a certified data base.

(j) "ICD-9-CM" means the commission on professional and hospital activities' international classification of diseases, 9th revision, clinical modification.

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(k) "Procedure" or "health service procedure" means any treatment of an injured worker under s. 102.42, Stats.

(l) "Provider" or "health service provider" includes a physician, podiatrist, psychologist, optometrist, chiropractor, dentist, physician's assistant, therapist, medical technician, or hospital.

(m) "Self-insurer" means an employer who been granted an exemption from the duty to insure under s. 102.28(2), Stats.

(3) JUSTIFICATION OF DISPUTED FEES. (a) In a case where liability or the extent of disability is not in issue, and a health care provider charges a fee which an insurer or self-insurer refuses to pay because it is more than the formula amount, the insurer or self-insurer shall, except as provided in sub. (6)(b), mail or deliver written notice to the provider within 30 days after receiving a completed bill which clearly identifies the provider's name, address and phone number; the patient-employe; the date of service; the health service procedure; and the amount charged for each procedure. The notice from the insurer or self-insurer to the provider shall specify:

1. The name of the patient-employe and the employer;

2. The date of the procedure in dispute;

3. The amount charged for the procedure;

4. The CPT code, ADA code, ICD-9-CM code, DRG code or other certified code for the procedure;

5. The formula amount for the procedure and the certified data base from which that amount was determined;

6. The amount of the fee that is in dispute beyond the formula amount;

7. The provider's obligation under par. (c), if the fee is beyond the formula amount, to provide the insurer or self-insurer with a written justification for the higher fee, at least 20 days prior to submitting the dispute to the department. The notice must clearly explain that the only justification for a fee more than the formula amount is that the service provided in this particular case is more difficult or more complicated than in the usual case; and

8. The insurer's or self-insurer's obligation under par. (d) to respond within 15 days of receiving the provider's written justification for charging a fee beyond the formula amount.

9. That pursuant to s. 102.16(2)(b), Stats., once the notice required by this subsection is received by a provider, a health service provider may not collect the disputed fee from, or bring an action for collection of the disputed fee against, the employe who received the services for which the fee was charged.

(b) If the provider and the insurer or self-insurer agree on the facts in sub. (3)(a) 1 to 6, the provider may submit the dispute to the department at any time. If the provider believes there is a factual error in the notice provided by the insurer or self-insurer, it must raise the issue as provided in par. (c).

(c) If, after receiving notice from the insurer or self-insurer, the provider believes a fee beyond the formula amount is justified, or if it does not agree with the factual information provided in the notice under par. (a), then, at least 20 days prior to submitting a dispute to the department, the provider must submit a written justification to the insurer or self-insurer noting the factual error or explaining the extent to which the service provided in the disputed case was more difficult or more complicated than in the usual case, or both.

(d) If the provider submits a written justification under par. (c), the insurer or self-insurer has 15 days after receiving the notice to notify the provider that it accepts the provider's explanation or to explain its continuing refusal to pay the fee. If the insurer or self-insurer accepts the provider's justification, the fee must be paid in full, or in an amount mutually agreed to by the provider and insurer or self-insurer, within 30 days from the date the insurer or self-insurer received written justification under par. (c).

(e) If only a portion of the fee is in dispute, the insurer or self-insurer shall, within the 30-day notice period specified in par.(a), pay the remainder of the fee which is not in dispute.

(4) SUBMITTING DISPUTED FEES. (a) For the department to determine whether or not a fee is reasonable under s. 102.16(2), Stats., a provider shall file a written request to the department to resolve the dispute within 6 months after an insurer or self-insurer first refuses to pay as provided in sub. (3)(a), and provide a copy of the request and all attachments to the insurer or self-insured employer.

(b) A request by a provider shall include copies of all correspondence in its possession related to the fee dispute.

(c) The department shall notify the insurer or self-insurer when a request to settle the dispute is submitted that the insurer or self-insurer has 20 days to file an answer or a default judgment will be ordered.

(d) The insurer or self-insurer shall file an answer with the department, and send a copy to the provider, within 20 days from the date of the department's notice of dispute. The answer shall include:

1. Copies of any prior correspondence relating to the fee dispute which the provider has not already filed.

2. Information from a certified data base on fees charged by other providers for comparable services or procedures which clearly demonstrates that the fee in dispute is beyond the formula amount for the service or procedure.

3. An explanation of why the service provided in the disputed case is not more difficult or complicated than in the usual case.

(e) The department shall examine the material submitted by all parties and issue its order resolving the dispute within 90 days after receiving the material submitted under par. (d). The department shall send a copy of the order to the provider, the insurer or self-insurer and the employee. If the fee dispute involves a claim for which an application for hearing is filed under s. 102.17, Stats., or an injury for which the insurer or self-insurer disputes the cause of the injury, the extent of disability, or other issues which could result in an application for hearing being filed, the department may delay resolution of the fee dispute until a hearing is held or an order is issued resolving the dispute between the injured employe and the insurer or self-insurer.

(f) The department may develop and require the use of forms to facilitate the exchange of information.

(5) DEPARTMENT INITIATIVE. The department may initiate resolution of a fee dispute when requested to do so by an injured worker, an insurer or a self-insurer. The department shall direct the parties to follow the process provided for in subs. (3) and (4), except where the department specifically determines that extraordinary circumstances justify some modification to expedite or facilitate a fair resolution of the dispute.

(6) INTEREST ON LATE PAYMENT. (a) Except as provided in par. (b), in addition to any amount paid or awarded in a fee dispute, where an insurer or self-insurer fails to respond as required in subs. (3) and (4) or as directed under sub. (5), the insurer or self-insurer shall pay simple interest on the payment or award to the provider at an annual rate of 12 percent, to be computed by the insurer or self-insurer, from the date that the insurer or self-insurer first missed a deadline for response, to the date of actual payment to the provider.

(b) If the insurer or self-insurer notifies the provider within 30 days of receiving a completed bill under sub. (3) (a), that it needs additional documentation from the provider regarding the bill or treatment, the insurer or self-insurer shall have 30 days from the date it receives the provider's response to this request for additional documentation to comply with the notice requirement in sub. (3) (a). Examples of additional documentation include requests for a narrative description of services provided or medical reports.

(c) For the purpose of calculating the extent to which any claim is overdue, the date of actual payment is the date on which a draft or other valid instrument which is equivalent to payment is postmarked in the U.S. mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

(7) CERTIFICATION OF DATA BASES. (a) Before the department may certify a data base under s. 102.16 (2), Stats., and sub. (8), it shall determine that all of the following apply:

1. The fees in the data base accurately reflect the amounts charged by providers for procedures rather than the amounts paid to or collected by providers, and do not include any medicare charges.

2. The information in the data base is compiled and sorted by CPT code, ICD-9-CM code, ADA code, DRG code or other similar coding accepted by the department.

3. The information in the data base is compiled and sorted into economically similar regions within the state, with the fee based on the location at which the service was provided.

4. The information in the data base can be presented in a way which clearly indicates the formula amount for each procedure.

5. The applicant authorizes and assists the department to audit or investigate the accuracy of any statements made in the application for certification by any reasonable method including, if the applicant did not collect or compile the data itself, providing a means for the department to audit or investigate the process used by the person who collected or compiled the data.

6. The information in the data base is up-dated and published or distributed by other methods at least every 6 months.

(b) Before the department may certify a data base under s. 102.16(2), Stats., it shall consider all of the following:

1. The coverage of the data base, including the number of CPT codes, ICD-9-CM codes or DRGs for which there are data; the number of data entries for each code or DRG; the number of different providers contributing to a code or DRG entry; and the extent to which reliable data exist for injuries most commonly associated with worker's compensation claims;

2. The sources from which the data are collected, including the number of different providers, insurers or self-insurers;

3. The age of the data, and the frequency of the updates in the data;

4. The method by which the data are compiled, including the method by which mistakes in charges are identified and corrected prior to entry and the extent to which this occurs; and the conditions under which charges reported to the applicant may be excluded and the extent to which this occurs;

5. The extent to which the data are representative of the entire geographic area for which certification is sought;

6. The length of time the applicant has been in business and doing business in Wisconsin;

7. The length of time the data base has been in existence;

8. Whether the data base has been certified by any organization or government agency.

(8) APPLICATION FOR CERTIFICATION; DECERTIFICATION. (a) To obtain certification from the department, an applicant shall submit a complete description of the items covered in sub. (7) to the department. The department may require the submission of other information which it deems relevant.

(b) The applicant shall clearly identify any trade secrets under s. 19.36(5), Stats. The department shall treat any information marked as trade secrets as confidential and shall use it solely for the purpose of certification and shall take appropriate steps to prevent its release.

(c) Notwithstanding par. (b), the department may create a technical advisory group consisting of individuals with special expertise from both the public and private sectors to assist the department in reviewing and evaluating an application.

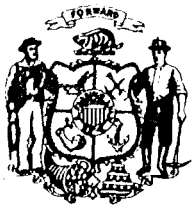
(d) The department shall certify a data base for one year at a time. The department may extend the one-year certification period while an application for renewal is under review by the department.

(e) If the department determines that an applicant has misrepresented a material fact in its application or that it no longer meets the requirements in sub. (7), the department may decertify a data base after providing the applicant with notice of the basis for decertification and an opportunity to respond.

(9) APPLICABILITY. This section first applies to health service procedures provided on July 1, 1992 and shall take effect on July 1, 1992.

Tommy G. Thompson
Governor

Carol Skornicka
Secretary



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State of Wisconsin
Department of Industry, Labor and Human Relations

May 13, 1992

Gary Poulson
Assistant Revisor of Statutes
2nd Floor
119 Martin Luther King Blvd.
Madison, Wisconsin 53703

Douglas LaFollette
Secretary of State
10th Floor
30 West Mifflin Street
Madison, Wisconsin 53703

Dear Messrs. Poulson and LaFollette:

TRANSMITTAL OF RULE ADOPTION

CLEARINGHOUSE RULE NO. 92-41

RULE NO. Section Ind 80.72

RELATING TO: Health Service Fee Dispute Resolution Process

Pursuant to section 227.20, Stats., agencies are required to file a certified copy of every rule adopted by the agency with the offices of the Secretary of State and the Revisor of Statutes.

At this time, the following material is being submitted to you:

1. Order of Adoption.
2. Rules Certificate Form.
3. Rules in Final Draft Form.

Pursuant to section 227.114, Stats., a summary of the final regulatory flexibility analysis is included for permanent rules. A fiscal estimate and fiscal estimate worksheet is included with an emergency rule.

Respectfully submitted,

Carol Skornicka
Secretary