Chapter HSS 104

RECIPIENTS' RIGHTS AND DUTIES

HSS 104.01 Recipient rights. (1) CIVIL RIGHTS. No applicant for or recipient of medical assistance shall be excluded from participation in medical assistance, or denied medical assistance benefits, or otherwise subjected to discrimination under the medical assistance program for reasons which violate Title VI of the Civil Rights Act.

(2) RIGHTS UNDER SECTION 504 OF THE REHABILITATION ACT OF 1973. No otherwise qualified handicapped individual shall, solely by reason of handicap, be excluded from the participation in, be denied benefits or be subjected to discrimination under any program or activity receiving federal financial assistance.

(3) CONFIDENTIALITY OF MEDICAL INFORMATION. Pursuant to s. 905.04 (4) (f), Stats., no privilege shall exist under the medical assistance program regarding communications or disclosures of information requested by appropriate federal or state agencies, or their authorized agents, concerning the extent or kind of services provided recipients under the program. The disclosure by a provider of such communications or medical records, made in good faith under the requirements of this program, shall not create any civil liability or provide any basis for criminal actions of unprofessional conduct.

(4) FREE CHOICE OF PROVIDER. (a) The department shall maintain a current list of certified providers and shall assist eligible persons in securing appropriate care.

(b) A recipient may request service from any certified provider, subject to HSS 104.02 (1) and 104.03.

(c) A recipient who believes the recipient's freedom of choice of provider has been denied or impaired may request a fair hearing pursuant to PW-PA 20.18 Wis. Adm. Code.

(d) Free choice of a skilled nursing home shall be limited so as to provide only care which is necessary to meet the medical and nursing needs of the recipient.

(e) A recipient's participation in medical assistance does not preclude the recipient's right to seek and pay for services not covered by the program.

(5) APPEALS (a) *Fair hearing.* Applicants and recipients have the right to a fair hearing in accordance with established procedures and consistent with applicable state law and federal regulations when aggrieved by action or inaction of the county agency or the department.

Note: This subsection does not apply to actions taken by the PSRO.

1. Every applicant or recipient shall be informed in writing at the time of application and at the time of any action affecting the recipient's claim, of the right to a fair hearing, of the manner by which a fair hearing may be obtained, and of the right to be represented or to represent self at such a fair hearing.

2. The applicant or recipient shall be provided reasonable time, not to exceed 90 days, in which to appeal an agency action. The department shall take prompt, definitive, and final administrative action within 90 days of the date of the request for a hearing.

3. The procedure for the fair hearing shall be found in PW-PA 20.18, Wis. Adm. Code.

(b) *Purpose of hearing.* The purpose of the fair hearing is to allow a recipient to appeal department actions which result in the denial, discontinuation, termination, suspension, or reduction of the recipient's medical assistance. The fair hearing process is not intended for recipients who wish to lodge complaints against providers concerning quality of services received, nor is it intended for recipients who wish to institute legal proceedings against providers. Recipients' complaints about quality of care should be lodged with the appropriate channels established for such purposes, such as provider peer review organizations, consumer advocacy organizations, regulatory agencies or the courts.

(c) *Concurrent review.* After the department has received a recipient's request for a fair hearing and has set the date for the hearing, the department shall review and investigate the facts surrounding the recipient's request for fair hearing in an attempt to resolve the problem informally.

1. If, before the hearing date, an informal resolution is proposed and is acceptable to the recipient, the recipient may withdraw the request for fair hearing.

2. If, before the fair hearing date, the concurrent review results in an informal resolution not acceptable to the recipient, the fair hearing shall proceed as scheduled.

3. If the concurrent review has not resolved the recipient's complaint satisfactorily by the fair hearing date but an informal resolution acceptable to the recipient appears imminent to all parties, the hearing may be dropped without prejudice and resumed at a later date. However, if the informal resolution proposed by the department is not acceptable to the recipient, the recipient may proceed with a fair hearing, and a new hearing date shall be set promptly.

4. If before the fair hearing date, the concurrent review has not been initiated, the fair hearing shall proceed as scheduled.

(6) OUT-OF-STATE COVERAGE. Medical assistance shall be furnished under the following circumstances to recipients who are Wisconsin residents but who are absent from the state:

(a) When an emergency arises from accident or illness; or

(b) When the health of the recipient would be endangered if the care and services were postponed until the recipient returned to Wisconsin; or

(c) When the recipient's health would be endangered if the recipient undertook travel to return to Wisconsin; or

(d) When prior authorization has been granted for provision of a non-emergency service, except that prior authorization is not required for non-emergency services provided to Wisconsin recipients by border status providers.

(7) FREE CHOICE OF FAMILY PLANNING METHOD. Recipients eligible for family planning services and supplies shall have freedom of choice of method so that a recipient may choose in accordance with the dictates of conscience and shall neither be coerced nor pressured into choosing any particular method of family planning.

(8) CONTINUATION OF BENEFITS TO COMMUNITY CARE ORGANIZATION CLIENTS. Recipients eligible for or receiving services from any of the local community care organization project sites (La Crosse county, Barron county, Milwaukee county), as of April 1976, shall be allowed to continue to receive any of the CCO services, and such services shall be reimbursed under the program.

(9) RIGHT TO INFORMATION CONCERNING PROGRAM POLICY. (a) *Program manuals.* Recipients may examine program manuals and policy issuances which affect the public, including rules and regulations governing eligibility, need and amount of assistance, recipients' rights and responsibilities and services offered under medical assistance, at the department's state, county or regional offices on regular work days during regular office hours.

(b) *Notice of the department's intention to discontinue, terminate, suspend, or reduce assistance.* 1. Except when changes in the law require automatic grant adjustments for classes of recipients, in every instance in which the department intends to discontinue, terminate, suspend or reduce a recipient's medical assistance, or coverage of services to a general class of recipients, the department shall send a written notice to the recipient's last known address no later than 10 days before the date upon which the action would become effective, informing the recipient of the following:

a. The nature of the intended action;

b. The reasons for the intended action;

c. The specific regulations supporting such action;

d. An explanation of the recipient's right to request a fair hearing; and,

e. The circumstances under which assistance is continued if a hearing is requested.

2. The department shall mail such individual written notice to be received no later than the date of intended action under any of the following circumstances:

a. The department receives a clear written statement signed by a recipient that states the recipient no longer wishes assistance, or that gives information which requires termination or reduction of assistance, and

the recipient has indicated, in writing, that the recipient understands that this must be the consequence of supplying such information;

b. The department has factual information confirming the death of a recipient;

c. The recipient has been admitted or committed to an institution and further payments to the recipient do not qualify for federal financial participation under the state plan;

d. The recipient has been placed in skilled nursing care, intermediate care or long-term hospitalization;

e. The recipient's whereabouts are unknown and departmental mail directed to the recipient has been returned by the post office indicating no known forwarding address;

f. A recipient has been accepted for assistance in a new jurisdiction and that fact has been established by the jurisdiction previously providing assistance;

g. An AFDC child is removed from the home as a result of judicial determination, or voluntarily placed in foster care by a legal guardian;

h. A change in level of medical care is prescribed by the recipient's physician.

(10) PROMPT ACCESS TO ASSISTANCE. Applicants have the right to prompt decisions on their applications. Eligibility decisions shall be made within 30 days of the date the application was signed. For individuals applying as disabled, where medical examination reports, determination of disability, and other additional medical and administrative information is necessary for the decision, eligibility decisions shall be made not more than 60 days after the date the application was signed. Care shall be furnished promptly to eligible recipients without any delay attributable to the department's administrative process and shall be continued regularly until the individuals are found ineligible.

(11) RIGHT TO REQUEST RETURN OF PAYMENTS FOR COVERED SERVICES MADE BY A RECIPIENT DURING PERIOD OF RETROACTIVE ELIGIBILITY. If a person has paid all or part of the cost of health care services received and then the person becomes a recipient of MA benefits and the recipient's eligibility is made retroactive to allow the MA program to pay for those covered services for which the recipient has previously made payment, then such recipient has the right to notify the provider of the retroactive eligibility period. At such time the provider shall submit claims to medical assistance for covered services provided to the recipient during the retroactive period. Upon the provider's receipt of MA payment, the provider shall be required to reimburse the lesser of amount received from MA or the amount paid by recipient or other person.

(12) FREEDOM FROM LIABILITY FOR COVERED SERVICES. (a) Recipients cannot be held liable by providers for covered services and items furnished by providers under the medical assistance program so long as the recipients are eligible for medical assistance benefits and meet all other program requirements.

(b) Recipients cannot be charged by providers for the amount of the difference between charge for service and the program's payment

amount, except that in the case of recipients wishing to be in a private room in a nursing home or hospital, in which case the provisions of section HSS 107.09 (3) (i) shall be met.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 104.02 Recipient duties. (1) A recipient shall not seek the same or similar services from more than one provider, except as provided in HSS 104.04 of this rule.

(2) Except in bona fide emergencies that preclude prior identification, the recipient shall, before receiving services, inform the provider that the recipient is receiving benefits under the medical assistance program, and present a valid MA identification card.

(3) Recipients shall review the monthly explanation of benefits notice sent to them by the department and shall report to the department any payments made for services not actually provided. The explanation of benefits notice shall not specify confidential services and shall not be sent if the only service furnished was confidential.

(4) Recipients are responsible for giving providers full, correct and truthful information requested by providers and necessary for the submission of correct and complete claims for medical assistance reimbursement. Such information includes but is not limited to:

(a) Information concerning the recipient's eligibility status, accurate name, address, and MA identification number;

(b) Information concerning the recipient's use of the medical assistance card;

(c) Information concerning the recipient's use of medical assistance benefits;

(d) Information concerning recipient's coverage under other insurance programs.

(5) Recipients who abuse or misuse the MA card or benefits in any manner may be subject to limitation of benefits or decertification from the program.

(6) Recipients shall inform the county agency within 10 days of any change in address, eligibility, income, need, or living arrangements.

(7) Within the limitations provided by ch. 52, Stats. and this rule, the spouse of an applicant of any age or the parent of an applicant under 18 years of age shall be charged with the cost of medical services before medical assistance payments shall be made. However, eligibility shall not be withheld, delayed or denied because a responsible relative fails or refuses to accept financial responsibility. When the county agency determines that a responsible relative is able to contribute without undue hardship to self or immediate family but refuses to contribute, the county agency shall exhaust all available administrative procedures to obtain that relative's contribution. If the responsible relative fails to contribute support after the county agency notifies the relative of the obligation to do so, the county agency shall notify the district attorney in an effort to commence legal action against that relative.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 104.03 Primary provider. (1) If the department discovers program abuse, including abuse under HSS 104.02 (1), the department may require the recipient to designate, in any or all categories of health provider, a primary health care provider of the recipient's choice.

(2) The department shall allow a recipient to choose a primary provider from the department's current list of certified providers. The recipient's choice shall become effective only with the concurrence of the designated primary provider. The name of the primary provider shall be endorsed on the recipient's medical assistance identification card.

(3) A primary provider may, within the scope of the provider's practice, make referrals to other providers of medical services for which reimbursement will be made if the referral can be documented as medically necessary and the services are covered by the medical assistance program. Such documentation shall be made by the primary provider in the recipient's medical record.

(4) The department may allow the designation of an alternate primary provider. When approval is given by the department to select an alternate primary provider, the recipient may designate an alternate primary provider in the same manner a primary provider is designated.

(5) The limitations imposed in this section do not apply in the case of an emergency.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 104.04 Second opinion program. Pursuant to chapter 29, Laws of 1977, the department may establish a second opinion program for elective surgical procedures, to promote the quality of care for recipients. The purpose of the program is to provide a recipient additional medical information about the medical appropriateness of the proposed procedure, before the recipient makes a decision to undergo a surgical procedure, and to allow reimbursement of the costs related to providing the second opinion. Second opinions apply only to non-emergency procedures.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.