Chapter HSS 104

MEDICAL ASSISTANCE: RECIPIENT RIGHTS AND DUTIES

HSS 104.01 Recipient rights. (1) CIVIL RIGHTS. No applicant for or recipient of medical assistance (MA) may be excluded from participation in MA or denied benefits or otherwise be subjected to discrimination under MA for reasons which violate Title VI of the civil rights act of 1964, as amended, 42 USC 200d et seq., and the implementing regulations, 45 CFR Part 80.

(2) RIGHTS OF HANDICAPPED PERSONS. No otherwise qualified handicapped individual may, solely by reason of handicap, be excluded from the participation in MA, be denied benefits of MA or be subjected to discrimination under MA.

Note: See s. 504 of the rehabilitation act of 1973, as amended, 29 USC 794, and the implementing regulations, 45 CFR Part 84.

(3) CONFIDENTIALITY OF MEDICAL INFORMATION. Information about recipients shall be confidential in accordance with ss. 146.81 to 146.83, Stats. No privilege exists under MA 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 these 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 for unprofessional conduct.

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

(b) *Limitations.* A recipient may request service from any certified provider, subject to ss. HSS 104.02 (1), 104.03, and 104.05, except as provided in par. (d).

(c) *Right to fair hearing.* A recipient who believes the recipient's freedom of choice of provider has been denied or impaired unfairly may request a fair hearing within 45 days of the department's action, pursuant to s. PW-PA 20.18 [ch. HSS 225].

(d) *Nursing home admission.* Free choice of a skilled nursing or intermediate care facility shall be limited so as to provide only care which is necessary to meet the medical and nursing needs of the recipient. A preadmission screening assessment shall take place to determine appropriate service needs.

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

(5) APPEALS. (a) *Fair hearing.* 1. Applicants and recipients have the right to a fair hearing in accordance with procedures set out in s. PW-PA 20.18 [ch. HSS 225] and this subsection when aggrieved by action or inaction of the agency or the department. This subsection does not apply to actions taken by a PRO.

2. Every applicant or recipient shall be informed in writing at the time of application for MA 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.

3. The applicant or recipient shall be provided reasonable time, not to exceed 45 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.

4. No fair hearing is required when the sole issue being petitioned involves an automatic grant adjustment or change which affects an entire class of recipients and is the result of a change in state or federal law.

(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 MA benefits. 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 this purpose, to include but not limited to provider peer review organizations, consumer advocacy organizations, regulatory agencies and the courts.

(c) *Concurrent review.* 1. 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.

2. 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.

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

4. 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.

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

(d) *Absence of petitioner.* Pursuant to s. 49.50 (8) (b) 1d, Stats., if the recipient does not appear at a scheduled hearing and does not contact the

department's office of administrative hearings with good cause for postponement, the hearing examiner may dismiss the petition.

(6) COVERAGE WHILE OUT-OF-STATE. Medical assistance shall be furnished under any of the following circumstances to recipients who are Wisconsin residents but absent from the state provided that they are within the United States, Canada or Mexico:

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

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

(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 certified by the Wisconsin MA program.

(7) FREE CHOICE OF FAMILY PLANNING METHOD. Recipients eligible for family planning services and supplies shall have freedom of choice of family planning 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 who were eligible for or receiving services from any of the local community care organization (CCO) projects in La Crosse county, Barron county, or Milwaukee county, in April 1976, shall be allowed to continue to receive any of the CCO services and these services shall be reimbursed under MA.

(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 covered under MA, at the department's state or regional offices, or an agency's offices, during regular office hours.

(b) *Notice of intended action.* 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 eligibility for MA or coverage of services to a general class of recipients, the department shall send a written notice to the recipient's last known address at least by the minimum time period required under 42 USC 601-613 and 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 the action;

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

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

2. The department shall mail the 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 the consequence of supplying the information will be termination or reduction of assistance;

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 for MA;

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;

i. The recipient's eligibility for MA is to be terminated or suspended under the provisions of s. HSS 104.02 (5); or

j. The recipient has received service during a period of ineligiblity and the department is preparing to take recovery action, pursuant to s. HSS 108.03 (3).

(10) RIGHT TO PROMPT DECISIONS AND 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. Health care shall be furnished promptly to eligible recipients without any delay attributable to the department's administrative process and shall be continued as needed until the individual is found ineligible.

(11) RIGHT TO REQUEST RETURN OF PAYMENTS MADE FOR COVERED SERVICES DURING PERIOD OF RETROACTIVE ELIGIBILITY. If a person has paid all or part of the cost of health care services received and then becomes a recipient of MA benefits with retroactive eligibility for those covered services for which the recipient has previously made payment, then the recipient has the right to notify the certified provider of the retroactive eligibility period. At that time the certified provider shall submit claims

to MA for covered services provided to the recipient during the retroactive period. Upon the provider's receipt of the MA payment, the provider shall reimburse the recipient for the lesser of the amount received from MA or the amount paid by recipient or other person, minus any relevant copayment. In no case may the department reimburse the recipient directly.

(12) FREEDOM FROM LIABILITY FOR COVERED SERVICES. (a) *Exceptions to cost-sharing.* 1. Recipients of MA are liable for payment of any copayment or deductible amount established by the department pursuant to s. 49.45 (18), Stats., for the cost of a service, except as provided in this subsection. The recipient shall pay the copayment or deductible to the provider of service. Copayments or deductibles are not required:

a. From recipients who are nursing home residents;

b. From recipients who are members of a health maintenance organization or other prepaid plan for those services provided by the HMO or PHP;

c. From any recipient who is under age 18;

d. For 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;

e. For emergency hospital and ambulance services and emergency services related to the relief of dental pain;

f. For family planning services and related supplies;

g. For transportation services by a specialized medical vehicle;

h. For transportation services provided through or paid for by a county social services department;

i. For home health services or for home nursing services if a home health agency is not available;

j. For physician office visits over 6 visits per recipient, per physician, in a calendar year;

k. For laboratory and x-ray services prescribed by a physician;

l. For outpatient psychotherapy services received over 15 hours or $500, whichever comes first, during one calendar year; or

m. For occupational, physical or speech therapy services received over 30 hours or $1,500 for any one therapy, whichever comes first, during one calendar year.

2. If the recipient uses one pharmacy or pharmacist as his or her sole provider of prescription drugs, the monthly amount of copayment a recipient is required to pay may not exceed $5.

(b) *Freedom from having to pay for services covered by MA.* Recipients may not be held liable by certified providers for covered services and items furnished under the MA program, except for copayments or de-

ductibles under par. (a), if the patient identifies himself or herself as an MA recipient and shows the provider the MA identification card.

Note: Recipients seeking nonemergency services from noncertified providers are liable for all charges, unless the services were authorized by the department prior to service delivery.

(c) *Prior authorization of services.* When a service must be authorized by the department in order to be covered, the recipient may not be held liable by the certified provider unless the prior authorization was denied by the department and the recipient was informed of the recipient's personal liability before provision of the service. In that case the recipient may request a fair hearing. Negligence on the part of the certified provider in the prior authorization process shall not result in recipient liability.

Note: For example, if a provider does not inform a recipient that a procedure or service requires prior authorization, and performs the service before submitting a prior authorization request or receiving an approval and then submits a claim for services rendered which is rejected, the recipient may not be held liable.

(d) *Freedom from having to pay the difference between charges and MA payment.* Providers may not charge recipients for the amount of the difference between charge for service and MA reimbursement, except in the case of recipients wishing to be in a private room in a nursing home or hospital, in which case the provisions of s. HSS 107.09 (3) (k) shall be met.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 104.02 Recipient duties. (1) NOT TO SEEK DUPLICATION OF SERVICES. A recipient may not seek the same or similar services from more than one provider, except as provided in s. HSS 104.04.

(2) PRIOR IDENTIFICATION OF ELIGIBILITY. Except in emergencies that preclude prior identification, the recipient shall, before receiving services, inform the provider that the recipient is receiving benefits under MA and shall present to the provider a current valid MA identification card.

(3) REVIEW OF BENEFITS NOTICE. Recipients shall review the monthly explanation of benefits (EOB) 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 may not specify confidential services, such as family planning, and may not be sent if the only service furnished is confidential.

(4) INFORMATIONAL COOPERATION WITH PROVIDERS. Recipients shall give providers full, correct and truthful information requested by providers and necessary for the submission of correct and complete claims for MA reimbursement. This information shall include 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 MA card;

(c) Information concerning the recipient's use of MA benefits; and

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

(5) NOT TO ABUSE OR MISUSE THE MA CARD OR BENEFITS. If a recipient abuses or misuses the MA card or benefits in any manner, the department or agency, as appropriate, may limit or terminate benefits. For purposes of this subsection, "abuses or misuses" includes, but is not limited to, any of the following actions:

(a) Altering or duplicating the MA card in any manner;

(b) Permitting the use of the MA card by any unauthorized individual for the purpose of obtaining health care through MA;

(c) Using an MA card that belongs to another recipient;

(d) Using the MA card to obtain any covered service for another individual;

(e) Duplicating or altering prescriptions;

(f) Knowingly misrepresenting material facts as to medical symptoms for the purpose of obtaining any covered service;

(g) Knowingly furnishing incorrect eligibility status or other information to a provider;

(h) Knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which MA has been billed;

(i) Knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary;

(j) Knowingly obtaining duplicate services from more than one provider for the same health care condition, excluding confirmation of diagnosis or a second opinion on surgery; or

(k) Otherwise obtaining health care by false pretenses.

(6) NOTIFICATION OF PERSONAL OR FINANCIAL STATUS CHANGES. Recipients shall inform the agency within 10 days of any change in address, income, assets, need, or living arrangements which may affect eligibility. In addition, the department may require as a condition for continuation of MA coverage that certain recipients report each month under ch. HSS 205 whether there has been any change of circumstances that may affect eligibility.

(7) FINANCIAL RESPONSIBILITY OF SPOUSE OR RESPONSIBLE RELATIVE. Within the limitations provided by ch. 52, Stats., and this chapter, 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 MA payments shall be made. However, eligibility may not be withheld, delayed or denied because a responsible relative fails or refuses to accept financial responsibility. When the agency determines that a responsible relative is able to contribute without undue hardship to self or immediate family but refuses to contribute, the agency shall exhaust all available administrative procedures to obtain that relative's contribution. If the responsible relative fails to contribute support after the agency noti-

fies the relative of the obligation to do so, the agency shall notify the district attorney in order to commence legal action against that relative.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 104.03 Primary provider. (1) REQUIRED DESIGNATION. (a) *Required when program is abused.* If the department discovers that a recipient is abusing the program, including abuse under s. HSS 104.02 (5), the department may require the recipient to designate, in any or all categories of health care provider, a primary health care provider of the recipient's choice, except when free choice is limited under s. HSS 104.035.

(b) *Selection of provider.* The department shall allow a recipient to choose a primary provider from the department's current list of certified providers, except when free choice is limited under s. HSS 104.035. The recipient's choice shall become effective only with the concurrence of the designated primary provider. The type of service and identification number of the primary provider shall be endorsed on the recipient's MA card.

(c) *Failure to cooperate.* If the recipient fails to designate a primary provider after receiving a formal request from the department, the department shall designate a primary provider for the recipient in the proximity of the recipient's residence.

(2) REFERRAL TO OTHER PROVIDERS. 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 MA. This documentation shall be made by the primary provider in the recipient's medical record.

(3) ALTERNATIVE PRIMARY PROVIDER. 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.

(4) EXCEPTION. The limitations imposed in this section do not apply in the case of an emergency. Emergency health care provided by any provider to a recipient restricted under this section shall be eligible for reimbursement if the claim for reimbursement is accompanied by a full explanation of the emergency circumstances.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 104.035 Prudent buyer limitations. Free choice of a provider may be limited by the department if the department contracts for alternate service arrangements which are economical for the MA program and are within state and federal law, and if the recipient is assured of reasonable access to health care of adequate quality.

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

HSS 104.04 Second opinion program. (1) PURPOSE. Under s. 49.45 (3) (i), Stats., the department shall require a second medical opinion for selected elective surgical procedures, in order to provide a recipient additional medical information about the medical appropriateness of the pro-

posed procedure before the recipient makes a decision to undergo the procedure. Procedures for which a second medical opinion is required are the following:

(a) Cataract extraction, with or without lens inplant;

(b) Cholecystectomy;

(c) Non-obstretrical D and C;

(d) Hemorrhoidectomy;

(e) Hernia repair, inguinal;

(f) Hysterectomy;

(g) Joint replacement, hip or knee;

(h) Tonsillectomy;

(i) Adenoidectomy; and

(j) Varicose vein surgery.

(2) APPLICABILITY. The requirement for a second opinion applies only to nonemergency procedures.

(3) SANCTIONS. (a) If a provider performs an elective surgical procedure covered under the program and no second opinion has been obtained, the primary surgeon's fees are not reimbursable by MA.

(b) If the provider who provides the second opinion also performs the surgery, the primary surgeon's fees are not reimbursable by MA.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 104.05 Preferred enrollment. (1) CONTRACTS FOR SERVICES FROM GROUP PLANS. The department may enter into contracts for MA services with health maintenance organizations (HMOs) or prepaid health plans (PHPs). Each contract shall include specific information about services to be provided by the group, the number and types of practitioners who will provide the services, the geographic service area covered by the group plan, the period of time in which recipients are enrolled, the procedures for recipient enrollment, additional services which may be available, and the cost of services for each enrollee.

(2) ENROLLMENT RESPONSIBILITY. MA recipients within the geographic area stipulated in a group plan service contract shall have the choice of enrolling for service membership under the following conditions:

(a) *Minimum enrollment period.* The department may enter into arrangements with HMOs or PHPs which establish minimum enrollment periods for MA recipients.

(b) *Disenrollment period.* In geographic areas where there is only one certified group plan provider, each recipient may be automatically enrolled in the group plan. A recipient may disenroll from the group plan, and the effective date of the disenrollment shall be no later than one month from the month in which the recipient disenrolls.

(3) CONTROL OF SERVICES. Enrollees in an HMO or PHP shall obtain services paid for by MA from that organization's providers, except for referrals or emergencies. Recipients who obtain services in violation of this section shall pay for these services.

(4) IDENTIFICATION OF COVERED SERVICES. Services available to MA recipients shall be identified in the provider's contract with the department and shall be made known to all MA enrollees.

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