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 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. In the preparation of claims, providers shall 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 codes. Every claim submitted shall be signed by the provider or by the provider's authorized agent.

(3) TIMELINESS. (a) A claim may not be submitted until the recipient has received the service which is the subject of the claim. A claim may not be submitted by a nursing home for a recipient who is a nursing home resident until the day following the last date of service in the month for which reimbursement is claimed. A claim may not be submitted by a hospital for a recipient who is a hospital inpatient until the day following the last date of service for which reimbursement is claimed. In order to be considered timely, an initial claim shall be submitted to the fiscal agent within 12 months of the date the service was provided. Payment may not be made for any claim submitted after that 12-month period, except where the provider demonstrates to the satisfaction of the department that circumstances beyond the provider's control prevented timely submission of the claim.

(b) If a provider is notified by an agency or recipient that a recipient has been determined to be eligible retroactively under s. 49.46 (1) (b), Stats., a claim shall be submitted to the fiscal agent within 12 months after the certifying agency notifies the fiscal agent of the effective date of eligibility.

(4) HEALTH CARE SERVICES REQUIRING PRIOR AUTHORIZATION. No payment may be made on a claim for service requiring prior authorization if written prior authorization was not 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;

(b) Where the service requiring prior authorization was provided 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 the service on a prepayment basis, except that payment may be made:

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

2. To a facility if a service was provided in a hospital, clinic or other facility, and there exists a contractual agreement between the individual provider and 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 in par. (a) shall apply for and receive certification from the department to submit claims and receive payment on behalf of the provider performing the services. Any claim submitted by an employer or facility so authorized shall identify the provider number of the individual provider who actually provided the service or item that is the subject of the claim.

(br) *Providers of professional services to hospital inpatients.* Notwithstanding pars. (a) and (b), in the case of a provider performing professional services to hospital inpatients, payment shall be made directly to the provider or to the hospital if it is separately certified to be reimbursed for the same professional services.

(c) *Prohibited payments.* No payment which under par. (a) (intro.) is made directly to an individual provider or provider organization may be made to anyone else under a reassignment or power of attorney except to an employer or facility under par. (a)1 or 2, but nothing in this paragraph shall be construed:

1. To prevent making the payment in accordance with an assignment from the person or institution providing the service if 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 the provider from receiving any payment if 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 the person or institution under the program is unrelated, directly or indirectly, to the amount of payments or the claims for them, and is not dependent upon the actual collection of the payment.

(6) ASSIGNMENT OF MEDICARE PART B BENEFITS. A provider providing a covered service to a dual entitlee shall accept assignment of the recipi-

ent'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.

(b) *Availability of information.* If the department identifies a third-party insurer that provides health or accident coverage for a recipient, the insurance coverage shall be identified in a code on the recipient's MA card. The department shall prepare and distribute to 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, a provider of any of the following services shall, before submitting an MA claim, seek to obtain payment from that third party 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.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86; renum. (3) to be (3) (a), cr. (3) (b), Register, February, 1988, No. 386, eff. 3-1-88; emerg. am. (3) (a), eff. 11-1-90; emerg. cr. (5) (br), eff. 1-1-91; am. (3) (a), Register, May, 1991, No. 425, eff. 6-1-91; cr. (5) (br), Register, September, 1991, No. 429, eff. 10-1-91.

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. 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).

(1m) PAYMENT MECHANISM. (a) *Definitions.* In this subsection:

1. "Automated claims processing system" means the computerized system operated by the department's fiscal agent for paying the claims of providers.

2. "Manual partial payment" means a method of paying claims other than through the automated claims processing system.

(b) *Automated claims processing.* Except as provided in par. (c), payment of provider claims for reimbursement for services provided to recipients shall be made through the department's automated claims processing system.

(c) *Manual partial payment.* The department may pay up to 75% of the reimbursable amount of a provider's claim in advance of payments made through the automated claims processing system if all the following conditions exist:

1. The provider requests a manual partial payment and signs a contract allowing for automatic recoupment of payment when the provider's claims are later processed through the automated claims processing system;

2. A provider's claims for services provided have been pending in the automated claims processing system for more than 30 days, or the provider provides services to MA recipients representing more than 50% of the provider's income and payment for these services has been significantly delayed beyond the claims processing time historically experienced by the provider;

3. The delay in payment under subd. 2 is due to no fault of the provider;

4. Further delay in payment will have a financial impact on the provider which is likely to adversely affect or disrupt the level of care otherwise provided to recipients; and

5. The provider has submitted documentation of covered services, including the provider name and MA billing number, the recipient's name and MA number, the date or dates of services provided, type and quantity of services provided as appropriate and any other information pertinent to payment for covered services.

(d) *Cash advances prohibited.* In no case may the department or its fiscal agent make advance payment for services not yet provided. No payment may be made unless covered services have been provided and a claim or document under par. (c) 5 for these services has been submitted to the department.

(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, except that the services and recipients listed in s. HSS 104.01 (12) (a) are exempt from cost-sharing requirements. Providers are not entitled to reimbursement from MA for the copayment, coinsurance or deductible amounts for which a recipient is liable.

(b) *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 sub. (1) as payment in full for services provided a recipient. A provider may not attempt to impose a charge for an individual procedure or for overhead which is included in the reimbursement for services provided nor may the provider attempt to impose an unauthorized charge or receive payment from a recipient, relative or other person for services provided, or 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 the service;

(b) An applicant is determined to be eligible retroactively under s. 49.46 (1) (b), Stats., and a provider has billed the applicant directly for services rendered during the retroactive period, in which case the provider shall, upon notification of the recipient's retroactive eligiblility, submit claims under this section for covered services provided during the retroactive period. Upon receipt of payment from the program for 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 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.

(5) RETURN OF OVERPAYMENT. If a provider receives a payment under the program to which the provider is not entitled or in an amount greater than that to which the provider is entitled, the provider shall promptly return to the department the amount of the erroneous or excess payment. In lieu of returning 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 owed the provider under the program. The department shall honor 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.

(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, requesting 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 45 days of receipt of 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 in question.

(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 is not entitled or in an amount greater than that to which the provider is entitled, the department may recover the amount of the improper or excess payment by any of the following methods:

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

2. If the amount 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 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 may be made by the department under 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 is not entitled or in excess of that to which the provider is entitled, and shall call to the provider's attention the right to appeal the intended action under par. (d).

(c) *Exception.* The department need not provide prior written notice under par. (b) when the payment was made as a result of a computer processing or clerical error or when the provider has requested or authorized the recovery to be made. In either of these cases the department or its fiscal agent shall provide written notice of any payment adjustments made on the next remittance issued the provider. 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 while the hearing proceeding is pending. If a timely request for hearing is not received, the department may recover from current or future obligations of the program to the provider the amount specified in the notice of intent to recover. All hearings on recovery actions by the department pursuant to s. 49.45 (2) (a)10, Stats., shall be in accordance with the provisions of ch. 227, Stats.

(e) *Request for hearing on payment adjustments.* If the provider contests the propriety of adjustments made under par. (c), the provider shall, within 30 days of receipt of the remittance, request in writing a hearing on the matter. 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. All hearings on contested adjustments shall be held in accordance with the provisions of ch. 227, Stats.

(f) *Date of service of notice.* 1. The date of service of the written notice required under par. (b) or the date of a remittance issued by the department under par. (c) shall be the date on which the provider receives the notice. The notice shall be conclusively presumed to have been received within 5 days after evidence of mailing.

2. The date of service of a provider's request for a hearing under par. (d) or (e) shall be the date on which the department's office of administrative hearings receives the request.

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

(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 s. HSS 105.02 (6) or (7) for purposes of disclosing and substantiating the nature, scope and necessity of services which are the subject of the claims.

(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 MA identification card which the provider saw on the date of service and which was apparently valid for the date of service.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86; r. (2) (b) 10. and 11., cr. (7) (f), Register, February, 1988, No. 386, eff. 3-1-88; renum. (2) (b) 5. to 9. to be 6. to 10. and am. 9. and 10., cr. (2) (b) 5., 11. and 12., Register, December, 1988, No. 396, eff. 1-1-89; emerg. am. (2) (a), r. (2) (b) to (e), renum. (2) (f) to be (2) (b), eff. 1-1-90; am. (2) (a), r. (2) (b) to (e), renum. (2) (f) to be (2) (b), Register, September, 1990, No. 417, eff. 10-1-90; emerg. cr. (1m), eff. 11-1-90; cr. (1m), Register, May, 1991, No. 425, eff. 6-1-91; am. (3) (intro.), Register, September, 1991, No. 429, eff. 10-1-91.

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 at least 30 days before the termination date notify the department in writing of 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 ch. HSS 105 as a skilled nursing facility or intermediate care facility may terminate participation in the program upon advance written notice to the department and to the facility's resident recipients or their legal guardians in accordance with s.

50.03 (14) (e), Stats. 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 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

Next page is numbered 107