Chapter HSS 105

PROVIDER CERTIFICATION

Note: Chapter HSS 105 as it existed on February 28, 1986 was repealed and a new chapter HSS 105 was created effective March 1, 1986.

HSS 105.01 Introduction. (1) PURPOSE. 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) "Group billing provider" means an entity which provides or arranges for the provision of medical services by more than one certified provider.

(b) "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.

(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 subd. 1 or 2, is related to another as spouse, parent, child or sibling;

(e) Execute a provider agreement with the department; and

(f) 1. Accept and consent to the use, based on a methodology determined by the investigating or auditing agency, of statistical sampling and extrapolation as the means to determine amounts owed by the provider to MA as the result of an investigation or audit conducted by the department, the department of justice medicaid fraud control unit, the federal department of health and human services, the federal bureau of investigation, or an authorized agent of any of these.

HSS 105.055 Certification of nurse anesthetists and anesthesiologist assistants. (1) CERTIFIED REGISTERED NURSE ANESTHETIST. For MA certification, a nurse anesthetist shall be licensed as a registered nurse pursuant to s. 441.06, Stat., and shall meet one of the following additional requirements:

(a) Be certified by either the council on certification of nurse anesthetists or the council on recertification of nurse anesthetists; or

(b) Have graduated within the past 18 months from a nurse anesthesia program that meets the standards of the council on accreditation of nurse anesthesia educational programs and be awaiting initial certification.

(2) ANESTHESIOLOGIST ASSISTANT. For MA certification, an anesthesiologist assistant shall meet the following requirements:

(a) Have successfully completed a 6 year program for anesthesiologist assistants, 2 years of which consists of specialized academic and clinical training in anesthesia; and

(b) Work under the direct supervision of an anesthesiologist who is physically present during provision of services.

History: Cr. Register, September, 1991, No. 429, eff. 10-1-91.

HSS 105.06 Certification of dentists. For MA certification, dentists shall be licensed pursuant to ss. 447.03 and 447.04, Stats.

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; correction made under s. 13.93 (2m) (b) 7, Stats., Register, June, 1994, No. 462.

HSS 105.07 Certification of general hospitals. For MA certification a hospital shall be approved as a general hospital under s. 50.35, Stats., and ch. HSS 124, shall meet conditions of participation for medicare and shall have a utilization review plan that meets the requirements of 42 CFR 456.101. No facility determined by the department or the federal health care financing administration to be an institution for mental disease (IMD) may be certified as a general hospital under this section. In addition:

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

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

(3) A hospital providing mental health day treatment services shall be certified under s. HSS 105.24;

(4) A hospital participating in a PRO review program shall meet the requirements of 42 CFR 456.101 and any additional requirements established under state contract with the PRO; and

(5) A hospital providing AODA day treatment services shall be certified under s. HSS 105.25.

Note: For certification of a hospital that is an institution for mental disease, see s. HSS 105.21. For covered hospital services, see s. HSS 107.08.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. (intro.), am. (1) to (4), cr. (5), Register, September, 1991, No. 429, eff. 10-1-91.

HSS 105.075 Certification of rehabilitation hospitals. For MA certification, a rehabilitation hospital shall be approved as a general hospital under s. 50.35, Stats., and ch. HSS 124, including the requirements for rehabilitation services under s. HSS 124.21, shall meet conditions of participation for medicare and shall have a utilization review plan that meets the requirements of 42 CFR 456.101. No facility determined by the department or the federal health care financing administration to be an institution for mental disease (IMD) may be certified as a rehabilitation hospital under this section.

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

History: Cr. Register, September, 1991, No. 429, eff. 10-1-91.

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.

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

HSS 105.09 Medicare bed requirement. (1) DEFINITION. In this section, "sufficient number of medicare-certified beds" means a supply of beds that accommodates the demand for medicare beds from both the home county and contiguous counties so that no dual eligible recipient is denied access to medicare SNF benefits because of a lack of available beds. In this subsection, "dual eligible recipient" means a person who qualifies for both medical assistance and medicare.

(2) 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 at least 3 beds per 1000 persons 65 years of age and older in the county.

(3) 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. (1), 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.

(4) 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) A home or portion of a home certified as an ICF/MR is exempt from this section.

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isfaction that it is common practice for recipients in a particular area of Wisconsin to go for medical services to the provider's locality in the neighboring state, the provider may be certified as a Wisconsin border status provider, subject to the certification requirements in this chapter and the same rules and contractual agreements that apply to Wisconsin providers, except that nursing homes are not eligible for border status.

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

(3) Other out-of-state providers who do not meet the requirements of sub. (1) may be reimbursed for non-emergency services provided to a Wisconsin MA recipient upon approval by the department under s. HSS 107.04.

(4) The department may review border status certification of a provider 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.

(5) (a) A provider certified in another state for services not covered in Wisconsin shall be denied border status certification for these services in the Wisconsin program.

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

(b) A provider denied certification in another state shall be denied certification in Wisconsin, except that a provider denied certification in another state because the provider's services are not MA-covered in that state may be eligible for Wisconsin border status certification if the provider's services are covered in Wisconsin.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. Register, September, 1991, No. 429, eff. 10-1-91.

HSS 105.49 Certification of ambulatory surgical centers. For MA certification, an ambulatory surgical center shall be certified to participate in medicare as an ambulatory surgical center under 42 CFR 416.39.

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

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; am. Register, February, 1988, No. 386, eff. 3-1-88.

HSS 105.50 Certification of hospices. For MA certification, a hospice shall be certified to participate in medicare as a hospice under 42 CFR 418.50 to 418.100.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88.

HSS 105.51 Certification of case management agency providers. (1) AGENCY. For MA certification, a provider of case management services shall be an agency with state statutory authority to operate one or more community human service programs. A case management agency may be a county or Indian tribal department of community programs, a department of social services, a department of human services, or a county or tribal aging unit. Each applicant agency shall specify each population eligible for case management under s. HSS 107.32 (1) (a) 2 for which it will provide case management services. Each certified agency shall offer all 3 case management components described under s. HSS 107.32 (1) so

that a recipient can receive the component or components that meet his or her needs.

(2) EMPLOYED PERSONNEL. (a) To provide case assessment or case planning services reimbursable under MA, persons employed by or under contract to the case management agency under sub. (1) shall:

1. Possess a degree in a human services-related field, possess knowledge regarding the service delivery system, the needs of the recipient group or groups served, the need for integrated services and the resources available or needing to be developed, and have acquired at least one year of supervised experience with the type of recipients with whom he or she will work; or

2. Possess 2 years of supervised experience or an equivalent combination of training and experience.

Note: The knowledge required in subd. 1 is typically gained through supervised experience working with persons in the target population.

(b) To provide ongoing monitoring and service coordination reimbursable under MA, personnel employed by a case management agency under sub. (1) shall possess knowledge regarding the service delivery system, the needs of the recipient group or groups served, the need for integrated services and the resources available or needing to be developed.

(3) SUFFICIENCY OF AGENCY CERTIFICATION FOR EMPLOYED PERSONNEL. Individuals employed by or under contract to an agency certified to provide case management services under this section may provide case management services upon the department's issuance of certification to the agency. The agency shall maintain a list of the names of individuals employed by or under contract to the agency who are performing case management services for which reimbursement may be claimed under MA. This list shall certify the credentials possessed by the named individuals which qualify them under the standards specified in sub. (2). Upon request, an agency shall promptly advise the department in writing of the employment of persons who will be providing case management services under MA and the termination of employes who have been providing case management services under MA.

(4) CONTRACTED PERSONNEL. Persons under contract with a certified case management agency to provide assessments or case plans shall meet the requirements of sub. (2) (a), and to provide ongoing monitoring and service coordination, shall meet the requirements of sub. (2) (b).

(5) RECORDKEEPING. The case manager under s. HSS 107.32 (1) (d) shall maintain a file for each recipient receiving case management services which includes the following:

(a) The assessment document;

(b) The case plan;

(c) Service contracts;

(d) Financial forms;

(e) Release of information forms;

(f) Case reviews;

(g) A written record of all monitoring and quality assurance activities; and

(h) All pertinent correspondence relating to the recipient's case management.

(6) REIMBURSEMENT. (a) Case management services shall be reimbursed when the services are provided by certified providers or their subcontractors to recipients eligible for case management.

(b) Payment shall be made to certified providers of case management services according to terms of reimbursement established by the department.

(7) COUNTY ELECTION TO PARTICIPATE. (a) The department may not certify a case management agency for a target population unless the county board or tribal government of the area in which the agency will operate has elected to participate in providing benefits under s. HSS 107.32 through providers operating in the county or tribal area. The county board or tribal government may terminate or modify its participation by giving a 30 day written notice to the department. This election is binding on any case management agencies providing services within the affected county or tribal area.

(b) Any case management agency provider requesting certification under this section shall provide written proof of the election of the county or tribal government to participate under this subsection.

History: Cr. Register, February, 1988, No. 386, eff. 3-1-88.

HSS 105.52 Certification of prenatal care coordination providers. (1) AGENCY. For MA certification, an agency that provides prenatal care coordination services under s. HSS 107.34 (1) may be:

(a) A community-based health organization;

(b) A community-based social services agency or organization;

(c) A county, city, or combined city and county public health agency;

(d) A county department of human services under s. 46.23, Stats., or social services under s. 46.215 or 46.22, Stats.;

(e) A family planning agency certified under s. HSS 105.36;

(f) A federally qualified health center (FQHC) as defined in 42 CFR 405.2401 (b);

(g) A health maintenance organization (HMO);

(h) An independent physician association (IPA);

(i) A hospital;

(j) A physician's office or clinic;

(k) A private case management agency;

(l) A certified nurse or nurse practitioner;

(m) A rural health clinic certified under s. HSS 105.35;

(n) A tribal agency health center; or

(o) A women, infants, and children (WIC) program under 42 USC 1786.

(2) QUALIFIED PROFESSIONALS. (a) *Definition.* In this subsection, "qualified professional" means and is limited to any of the following:

1. A nurse practitioner licensed as a certified nurse pursuant to s. 441.06, Stats., and currently certified by the American nurses' association, the national board of pediatric nurse practitioners and associates or the nurses' association of the American college of obstetricians and gynecologists' certification corporation;

2. A nurse midwife certified under s. HSS 105.201;

3. A public health nurse meeting the qualifications of s. HSS 139.08;

4. A physician licensed under ch. 448, Stats., to practice medicine or osteopathy;

5. A physician assistant certified under ch. 448, Stats;

6. A dietician certified or eligible for registration by the commission on dietetic registration of the American dietetic association with at least 2 years of community health experience;

7. A certified nurse with at least 2 years of experience in maternity nursing or community health services or a combination of maternity nursing and community health services;

8. A social worker with at least a bachelor's degree and 2 years of experience in a health care or family services program; or

9. A health educator with a master's degree in health education and at least 2 years of experience in community health services.

(b) *Required qualified professionals.* To be certified to provide prenatal care coordination services that are reimbursable under MA, the prenatal care coordination agency under sub. (1) shall:

1. Employ at least one qualified professional with at least 2 years of experience in coordinating services for at-risk or low income women;

2. Have on staff, under contract or available in a volunteer capacity a qualified professional to supervise risk assessment and ongoing care coordination and monitoring; and

3. Have on staff, under contract or available in a volunteer capacity one or more qualified professionals with the necessary expertise, based on education or at least one year of work experience, to provide health education and nutrition counseling.

(3) SUFFICIENCY OF AGENCY CERTIFICATION. Individuals employed by or under contract with an agency that is certified to provide prenatal care coordination services under this section may provide prenatal care coordination services upon the department's issuance of certification to the agency. The agency shall maintain a list of all persons who provide or supervise the provision of prenatal care coordination services. The list shall include the credentials of each named individual who is qualified to supervise risk assessment and ongoing care coordination under sub. (2) (b) 2 and to provide health education or nutrition counseling under sub. (2) (b) 3. Upon the department's request, an agency shall promptly re-

port to the department in writing the names of persons hired to provide prenatal care coordination services under MA and the termination of employes who have been providing prenatal care coordination services under MA.

(4) ADMINISTRATIVE RECORDS AND REQUIRED DOCUMENTATION. To be certified to provide prenatal care coordination services reimbursable under MA, the prenatal care coordination agency under sub. (1) shall comply with s. HSS 106.02 (9) and shall submit a plan to the department documenting:

(a) That the agency is located in the area it will serve;

(b) That the agency has a variety of techniques to identify low-income pregnant women;

(c) That, at a minimum, the agency has the name, location and telephone number of the following resources in the area to be served:

1. Women, infants, and children (WIC) programs;

2. Maternal and child health services;

3. The county, city, or combined city and county public health agency;

4. Child day care services;

5. Mental health and alcohol or other drug abuse prevention and treatment agencies;

6. The county protective service agency;

7. Domestic abuse agencies;

8. Translator and interpreter services including services for the hearing-impaired;

9. Family support services;

10. Transportation services; and

11. MA-certified primary care and obstetric providers, including health maintenance organizations participating in the medical assistance program's HMO program.

(d) That the agency, if located in a county with health maintenance organizations (HMO) participating in the medical assistance HMO program, has on file a signed copy of a memorandum of understanding with each HMO participating in the medical assistance HMO program in the county;

(e) That the agency has contacted in writing MA-certified primary and obstetric care providers in its area and has identified the types of services the prenatal care coordination agency provides. These contacts and this information shall be documented and the documentation retained in the agency's administrative records;

(f) That the agency has the ability and willingness to deliver services in a manner that is sensitive to the particular characteristics of the racial or ethnic group or groups with which it intends to work. Documentation of that ability shall be maintained and kept up-to-date. Documentation shall consist of one or more of the following at all times:

1. Records showing the racial and ethnic composition of the population served in the past;

2. Records showing that the agency has developed, implemented and evaluated programs specifically targeted toward the racial or ethnic group or groups;

3. Records showing that the agency has provided health care services in a geographic area where a significant percentage of the population was the same as the agency's targeted racial or ethnic group or groups;

4. Evidence that the agency's board or administration has a significant amount of representation from the targeted group or groups;

5. Letters of support from minority health service organizations which represent the targeted group or groups; or

6. Evidence of the agency's ability to address pertinent cultural issues such as cultural norms and beliefs, language, outreach networking and extended family relationships;

(g) That the agency has the ability to arrange for supportive services provided by other funding sources such as county transportation, county protective services, interpreter services, child care services and housing. This description shall include the methods, techniques and contacts which will be used to offer and provide assistance in accessing those services;

(h) That the agency has the capability to provide ongoing prenatal care coordination monitoring of high-risk pregnant women and to ensure that all necessary services are obtained; and

(i) That the agency has on staff, under contract or available in a volunteer capacity, individuals who are qualified professionals under sub. (2) (a) with the expertise required under sub. (2) (b).

(5) RECIPIENT RECORD. The prenatal care coordination agency shall maintain a confidential prenatal care coordination file for each recipient receiving prenatal care coordination services, which includes the following items required or produced in connection with provision of covered services under s. HSS 107.34 (1):

(a) Verification of the pregnancy;

(b) Completed risk assessment document;

(c) Care plan;

(d) Completed consent documents for release of information;

(e) A written record of all recipient-specific prenatal care coordination monitoring which includes, but is not limited to: the dates of service, description of service provided, the staff person doing the monitoring, the contacts made and the results;

(f) Referrals and follow-up; and

(g) All pertinent correspondence relating to coordination of the recipient's prenatal care.

History: Cr. Register, June, 1994, No. 462, eff. 7-1-94.