Chapter HFS 154

REIMBURSEMENT FOR TREATMENT OF ADULTS WITH CYSTIC FIBROSIS

Note: Chapter HSS 154 was created as an emergency rule effective September 1, 1993. **Chapter HSS 154 was renumbered to chapter HFS 154 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 1., Stats., Register, September, 1999, No. 525.**

HFS 154.01 Authority and purpose. This chapter is promulgated under the authority of ss. 49.683, 49.687 (1) and 227.11 (2), Stats., to establish and implement a treatment cost reimbursement program for Wisconsin residents 18 years of age or older who have cystic fibrosis.

History: Cr. Register, December, 1994, No. 468, eff. 1–1–95.

HFS 154.02 Definitions. In this chapter:

(1) "Adult" means a person 18 years of age or older.

(2) "Current year" means the later of the 12–month period beginning with the month of a patient's first application to the adult cystic fibrosis program or the 12–month period beginning with the month of a participant's most recent subsequent annual recertification for the adult cystic fibrosis program.

(3) "Cystic fibrosis" means an inherited disorder of the exocrine or outward secreting glands of the body, causing those glands to produce abnormally thick secretions of mucus.

(4) "Cystic fibrosis treatment center" means a hospital unit which furnishes the full spectrum of diagnostic, therapeutic and rehabilitation services required for the care of cystic fibrosis patients and which is certified by the national cystic fibrosis foundation.

(5) "Department" means the Wisconsin department of health and family services.

(6) "Family" means a patient and that patient's spouse, if any, and any other person who is claimed as a dependent of that patient or that patient's spouse or who claims that patient as a dependent under the U.S. internal revenue code for the purpose of filing a federal income tax return.

(7) "Federal poverty guidelines" means the annually updated poverty income thresholds by family size published each year by the U.S. department of health and human services in the federal register.

Note: The federal poverty guidelines for 1999 were published in the *Federal Register*, March 18, 1999, 13428.

(8) "Income" means a family's total earnings, including wages and salary and net income from self–employment, as well as unearned income, including social security and supplemental security income, dividends and interest income, income from estates or trusts, net rental income, public assistance, pensions or annuities, unemployment compensation, maintenance or alimony, child support or family support, nontaxable deferred compensation, and nontaxable interest such as interest on federal, state or municipal bonds, but not capital gains income.

(9) "Maintenance program" means a patient's therapeutic and treatment regimen, including medical, dental, social and vocational rehabilitation services and home health care.

(10) "Medical assistance" has the meaning specified in s. 49.43 (8), Stats.

(11) "Medical director" means a physician licensed under ch. 448, Stats., to practice medicine or osteopathy who is certified by the American board of internal medicine or is eligible for certification by that board, and who is directly responsible for a patient's maintenance program.

(12) "Medicare" means the health insurance program operated by the U.S. department of health and social services under 42 USC 1395 to 1395zz and 42 CFR Pts. 405 to 421.

(13) "Participant" means a patient who has been found eligible by the department under s. 49.683, Stats., and this chapter for reimbursement for the costs of treatment of cystic fibrosis.

(14) "Patient" means an adult who has been diagnosed as having cystic fibrosis.

(15) "Provider" means a cystic fibrosis treatment center or another source of treatment approved by the department under s. HFS 154.05.

(16) "Resident" means any adult who is living in Wisconsin with the intention of remaining permanently in the state.

History: Cr. Register, December, 1994, No. 468, eff. 1–1–95.

HFS 154.03 Eligibility. To be eligible for the adult cystic fibrosis program, a patient shall:

(1) Be a resident of Wisconsin;

(2) Be diagnosed by the medical director of a cystic fibrosis treatment center as having cystic fibrosis;

(3) Be at least 18 years of age; and

(4) Provide to the department or its designated agent full, truthful and correct information necessary for the department to determine eligibility and liability on forms specified by the department. A patient shall be ineligible for financial assistance if he or she refuses to provide information, withholds information, refuses to assist the department in verifying the information or provides inaccurate information. The department may verify or audit an applicant's total family income.

History: Cr. Register, December, 1994, No. 468, eff. 1–1–95.

HFS 154.04 Patient certification. (1) APPLICATION. To apply for assistance in paying for the costs of treatment of adult cystic fibrosis, a patient shall complete a form available from a cystic fibrosis treatment center, and shall submit the completed form either to the center or directly to the department. When an application form is submitted to a cystic fibrosis treatment center, the center shall forward the application form to the department within 14 days from the date of receipt.

(2) NOTIFICATION OF APPLICANT. The department shall certify a patient as eligible for reimbursement for part of the medical costs of treatment of cystic fibrosis if all requirements under s. HFS 154.03 are met. The department shall notify the patient, in writing, of its decision within 60 days after the department receives an application for assistance. If the application is denied, the notice shall include the reason for denial with information that the patient may request a hearing under sub. (7) on that decision.

(3) RECERTIFICATION. Certification is for one year. To be recertified, a participant shall complete, sign and submit to the department a financial statement form received from the department. The participant shall provide to the department full, truthful

and correct information necessary for the department to determine eligibility and liability.

(4) REVOCATION OR NONRENEWAL OF CERTIFICATION. The department shall revoke or not renew a participant's certification if the department finds that the participant is no longer eligible for the program. The department shall send written notice of revocation or nonrenewal to the participant, stating the reason for it and with information that the participant may request a hearing under sub. (7) on that decision.

(5) PARTICIPANT RESPONSIBILITY TO PROVIDE INFORMATION. (a) A participant shall inform the department within 30 days of any change in address, other source of health care coverage or family size, or any change in income of more than 10%.

(b) The department may verify or audit a participant's total family income. The department may redetermine a participant's estimated total family income for the current year based on change in the family's financial circumstances.

(6) CONFIDENTIALITY OF PATIENT INFORMATION. All personally identifiable information provided by or on behalf of a patient to the department shall remain confidential and may not be used for any purpose other than to determine program eligibility, participant liability, the types of medical services required for proper care and the payment of claims. Statistical analyses of program data may not reveal patient identity.

(7) APPEAL. A patient denied assistance under sub. (2) or a participant whose certification is revoked or not renewed under sub. (4) may request a hearing on that decision under ss. 227.44 to 227.50, Stats., by the department of administration's division of hearings and appeals. The request for a hearing shall be in writing and shall be sent to the office of administrative hearings so that it is received there within 30 days after the date of the notice of denial, revocation or nonrenewal of certification.

Note: The mailing address of the Division of Hearings and Appeals is P.O. Box 7875, Madison, Wisconsin 53707.

History: Cr. Register, December, 1994, No. 468, eff. 1–1–95.

HFS 154.05 Provider approval. (1) CYSTIC FIBROSIS TREATMENT CENTERS. (a) *Condition.* To be reimbursed by the program for medical care provided to program participants, a cystic fibrosis treatment center shall be certified by the national cystic fibrosis foundation and, except as provided in par. (b), shall be located in Wisconsin.

(b) *Border state treatment centers.* The department may approve a treatment center in a state bordering on Wisconsin as a cystic fibrosis treatment center if the center is within 100 miles of the Wisconsin border, has a practice that includes providing services to Wisconsin residents and is certified by the national cystic fibrosis foundation. A border state cystic fibrosis treatment center is subject to the same requirements and contractual agreements as cystic fibrosis treatment centers located in Wisconsin.

(c) *Availability of a grievance mechanism for program participants.* A cystic fibrosis treatment center shall have a written grievance procedure and shall provide a copy to each program participant. The cystic fibrosis treatment center may not discriminate against or take other retaliatory measures against a participant because the participant filed a grievance.

(2) OTHER PROVIDERS. (a) A hospital or physician located in Wisconsin shall be deemed approved for reimbursement for treatment rendered to a program participant upon the department's receipt of a valid claim for services rendered.

(b) A pharmacy or a provider of home health care supplies shall be deemed approved for reimbursement for treatment–related services provided to a program participant upon the department's receipt of a valid claim for services rendered.

History: Cr. Register, December, 1994, No. 468, eff. 1–1–95.

HFS 154.06 Provider reimbursement. (1) CLAIM FORMS. (a) A provider shall use claim forms furnished or prescribed by the department or its fiscal agent, except that a provider may submit claims by electronic media or electronic submission if the provider or billing service is approved by the department for electronic claims submission.

(b) Claims shall be submitted in accordance with the claims submission requirements, claim form instructions and coding information provided by the department or its fiscal agent.

(c) Every claim submitted shall be signed by the provider or the provider's authorized representative, certifying to the truthfulness, accuracy and completeness of the claim.

(2) TIMELINESS. (a) A claim shall be submitted within 12 months after the date that medical services were provided, except that a claim may be submitted later if the department is notified within that 12 month period that the sole reason for late submission concerns another funding source and the claim is submitted within 180 days after obtaining a decision on reimbursement from the other funding source.

(b) A claim may not be submitted until after the patient has received the medical services.

(3) PAYMENT. (a) The department shall establish allowable costs for medical services as a basis for reimbursing providers.

(b) Reimbursement may not be made for any portion of the cost of medical care which is payable under any other state or federal program or any grant, contract or contractual agreement.

(c) Before submitting a claim to the adult cystic fibrosis program, a provider shall seek payment for services provided to a participant from medicare, medical assistance or another health care plan if the participant is eligible for services under medicare, medical assistance or the other health care plan.

(d) When benefits from medicare, medical assistance or another health care plan or other third party payer have been paid, in whole or in part to the provider or participant, the amount of the payment from all other payers shall be indicated on or with the bill to the adult cystic fibrosis program. The amount of the medicare, medical assistance, other health care plan or other third party payer reimbursement shall reduce the amount of the claim for adult cystic fibrosis program payment.

(e) 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 the amount of the erroneous or excess payment to the department.

(f) A provider may request a hearing to review a decision to deny payment or the level of payment. A request for a hearing shall be filed with the department of administration's division of administrative hearings within 90 days after the date of the payment or decision to deny payment. A request for a hearing is considered filed upon its receipt by the division of administrative hearings. All appeals shall include written documentation and any information deemed necessary by the department. Hearings shall be conducted in accordance with subch. III of ch. 227, Stats.

Note: The mailing address of the Division of Administrative Hearings is P.O. Box 7875, Madison, Wisconsin 53707.

History: Cr. Register, December, 1994, No. 468, eff. 1–1–95.

HFS 154.07 Participant liability. (1) CALCULATION. A participant's liability to contribute toward the cost of treatment shall be calculated in accordance with subs. (2) to (4). If there are 2 or more participants in the same family, the family's liability shall be limited to the liability of one member of the family.

(2) INCOME DEDUCTIBLE. A participant whose estimated total family income in the current year exceeds 300% of the federal poverty guidelines shall obligate or expend the following percentage of that income to pay the cost of medical treatment for the condition before the adult cystic fibrosis program will provide assistance in paying for the cost of treatment:

(a) When total family income is from 300% to 325% of the federal poverty guidelines, 0.75% of that income;

(b) When total family income is more than 325% but less than or equal to 350% of the federal poverty guidelines, 1.5% of that income;

(c) When total family income is more than 350% but less than or equal to 375% of the federal poverty guidelines, 2.25% of that income;

(d) When total family income is more than 375% but less than or equal to 400% of the federal poverty guidelines, 3.0% of that income; and

(e) When total family income is more than 400% of the federal poverty guidelines, 4.0% of that income.

(3) PARTICIPANT COINSURANCE. (a) A participant shall pay a coinsurance amount to cover part of the cost of treating the participant's adult cystic fibrosis.

(b) A participant's coinsurance amount shall be determined at the time the patient is certified for eligibility and annually thereafter.

(c) The amount of a participant's coinsurance shall be related to family size and to family income rounded to the nearest whole dollar, in accordance with the schedule in Table 154.07.

(d) The amount that a participant pays in coinsurance annually may not exceed the following applicable percentage of the family's income, rounded to the nearest whole dollar:

1. For an income of up to $10,000, 3%;
2. For an income of $10,001 to $20,000, 4%;
3. For an income of $20,001 to $40,000, 5%;
4. For an income of $40,001 to $60,000, 6%;
5. For an income of $60,001 to $80,000, 7%;
6. For an income of $80,001 to $100,000, 9%; and
7. For an income of $100,001 and over, 10%.

(4) PARTICIPANT COPAYMENT. When a pharmacy directly bills the adult cystic fibrosis program for a prescription received by a program participant, the participant is responsible for the same copayment amount a medical assistance recipient incurs for a similar prescription pursuant to s. 49.45 (18), Stats. However, the partial medical assistance copayment exemptions in s. 49.45 (18), Stats., do not apply to a program participant.

(5) ESTATE RECOVERY. (a) An heir or beneficiary of the estate of a participant or a participant's surviving spouse may apply to the department for a waiver of an estate claim filed by the department pursuant to s. 49.682 or 867.035, Stats. The criteria for granting waivers in s. HFS 108.02 (12) (b) shall apply to applications under this subsection. All of the procedures and rights in s. HFS 108.02 (12) (b) to (e) shall apply to this subsection.

(b) For purposes of applying s. HFS 108.02 (12) (b) to (e) to this subsection the following definitions apply:

1. "Beneficiary" means any person nominated in a will to receive an interest in property other than in a fiduciary capacity;

2. "Decedent" means a deceased participant or the deceased surviving spouse of a participant who received benefits that are subject to recovery under s. 49.682 or 867.035, Stats.;

3. "Heir" means any person who is entitled under the statutes of intestate succession, ch. 852, Stats., to an interest in property of a decedent;

4. "Recipient" means a participant who received reimbursement under s. 49.683, Stats.; and

5. "Waiver applicant" means a beneficiary or heir of a decedent who requests the department to waive an estate claim filed by the department pursuant to s. 49.682 or 867.035, Stats.

(c) The department may make adjustments to and settle estate claims filed under s. 49.682 or 867.035, Stats., to obtain the fullest amount practicable.

History: Cr. Register, December, 1994, No. 468, eff. 1–1–95; emerg. cr. (5), eff. 11–1–95; cr. (5), Register, April, 1996, No. 484, eff. 5–1–96.

TABLE 154.07
PATIENT COINSURANCE LIABILITY FOR THE DIRECT COST OF TREATMENT

Annual Family Income	Percent of Charges for Which Patient is Liable, by Family Size									
	1	2	3	4	5	6	7	8	9	10
$0–7,000	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
7,001–10,000	2	1	0	0	0	0	0	0	0	0
10,001–15,000	3	2	1	0	0	0	0	0	0	0
15,001–20,000	4	3	2	1	0	0	0	0	0	00
20,001–25,000	5	4	3	2	1	0	0	0	0	0
25,001–30,000	14	5	4	3	2	1	0	0	0	0
30,001–35,000	17	13	5	4	3	2	1	0	0	0
35,001–40,000	20	16	6	5	4	3	2	1	0	0
40,001–45,000	24	19	15	6	5	4	3	2	1	0
45,001–50,000	29	24	20	17	6	5	4	3	2	1
50,001–55,000	34	29	25	21	7	6	5	4	3	2
55,001–60,000	39	34	29	25	23	7	6	5	4	3
60,001–65,000	44	39	34	30	28	25	7	6	5	4
65,001–70,000	49	44	39	35	32	29	8	7	6	5
70,001–75,000	55	49	44	40	37	34	32	8	7	6
75,001–80,000	61	55	50	46	43	40	37	35	7	6
80,001–85,000	67	61	56	52	49	46	43	40	7	6
85,001–90,000	74	68	63	59	56	53	50	47	45	6
90,001–95,000	81	75	70	66	63	60	57	55	53	51
95,001–100,000	88	82	77	73	70	67	64	62	60	58
$ 100,000+	97	91	86	82	79	76	73	71	69	67

Note: To illustrate how a patient's coinsurance liability is calculated, assume that the family has 2 members and an annual income of $38,000, and that a bill has been received for treatment in the amount of $600. The patient would be liable for 16% of that bill, or $96.