Chapter HFS 106

PROVIDER RIGHTS AND RESPONSIBILITIES

Note: Chapter HSS 106 was renumbered Chapter HFS 106 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, January, 1997, No. 493.

HFS 106.01 Introduction. In addition to provisions of chs. HFS 105 and 107 relating to individual provider types and the manner by which specified services are to be provided and paid for under medical assistance (MA), the participation of all providers certified under ch. HFS 105 to provide or claim reimbursement for services under the program shall be subject to the conditions set forth in this chapter.

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

HFS 106.02 General requirements for provision of services. Providers shall comply with the following general conditions for participation as providers in the MA program:

(1) CERTIFICATION. A provider shall be certified under ch. HFS 105.

(2) COVERED SERVICES. A provider shall be reimbursed only for covered services specified in ch. HFS 107.

(3) RECIPIENT ELIGIBLE ON DATE OF SERVICE. A provider shall be reimbursed for a service only if the recipient of the service was eligible to receive MA benefits on the date the service was provided.

(4) COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS. A provider shall be reimbursed only if the provider complies with applicable state and federal procedural requirements relating to the delivery of the service.

(5) APPROPRIATE AND MEDICALLY NECESSARY SERVICES. A provider shall be reimbursed only for services that are appropriate and medically necessary for the condition of the recipient.

(6) PROVISION OF NON−COVERED SERVICES. If a provider determines that, to assure quality health care to a recipient, it is necessary to provide a non−covered service, nothing in this chapter shall preclude the provider from furnishing the service, if before rendering the service the provider advises the recipient that the service is not covered under the program and that, if provided, the recipient is responsible for payment.

(7) SERVICES TO RECIPIENTS WITH A PRIMARY PROVIDER. A provider other than the designated primary provider may not claim reimbursement for a service to an individual whose freedom to choose a provider has been restricted under s. HFS 104.03 or 104.05 as indicated on the recipient's MA identification card unless the service was rendered pursuant to a written referral from the recipient's designated primary provider or the service was rendered in an emergency. If rendered in an emergency, the provider seeking reimbursement shall submit to the fiscal agent a written description of the nature of the emergency along with the service claim.

(8) REFUSAL TO PROVIDE MA SERVICES. A provider is not required to provide services to a recipient if the recipient refuses or fails to present a currently valid MA identification card. If a recipient fails, refuses or is unable to produce a currently valid identification card, the provider may contact the fiscal agent to confirm the current eligibility of the recipient. The department shall require its fiscal agent to install and maintain adequate toll−free telephone service to enable providers to verify the eligibility of recipients to receive benefits under the program.

(9) MEDICAL AND FINANCIAL RECORDKEEPING AND DOCUMENTATION. (a) *Preparation and maintenance.* A provider shall prepare and maintain truthful, accurate, complete, legible and concise documentation and medical and financial records specified under this subsection, s. HFS 105.02 (6), the relevant provisions of s. HFS 105.02 (7), other relevant sections in chs. HFS 105 and 106 and the relevant sections of ch. HFS 107 that relate to documentation and medical and financial recordkeeping for specific services rendered to a recipient by a certified provider. In addition to the documentation and recordkeeping requirements specified in pars. (b) to (d), the provider's documentation, unless otherwise specifically contained in the recipient's medical record, shall include:

1. The full name of the recipient;
2. The identity of the person who provided the service to the recipient;
3. An accurate, complete and legible description of each service provided;
4. The purpose of and need for the services;
5. The quantity, level and supply of service provided;
6. The date of service;
7. The place where the service was provided; and
8. The pertinent financial records.

(b) *Medical record content.* A provider shall include in a recipient's medical record the following written documentation, as applicable:

1. Date, department or office of the provider, as applicable, and provider name and profession;
2. Chief medical complaint or purpose of the service or services;
3. Clinical findings;
4. Diagnosis or medical impression;
5. Studies ordered, such as laboratory or x−ray studies;
6. Therapies or other treatments administered;
7. Disposition, recommendations and instructions given to the recipient, including any prescriptions and plans of care or treatment provided; and
8. Prescriptions, plans of care and any other treatment plans for the recipient received from any other provider.

(c) *Financial records.* A provider shall maintain the following financial records in written or electronic form:

1. Payroll ledgers, canceled checks, bank deposit slips and any other accounting records prepared by the provider;

2. Billings to MA, medicare, a third party insurer or the recipient for all services provided to the recipient;

3. Evidence of the provider's usual and customary charges to recipients and to persons or payers who are not recipients;

4. The provider's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable;

5. Billing claims forms for either manual or electronic billing for all health services provided to the recipient;

6. Records showing all persons, corporations, partnerships and entities with an ownership or controlling interest in the provider, as defined in 42 CFR 455.101; and

7. Employee records for those persons currently employed by the provider or who have been employed by the provider at any time within the previous 5 years. Employee records shall include employee name, salary, job qualifications, position description, job title, dates of employment and the employee's current home address or the last known address of any former employee.

(d) *Other documentation.* 1. The provider shall maintain documentation of all information received or known by the provider of the recipient's eligibility for services under MA, medicare or any other health care plan, including but not limited to an indemnity health insurance plan, a health maintenance organization, a preferred provider organization, a health insuring organization or other third party payer of health care.

2. The provider shall retain all evidence of claims for reimbursement, claim denials and adjustments, remittance advice, and settlement or demand billings resulting from claims submitted to MA, medicare or other health care plans.

3. The provider shall retain all evidence of prior authorization requests, cost reports and supplemental cost or medical information submitted to MA, medicare and other third party payers of health care, including the data, information and other documentation necessary to support the truthfulness, accuracy and completeness of the requests, reports and supplemental information.

(e) *Provider responsibility.* 1. Each provider is solely responsible for the truthfulness, accuracy, timeliness and completeness of claims, cost reports, prior authorization requests and any supplementary information relating to the provider's MA certification or reimbursement for services submitted to MA or to medicare or any other third party payer for claims or requests for MA recipients, whether or not these claims, reports and requests are submitted on paper or in electronic form. This includes but is not limited to the truthfulness, accuracy, timeliness and completeness of the documentation necessary to support each claim, cost report and prior authorization request. The use or consent to use of a service, system or process for the preparation and submission of claims, cost reports or prior authorization requests, whether in electronic form or on paper, does not in any way relieve a provider from sole responsibility for the truthfulness, accuracy, timeliness and completeness of claims, cost reports, prior authorization requests and any supplementary information relating to the provider's MA certification and claims for reimbursement for services submitted to MA or to medicare or any other third party payer in the case of claims, reports or requests for MA recipients. The provider is responsible whether or not the provider is charged for the services, systems or processes and whether or not the department or its fiscal agent consents to the electronic preparation and submission of claims, cost reports, prior authorization requests and any supplementary information relating to the provider's MA certification and claims for reimbursement for services.

2. All records under pars. (a) to (d) shall be retained by a provider for a period of not less than 5 years, except that a rural health clinic provider shall retain the records for not less than 6 years. This period shall begin on the date on which the provider received payment from the program for the service to which the records relate. Termination of a provider's participation does not terminate the provider's responsibility to retain the records unless an alternative arrangement for record retention and maintenance has been established by the provider.

3. Providers are solely responsible for all costs associated with meeting the responsibilities under the provider agreement required under s. HFS 105.01 (3) (e) and the preparation and submission of claims, whether in electronic form or on paper, to MA or to medicare or other third party payers in the case of claims for MA recipients, regardless of the means or source of the preparation and submission. This includes but is not limited to claims preparation, acquisition or submission services and services which prepare, acquire or submit claims to payers, including but not limited to MA, on behalf of the provider, whether or not the provider or the provider's membership organization is charged for the preparation or submission of claims, and any other activity required under the provider agreement in accordance with s. HFS 105.01 (3) (e).

4. At the request of a person authorized by the department and on presentation of that person's credentials, a provider shall permit access to any requested records, whether in written, electronic, or micrographic form. Access for purposes of this subsection shall include the opportunity to inspect, review, audit and reproduce the records.

5. Except as otherwise provided under a contract between the department and providers or pre−paid health plans, and except for records requested by the peer review organization under contract with the department, all costs of reproduction by a provider of records under this subsection shall be paid by the department at the per−page rate for record reproduction established by the department under s. HFS 108.02 (4). Reproduction costs for records requested by the peer review organization shall be paid at the prevailing per−page rate for MA records established by that organization.

(f) *Condition for reimbursement.* Services covered under ch. HFS 107 are non−reimbursable under the MA program unless the documentation and medical recordkeeping requirements under this section are met.

(g) *Supporting documentation.* The department may refuse to pay claims and may recover previous payments made on claims where the provider fails or refuses to prepare and maintain records or permit authorized department personnel to have access to records required under s. HFS 105.02 (6) or (7) and the relevant sections of chs. HFS 106 and 107 for purposes of disclosing, substantiating or otherwise auditing the provision, nature, scope, quality, appropriateness and necessity of services which are the subject of claims or for purposes of determining provider compliance with MA requirements.

(10) NONDISCRIMINATION. Providers shall comply with the civil rights act of 1964, 42 USC 2000d et. seq., and s. 504 of the rehabilitation act of 1973, as amended. Accordingly, providers may not exclude, deny or refuse to provide health care services to recipients on the grounds of race, color, gender, age, national origin or handicap, nor may they discriminate in their employment practices.

(11) PROVISION OF NON−REIMBURSABLE COVERED SERVICES. A provider may not bill a recipient for covered services which are non−reimbursable under s. HFS 107.02 (2).

History: Cr. Register, December, 1979, No. 288, eff. 2−1−80; am. Register, February, 1986, No. 362, eff. 3−1−86; emerg. r. and recr. (9), eff. 7−1−92; r. and recr. (9), cr. (11), Register, February, 1993, No. 446, eff. 3−1−93; correction made in (10) under s. 13.93 (2m) (b) 7., Stats., Register, June, 1994, No. 462.

HFS 106.03 Manner of preparing and submitting claims for reimbursement. (1) FORMAT. (a) In this subsection, "billing service" means a provider or an entity under contract to a provider which provides electronic media billing or electronic billing transmission for one or more providers.

(b) A provider shall use claim forms prescribed or furnished by the department, except that a provider may submit claims by

electronic media or electronic transmission if the provider or billing service is approved by the department for electronic claims submission. A billing service shall be approved in writing by the department based on the billing service's ability to consistently meet format and content specifications required for the applicable provider type. The department shall, upon request, provide a written format and the content specifications required for electronic media or electronic transmission billings and shall advise the provider or billing service of procedures required to obtain department approval of electronic billing.

(c) Upon the department's approval of the provider or the provider's billing service to submit claims through electronic media or electronic transmission billing, the provider shall sign an agreement to comply with the format, content and procedural requirements of the department.

(d) The department may at its discretion revoke its approval and rescind the agreement for electronic media or electronically transmitted claims submission at any time if the provider or billing service fails to fully comply with all of the department's instructions for submission of electronic media or electronically transmitted claims, or repeatedly submits duplicate, inaccurate or incomplete claims. The department may at its discretion revoke its approval and rescind the agreement under par. (c) when the provider's claims repeatedly fail to provide correct and complete information necessary for timely and accurate claims processing and payment in accordance with billing instructions provided by the department or its fiscal agent.

(2) CONTENT. (a) In the preparation of claims, the provider shall use, as applicable, diagnosis, place of service, type of service, procedure codes and other information specified by the department under s. HFS 108.02 (4) for identifying services billed on the claim. The department shall inform affected providers of the name and source of the designated diagnosis and procedure codes.

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

(c) service or by another agent of the provider, the truthfulness, completeness, timeliness and accuracy of any claim are the sole responsibility of the provider.

(d) Every claim submitted shall be signed by the provider or by the provider's authorized agent, certifying to the accuracy and completeness of the claim and that services billed on the claim are consistent with the requirements of chs. HFS 101 to 108 and the department's instructions issued under s. HFS 108.02 (4). For claims submitted by electronic media or electronic transmission, the provider agreement under sub. (1) (c) substitutes for the signature required by this paragraph for each claims submission.

(3) TIMELINESS OF SUBMISSION. (a) A claim may not be submitted to MA until the recipient has received the service which is the subject of the claim and the requirements of sub. (7) have been met. 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.

(b) 1. To be considered for payment, a correct and complete claim or adjustment shall be received by the department's fiscal agent within 365 days after the date of the service except as provided in subd. 4. and par. (c). The department fiscal agent's response to any claim or adjustment received more than 365 days after the date of service shall constitute final department action with respect to payment of the claim or adjustment in question.

2. The provider is responsible for providing complete and timely follow−up to each claim submission to verify that correct and accurate payment was made, and to seek resolution of any disputed claims.

3. To ensure that submissions are correct and there is appropriate follow−up of all claims, providers shall follow the claims preparation and submission instructions in provider handbooks and bulletins issued by the department.

4. If a claim was originally denied or incorrectly paid because of an error on the recipient eligibility file, an incorrect HMO designation, an incorrect nursing home level of care authorization or nursing home patient liability amount, the department may pay a correct and complete claim or adjustment only if the original claim was received by the department's fiscal agent within 365 days after the date of service and the resubmission or adjustment is received by the department's fiscal agent within 455 days after the date of service.

5. 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 submissions of claims payment adjustments shall be made within 365 days from the date of service, except as provided in subd. 4. and par. (c). 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.

(c) The sole exceptions to the 365 day billing deadline are as follows:

1. If a claim was initially processed or paid and the department subsequently initiates an adjustment to increase a rate or payment or to correct an initial processing error of the department's fiscal agent, the department may pay a correct and complete claim or adjustment only if the provider submits a request for an adjustment or claim and that request or claim is received by the department's fiscal agent within 90 days after the adjustment initiated by the department;

2. a. If a claim for payment under medicare has been filed with medicare within 365 days after the date of service, the department may pay a claim relating to the same service only if a correct and complete claim is received by the fiscal agent within 90 days after the disposition of the medicare claim;

b. If medicare or private health insurance reconsiders its initial payment and requests recoupment of a previous payment, the department may pay a correct and complete request for an adjustment which is received within 90 days after the notice of recoupment;

3. If a claim for payment cannot be filed in a timely manner due to a delay in the determination of a recipient's retroactive eligibility under s. 49.46 (1) (b), Stats., the department may pay a correct and complete claim only if the claim is received by the fiscal agent within 180 days after mailing of the backdated MA identification card to the recipient; and

4. The department may make a payment at any time in accordance with a court order or to carry out a hearing decision or department−initiated corrective action taken to resolve a dispute. To request payment the provider shall submit a correct and complete claim to the department's fiscal agent within 90 days after mailing of a notice by the department or the court of the court order, hearing decision or corrective action to the provider or recipient.

(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 recipient'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) MEDICARE AND OTHER HEALTH CARE PLANS. (a) In this subsection:

1. "Health care plan" means a plan or policy which provides coverage of health services, regardless of the nature and extent of coverage or reimbursement, including an indemnity health insurance plan, a health maintenance organization, a health insuring organization, a preferred provider organization or any other third party payer of health care.

2. "Properly seek payment" means taking the following actions:

a. When required by the payer as a condition for payment for the particular service, the provider shall request prior authorization or pre−certification from medicare or the other health care plan, except in the case of emergency services. This includes following the preparation and submission requirements of the payer and ensuring that the information provided to the payer is truthful, timely, complete and accurate. Prior authorization or pre−certification means a process and procedures established by medicare or the other health care plan which involve requiring the review or approval by the payer or its agent prior to the provision of a service in order for the service to be considered for payment;

b. The provider shall file a truthful, timely, complete and accurate claim or demand bill for the services which complies with the applicable claim preparation and submission requirements of medicare or the other health care plan. This includes providing necessary documentation and pertinent medical information when requested by medicare or the other health care plan as part of pre−payment or post−payment review performed by medicare or the other health care plan; and

c. In the case of prior authorization or pre−certification requests, claims or demand bills which are returned or rejected, in whole or in part, by the payer for non−compliance with preparation or submission requirements of medicare or the other health care plan, the provider shall promptly correct and properly resubmit the prior authorization or pre−certification request, claim or demand bill, as applicable to the payer.

(b) Before submitting a claim to MA for the same services, a provider shall properly seek payment for the services provided to an MA recipient from medicare or, except as provided in par. (g), another health care plan if the recipient is eligible for services under medicare or the other health care plan.

(c) When benefits from medicare, another health care plan or other third party payer have been paid or are expected to be paid, in whole or in part, to either the provider or the recipient, the provider shall accurately identify the amount of the benefit payment from medicare, other health care plan or other third party payer on or with the bill to MA, consistent with the department's claims preparation, claims submission, cost avoidance and post−payment recovery instructions under s. HFS 108.02 (4). The amount of the medicare, health care plan or other third party payer reimbursement shall reduce the MA payment amount.

(d) If medicare or another health care plan makes payment to the recipient or to another person on behalf of the recipient, the provider may bill the payee for the amount of the benefit payment and may take any necessary legal action to collect the amount of the benefit payment from the payee, notwithstanding the provisions set forth in ss. HFS 104.01 (12) and 106.04 (3).

(e) The provider shall bill medicare or another health care plan for services provided to a recipient in accordance with the claims preparation, claims submission and prior authorization instructions issued by the department under s. HFS 108.02 (4). The provider shall also comply with the instructions issued by the department under s. HFS 108.02 (4) with respect to cost avoidance and post−payment recovery from medicare and other health care plans.

(f) If, after the provider properly seeks payment, medicare or another provider may submit a claim to MA for the unpaid service, except as provided in par. (k). The provider shall retain all evidence of claims for reimbursement, settlements and denials resulting from claims submitted to medicare and other health care plans.

(g) If eligibility for a health care plan other than medicare is indicated on the recipient's MA identification card and billing against that plan is not required by par. (e), the provider may bill either MA or the indicated health care plan, but not both, for the services provided, as follows:

1. If the provider elects to bill the health care plan, the provider shall properly seek payment from the health care plan. A claim may not be submitted to MA until the health care plan pays part of or denies the original claim or 45 days have elapsed with no response from the health care plan; and

2. If the provider elects to submit a claim to MA, no claim may be submitted to the health care plan.

(h) In the event a provider receives a payment first from MA and then from medicare, another health care plan or another third party payer for the same service, the provider shall, within 30 days after receipt of the second and any subsequent payment, refund to MA the MA payment or the payment from medicare, the health care plan or other third party, whichever is less.

(i) Before billing MA for services provided to any recipient who is also a medicare beneficiary, a medicare−certified provider shall accept medicare assignment and shall properly seek payment from medicare for services covered under the medicare program. In filing claims or demand bills with medicare, a provider shall adhere to the requirements for properly seeking payment as defined under par. (a) 2. and to the instructions issued by the department under s. HFS 108.02 (4) relating to claims preparation, claims submission, prior authorization, cost−avoidance and post−payment recovery.

(j) If another health care plan, other than medicare, provides coverage for services provided for an MA recipient and the provider has the required billing information, including any applicable assignment of benefits, the provider shall properly seek payment from the health care plan, except as provided in par. (g), and receive a response from that plan prior to billing MA unless 45 days have elapsed with no response from the health care plan, after which the provider may bill MA. This requirement does not apply to a managed health care plan as defined in par. (k).

(k) A provider authorized to provide services to a recipient under a managed health care plan other than MA, who receives a referral for services from the recipient's managed health care plan or provides emergency services for a recipient in a managed health care plan, shall properly seek payment from that managed health care plan before billing MA. A provider who does not participate in a managed health care plan, other than MA, that provides coverage to the recipient but who provides services covered by the plan may not bill MA for the services. In this paragraph, "managed health care plan" means a health maintenance organization, preferred provider organization or similarly organized health care plan.

(8) PERSONAL INJURY AND WORKERS COMPENSATION CLAIMS. If a provider treats a recipient for injuries or illness sustained in an event for which liability may be contested or during the course of employment, the provider may elect to bill MA for services provided without regard to the possible liability of another party or the employer. The provider may alternatively elect to seek payment by joining in the recipient's personal injury claim or workers compensation claim, but in no event may the provider seek payment from both MA and a personal injury or workers compensation claim. Once a provider accepts the MA payment for services provided to the recipient, the provider shall not seek or accept payment from the recipient's personal injury or workers compensation claim.

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; emerg. r. and recr. (1) to (3) and (7), cr. (8), eff. 7−1−92; r. and recr. (1) to (3) and (7), cr. (8), Register, February, 1993, No. 446, eff. 3−1−93.

HFS 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 is informed that the payment will be automatically recouped 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) *Recoupment of manual partial payments.* Manual partial payments shall be automatically recouped when the provider's claims are processed through the automated claims system.

(e) *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. HFS 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 eligibility, 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. HFS 107.09 (4) (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. (a) Except as provided in par. (b), if a provider receives a payment under the MA program to which the provider is not entitled or in an amount greater than that to which the provider is entitled, the provider shall return to the department the amount of the overpayment, including but not limited to erroneous, excess, duplicative and improper payments, regardless of cause, within 30 days after the date of the overpayment in the case of a duplicative payment from MA, medicare or other health care payer and within 30 days after the date of discovery in the case of all other overpayments.

(b) In lieu of returning the overpayment, a provider may notify the department in writing within 30 days after the date of the overpayment or its discovery, as applicable, of the nature, source and amount of the overpayment and request that the overpayment be deducted from future amounts owed the provider by the MA program.

(c) The department shall honor the request under par. (b) if the provider is actively participating in the program, is not currently under investigation for fraud or MA program abuse, is not subject to an intermediate sanction under s. HFS 106.08, and is claiming and receiving MA reimbursement in amounts sufficient to reasonably ensure full recovery of the overpayment within a limited period of time. Any limited recovery period shall be consistent with the applicable federally required time period for the department's repayment of the federal financial participation associated with the overpayment as stated in 42 CFR 433.300−322.

(d) If the department denies the provider's request under par. (b) to have the overpayment deducted from future amounts paid, the provider shall return to the department the full amount of the overpayment within 30 days after receipt of the department's written denial.

(6) 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; emerg. am. (1m) (c) 1., renum. (1m) (d), (5) and (9) to be (1m) (e), (4) and (6) and am. (4), cr. (1m) (d), r. (4), (7) and (8), r. and recr. (6), eff. 7−1−92; am. (1m) (c) 1., renum. (1m) (d) and (9) to be (1m) (e) and (6), cr. (1m) (d), r. and recr. (5), r. (6) to (8), Register, February, 1993, No. 446, eff. 3−1−93; correction in (3) (b) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1999, No. 520.

HFS 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. HFS 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

2. The facility demonstrates to the satisfaction of the department that it has made reasonable efforts to facilitate the orderly transfer of affected resident recipients to another appropriate facility.

(3) RECORD RETENTION. Voluntary termination of a provider's program participation under this section does not end the provider's responsibility to retain and provide access to records as required under s. HFS 106.02 (9) unless an alternative arrangement for retention, maintenance and access has been established by the provider and approved in writing by the department.

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

HFS 106.06 Involuntary termination or suspension from program participation. The department may suspend or terminate the certification of any person, partnership, corporation, association, agency, institution or other entity participating as a health care provider under the program, if the suspension or termination will not deny recipients access to MA services and if after reasonable notice and opportunity for a hearing the department finds that:

(1) NON−COMPLIANCE WITH MA REQUIREMENTS. The provider has repeatedly and knowingly failed or refused to comply with federal or state statutes, rules or regulations applicable to the delivery of, or billing for, services under the program;

(2) REFUSAL TO COMPLY WITH PROVIDER AGREEMENT. The provider has repeatedly and knowingly failed or refused to comply with the terms and conditions of its provider agreement;

(3) IMPROPER ACTIVITIES. (a) The provider has prescribed, provided, or claimed reimbursement for services under the program which were:

1. Inappropriate;
2. Unnecessary or in excess of the recipient's needs;
3. Detrimental to the health and safety of the recipient; or
4. Of grossly inferior quality.

(b) Findings precipitating action by the department under this subsection shall be based on the written findings of a peer review committee established by the department or a PRO under contract to the department to review and evaluate health care services provided under the program. The findings shall be presumptive evidence that the provider has engaged in improper activities under this subsection.

(4) SUSPENSION OR REVOCATION. The licensure, certification, authorization or other official entitlement required as a prerequisite to the provider's certification to participate in the program has been suspended, restricted, terminated, expired or revoked;

(5) PUBLIC HEALTH IN JEOPARDY. A provider's licensure, certification, authorization or other official entitlement has been suspended, terminated, expired or revoked under state or federal law following a determination that the health, safety or welfare of the public is in jeopardy;

(6) MEDICARE SANCTIONS. (a) The provider is excluded or terminated from the medicare program or otherwise sanctioned by the medicare program because of fraud or abuse of the medicare program under 42 CFR 420.101 or 474.10.

(b) The provider is suspended from the medicare program for conviction of a medicare program−related crime under 42 CFR 420.122.

(c) The provider is a party convicted of a crime, ineligible to participate in the medicare program and the health care financing administration directs the department to suspend the provider;

(7) SERVICE DURING PERIOD OF NONCERTIFICATION. The provider has provided a service to a recipient during a period in which provider's licensure, certification, authorization, or other entitlement to provide the service was terminated, suspended, expired or revoked;

(8) CRIMINAL CONVICTION. The provider has been convicted of a criminal offense related to providing or claiming reimbursement for services under medicare or under this or any other state's MA program. In this subsection, "convicted" means that a judgment of conviction has been entered by a federal, state or local court, irrespective of whether an appeal from that judgment is pending;

(9) FALSE STATEMENTS. The provider knowingly made or caused to be made a false statement or misrepresentation of material fact in connection with provider's application for certification or recertification;

(10) FAILURE TO REPORT STATUS CHANGE. The provider has concealed, failed or refused to disclose any material change in licensure, certification, authorization, or ownership which, if known to the department, would have precluded the provider from being certified;

(11) CONCEALMENT OF OUTSIDE CONTROLLING INTERESTS. The provider at the time of application for certification under ch. HFS 105 or after receiving that certification knowingly misrepresented, concealed or failed to disclose to the department full and complete information as to the identity of each person holding an ownership or controlling interest in the provider;

(12) CONCEALMENT OF PROVIDER'S CONTROLLING INTERESTS. The provider at the time of application for certification under ch. HFS 105 or after receiving that certification knowingly misrepresented, concealed or failed to disclose to the department an ownership or controlling interest the provider held in a corporation, partnership, sole proprietorship or other entity certified under the program;

(13) FALSE STATEMENTS CONCERNING THE NATURE AND SCOPE OF SERVICES. The provider made or caused to be made false statements or misrepresentation of material facts in records required under s. HFS 105.02 (4), (6) or (7) and maintained by the provider for purposes of identifying the nature and scope of services provided under the program;

(14) FALSE STATEMENTS CONCERNING THE COSTS OF SERVICES. The provider has knowingly made or caused to be made false statements or has misrepresented material facts in connection with the provider's usual and customary charges submitted to the department as a claim for reimbursement;

(15) FALSE STATEMENTS CONCERNING COST REPORTS. The provider has knowingly made or caused to be made false statements or misrepresentation of material facts in cost reports relating to the provider's costs, expenditures or usual and customary charges submitted to the department for the purpose of establishing reimbursement rates under the program;

(16) FAILURE TO KEEP RECORDS. The provider has failed or refused to prepare, maintain or make available for inspection, audit or copy by persons authorized by the department, records necessary to fully disclose the nature, scope and need of services provided recipients;

(17) FALSE STATEMENT ON CLAIM. The provider has knowingly made or caused to be made a false statement or misrepresentation of a material fact in a claim;

(18) OBSTRUCTION OF INVESTIGATION. The provider has intentionally by act of omission or commission obstructed an investigation or audit being conducted by authorized departmental personnel pursuant to s. 49.45 (3) (g), Stats.;

(19) PAYMENT FOR REFERRAL. The provider has offered or paid to another person, or solicited or received from another person, any remuneration in cash or in kind in consideration for a referral of a recipient for the purpose of procuring the opportunity to pro-

vide covered services to the recipient, payment for which may be made in whole or in part under the program;

(20) FAILURE TO REQUEST COPAYMENTS. The provider has failed to request from recipients the required copayment, deductible or coinsurance amount applicable to the service provided to recipients after having received a written statement from the department noting the provider's repeated failure to request required copayments, deductible or coinsurance amounts and indicating the intent to impose a sanction if the provider continues to fail to make these requests;

Note: See s. 49.45 (18), Stats., and s. HFS 106.04 (2) for requirements on copayments, deductibles and coinsurance amounts.

(21) CHARGING RECIPIENT. The provider has, in addition to claiming reimbursement for services provided a recipient, imposed a charge on the recipient for the services or has attempted to obtain payment from the recipient in lieu of claiming reimbursement through the program contrary to provisions of s. HFS 106.04 (3);

(22) RACIAL OR ETHNIC DISCRIMINATION. The provider has refused to provide or has denied services to recipients on the basis of the recipient's race, color or national origin in violation of the civil rights act of 1964, as amended, 42 USC 200d, et. seq., and the implementing regulations, 45 CFR Part 80;

(23) HANDICAPPED DISCRIMINATION. The provider has refused to provide or has denied services to a handicapped recipient solely on the basis of handicap, thereby violating s. 504 of the rehabilitation act of 1973, as amended, 29 USC 794;

(24) FUNDS MISMANAGEMENT. A provider providing skilled nursing or intermediate care services has failed to or has refused to establish and maintain an accounting system which ensures full and complete accounting of the personal funds of residents who are recipients, or has engaged in, caused, or condoned serious mismanagement or misappropriation of the funds;

Note: See s. HFS 107.09 (3) (i) for requirements concerning accounting for the personal funds of nursing home residents.

(25) REFUSAL TO REPAY ERRONEOUS PAYMENTS. The provider has failed to repay or has refused to repay amounts that have been determined to be owed the department either under s. HFS 106.04 (5) or pursuant to a judgment of a court of competent jurisdiction, as a result of erroneous or improper payments made to the provider under the program;

(26) FAULTY SUBMISSION OF CLAIMS, FAILURE TO HEED MA BILLING STANDARDS, OR SUBMISSION OF INACCURATE BILLING INFORMATION. The provider has created substantial extraordinary processing costs by submitting MA claims for services that the provider knows, or should have known, are not reimbursable by MA, MA claims which fail to provide correct or complete information necessary for timely and accurate claims processing and payment in accordance with proper billing instructions published by the department or the fiscal agent, or MA claims which include procedure codes or procedure descriptions that are inconsistent with the nature, level or amount of health care provided to the recipient, and, in addition, the provider has failed to reimburse the department for extraordinary processing costs attributable to these practices;

(27) REFUSAL TO PURGE CONTEMPT ORDER. The provider failed or refused to purge a contempt order issued under s. 885.12, Stats., as a result of the provider's refusal to obey a subpoena under s. 49.45 (3) (h) 1., Stats.;

(28) OTHER TERMINATION REASONS. The provider, a person with management responsibility for the provider, an officer or person owning directly or indirectly 5% or more of the shares or other evidences of ownership of a corporate provider, a partner in a partnership which is a provider, or the owner of a sole proprietorship which is a provider, was:

(a) Terminated from participation in the program within the preceding 5 years;

(b) A person with management responsibility for a provider previously terminated under this section, or a person who was employed by a previously terminated provider at the time during which the act or acts occurred which served as the basis for the termination of the provider's program anticipation and knowingly caused, concealed, performed or condoned those acts;

(c) An officer of or person owning, either directly or indirectly, 5% of the stock or other evidences of ownership in a corporate provider previously terminated at the time during which the act or acts occurred which served as the basis for the termination;

(d) An owner of a sole proprietorship or a partner in a partnership that was terminated as a provider under this section, and the person was the owner or a partner at the time during which the act or acts occurred which served as the basis for the termination;

(e) Convicted of a criminal offense related to the provision of services or claiming of reimbursement for services under medicare or under this or any other state's medical assistance program. In this subsection, "convicted" means that a judgment of conviction has been entered by a federal, state or local court, irrespective of whether an appeal from the judgment is pending;

(f) Excluded, terminated, suspended or otherwise sanctioned by medicare or by this or any other state's medical assistance program; or

(g) Barred from participation in medicare by the federal department of health and human services, and the secretary of the federal department of health and human services has directed the department to exclude the individual or entity from participating in the MA program under the authority of section 1128 or 1128A of the social security act of 1935, as amended.

(29) BILLING FOR SERVICES OF A NON−CERTIFIED PROVIDER. The provider submitted claims for services provided by an individual whose MA certification had been terminated or suspended, and the submitting provider had knowledge of the individual's termination or suspension; or

(30) BUSINESS TRANSFER LIABILITY. The provider has failed to comply with the requirements of s. 49.45 (21), Stats., regarding liability for repayment of overpayments in cases of business transfer.

History: Cr. Register, December, 1979, No. 288, eff. 2−1−80; am. Register, February, 1986, No. 362, eff. 3−1−86; emerg. am. (28) (e) and (f), cr. (28) (g), eff. 2−19−88; am. (28) (e) and (f), cr. (28) (g), Register, August, 1988, No. 392, eff. 9−1−88**; correction in (25) made under s. 13.93 (2m) (b) 7., Stats., Register February 2002 No. 554**.

HFS 106.065 Involuntary termination and alternative sanctions for home care providers. (1) TERMINATION. (a) The department may terminate a home care provider's certification to participate in the MA program for failure to comply with the requirements of s. HFS 105.19, 107.11, 107.113 or 107.12, as applicable, or for any of the reasons described in s. HFS 106.06 after reasonable notice and opportunity for a hearing under s. HFS 106.12 (4).

(b) The department shall provide at least 15 working days advance notice of termination to the provider, except at least 5 calendar days advance notice to providers is required in situations where the recipient's health and safety is in immediate jeopardy.

(c) Any provider terminated under this section shall have 30 calendar days from the date of termination of certification to make alternative care arrangements for MA recipients under the provider's care before the effective date of termination. After the 30−day period, MA payment for services provided will cease, except for payments to providers terminated in immediate jeopardy situations. In immediate jeopardy situations, as determined by the department, the department may make alternative care arrangements to preserve continuity of care and for the protection of the recipient.

(2) ALTERNATIVE SANCTIONS. (a) In the event the department finds it more appropriate to take alternative action to termination

of certification under sub. (1) to ensure compliance with program requirements, it may impose one or more sanctions under par. (b) for no more than 6 months following the last day of the department's review of the provider. If, at the end of the 6 month period, the provider continues to not comply with the MA program requirement or requirements, the provider shall be terminated from MA program participation under sub. (1).

(b) The department may apply one or several of the following sanctions:

1. Suspension of payment for new admissions;

2. Suspension of payments for new admissions who require particular types of services;

3. Suspension of payments for any MA recipient requiring a particular type of service;

4. A plan of correction prescribed by the department;

5. Provider monitoring by the department;

6. Appointment of a temporary manager; or

7. Any of the sanctions described in s. HFS 106.07 (4).

(c) In determining the most effective sanctions to be applied to a non−compliant provider, the department shall consider:

1. The severity and scope of noncompliance;

2. The relationship of several areas of the deficiencies or noncompliance;

3. The provider's previous compliance history, particularly as it relates to the insufficiencies under consideration;

4. Immediate or potential jeopardy to patient health and safety;

5. The direct relationship to patient care; and

6. The provider's financial condition.

(d) The department may revisit the provider during the sanction period. Termination procedures may be initiated as a result of the review conducted during the revisit if substantial noncompliance is found to persist, or if recipient safety is potentially or actually compromised.

History: Cr. Register, February, 1993, No. 446, eff. 3−1−93.

HFS 106.07 Effects of suspension or involuntary termination. (1) LENGTH OF SUSPENSION OR INVOLUNTARY TERMINATION. In determining the period for which a party identified in this chapter is to be disqualified from participation in the program, the department shall consider the following factors:

(a) The number and nature of the program violations and other related offenses;

(b) The nature and extent of any adverse impact on recipients caused by the violations;

(c) The amount of any damages;

(d) Any mitigating circumstances; and

(e) Any other pertinent facts which have direct bearing on the nature and seriousness of the program violations or related offenses.

(2) FEDERAL EXCLUSIONS. Notwithstanding any other provision in this chapter, a party who is excluded from participation in the MA program under s. HFS 106.06 (28) (e), (f) or (g) as the result of a directive from the secretary of the federal department of health and human services under the authority of s. 1128 or 1128A of the social security act of 1935, as amended, shall be excluded from participation in the MA program for the period of time specified by the secretary of that federal agency.

(3) REFERRAL TO LICENSING AGENCIES. The secretary shall notify the appropriate state licensing agency of the suspension or termination by MA of any provider licensed by the agency and of the act or acts which served as the basis for the provider's suspension or termination.

(4) OTHER POSSIBLE SANCTIONS. In addition or as an alternative to the suspension or termination of a provider's certification, the secretary may impose any or all of the following sanctions against a provider who has been found to have engaged in the conduct described in s. HFS 106.06:

(a) Referral to the appropriate state regulatory agency;

(b) Referral to the appropriate peer review mechanism;

(c) Transfer to a provider agreement of limited duration not to exceed 12 months; or

(d) Transfer to a provider agreement which stipulates specific conditions of participation.

History: Cr. Register, December, 1979, No. 288. eff. 2−1−80; am. Register, February, 1986, No. 362, eff. 3−1−86; emerg. r. and recr. (2), eff. 2−19−88; am. (2), Register, February, 1988, No. 386, eff. 3−1−88; r. and recr. (2), Register, August, 1988, No. 392, eff. 9−1−88.

HFS 106.08 Intermediate sanctions. (1) To enforce compliance with MA program requirements, the department may impose on a provider for a violation listed under sub. (2) one or more of the sanctions under sub. (3) unless the requirements of s. HFS 106.065 apply. Any sanction imposed by the department pursuant to this section may be appealed by the provider under s. HFS 106.12. Prior to imposing any alternative sanction under this section the department shall issue a written notice to the provider in accordance with s. HFS 106.12 (3). Nothing in this chapter shall be construed to compel the department, through a fair hearing or otherwise, to impose an intermediate sanction in lieu of suspension or termination of certification, a different intermediate sanction, monetary recoveries, auditing, withholding of claims or pre−payment review, nor may imposition of an intermediate sanction on a provider be construed to limit the department's authority under s. HFS 106.06, 106.065, 106.07, 106.10 or 106.11, under this section, or under the applicable provider agreement, concluded pursuant to s. 49.45 (2) (a) 9., Stats.

(2) The department may impose an intermediate sanction under sub. (3) for any of the following violations of this chapter:

(a) For conduct specified in s. HFS 106.06;

(b) For refusal to grant the department access to records under s. HFS 106.02 (9) (e);

(c) For conduct resulting in repeated recoveries under s. HFS 108.02 (9);

(d) For non−compliance with one or more certification requirement applicable to the type of provider under ch. HFS 105;

(e) For interference with recipient rights specified under ch. HFS 104; or

(f) For refusal or repeated failure to comply with one or more requirement specified under this chapter.

(3) The department may impose one or more of the following intermediate sanctions for a violation listed under sub. (2):

(a) Referral to the appropriate peer review organization, licensing authority or accreditation organization;

(b) Transfer to a provider agreement of limited duration which also may stipulate specific conditions of participation;

(c) Requiring prior authorization of some or all of the provider's services;

(d) Review of the provider's claims before payment;

(e) Restricting the provider's participation in the MA program;

(f) Requiring an independent audit of the provider's practices and records, with the findings and recommendations to be provided to the department;

(g) Requiring the provider to perform a self−audit following instructions provided by the department; and

(h) Requiring the provider, in a manner and time specified by the department, to correct deficiencies identified in a department audit, independent audit or department survey or inspection.

(4) In determining the appropriate sanction or sanctions to be applied to a non−compliant provider and the duration of the sanction or sanctions, the department shall consider:

(a) The seriousness and extent of the offense or offenses;

(b) History of prior offenses;

(c) Prior sanctions;

(d) Provider willingness and ability to comply with MA program requirements;

(e) Whether a lesser sanction will be sufficient to remedy the problem in a timely manner;

(f) Actions taken or recommended by peer review organizations, licensing authorities and accreditation organizations;

(g) Potential jeopardy to recipient health and safety and the relationship of the offense to patient care; and

(h) Potential jeopardy to the rights of recipients under federal or state statutes or regulations.

History: Cr. Register, February, 1993, No. 446, eff. 3−1−93.

HFS 106.09 Departmental discretion to pursue monetary recovery. (1) Nothing in this chapter shall preclude the department from pursuing monetary recovery from a provider at the same time action is initiated to impose sanctions provided for under this chapter.

(2) The department may pursue monetary recovery from a provider of case management services or community support program services when an audit adjustment or disallowance has been attributed to the provider by the federal health care financing administration or the department. The provider shall be liable for the entire amount. However, no fiscal sanction under this subsection shall be taken against a provider unless it is based on a specific policy which was:

(a) In effect during the time period being audited; and

(b) Communicated to the provider in writing by the department or the federal health care financing administration prior to the time period audited.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; r. and recr. Register, February, 1988, No. 386, eff. 3−1−88; emerg. am. (2) (intro.), eff. 1−1−90; am. (2) (intro.), Register, September, 1990, No. 417, eff. 10−1−90; renum. from HSS 106.075, Register, February, 1993, No. 446, eff. 3−1−93.

HFS 106.10 Withholding payment of claims. (1) Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association for any health care provided under MA, except for health care provided prior to the suspension or termination.

(2) No clinic, group, corporation or other association which is a provider of services may submit any claim for payment for any health care provided by an individual provider within that organization who has been suspended or terminated from participation in MA, except for health care provided prior to the suspension or termination.

(3) The department may recover any payments made in violation of this subsection. Knowing submission of these claims shall be a grounds for administrative sanctions against the submitting provider.

History: Cr. Register, December, 1979, No. 288. eff. 2−1−80; am. Register, February, 1986, No. 362, eff. 3−1−86; r. (1), renum. (2) (a) to (c) to be (1) to (3), Register, February, 1988, No. 386, eff. 3−1−88; renum. from HSS 106.08, Register, February, 1993, No. 446, eff. 3−1−93.

HFS 106.11 Pre−payment review of claims. (1) HEALTH CARE REVIEW COMMITTEES. The department shall establish committees of qualified health care professionals to evaluate and review the appropriateness, quality and quantity of services furnished recipients.

(2) REFERRAL OF ABERRANT PRACTICES. If the department has cause to suspect that a provider is prescribing or providing services which are not necessary for recipients, are in excess of the medical needs of recipients, or do not conform to applicable professional practice standards, the department shall, before issuing payment for the claims, refer the claims to the appropriate health care review committee established under sub. (1). The committee shall review and evaluate the medical necessity, appropriateness and propriety of the services for which payment is claimed. The decision to deny or issue the payment for the claims shall take into consideration the findings and recommendation of the committee.

(3) WITHDRAWAL OF REVIEW COMMITTEE MEMBERS FOR CONFLICT OF INTEREST. No individual member of a health care review committee established under sub. (1) may participate in a review and evaluation contemplated in sub. (2) if the individual has been directly involved in the treatment of recipients who are the subject of the claims under review or if the individual is financially or contractually related to the provider under review or if the individual is employed by the provider under review.

(4) PROVIDER NOTIFICATION OF PREPAYMENT REVIEW. A provider shall be notified by the department of the institution of the pre−payment review process under sub. (2). Payment shall be issued or denied, following review by a health care review committee, within 60 days of the date on which the claims were submitted to the fiscal agent by the provider.

(5) APPLICATION OF SANCTION. If a health care review committee established under sub. (1) finds that a provider has delivered services that are inappropriate or not medically necessary, the department may require the provider to request and receive from the department authorization prior to the delivery of any service under the program.

History: Cr. Register, December, 1979, No. 288, eff. 2−1−80; am. Register, February, 1986, No. 362, eff. 3−1−86; renum. from HSS 106.09, Register, February, 1993, No. 446, eff. 3−1−93.

HFS 106.12 Procedure, pleadings and practice. (1) SCOPE. The provisions of this section shall govern the following administrative actions by the department:

(a) Decertification or suspension of a provider from the medical assistance program pursuant to s. 49.45 (2) (a) 12., Stats.;

(b) Imposition of additional sanctions for non−compliance with the terms of provider agreements under s. 49.45 (2) (a) 9., Stats., or certification criteria established under s. 49.45 (2) (a) 11., Stats., pursuant to s. 49.45 (2) (a) 13., Stats.; and

(c) Any action or inaction for which due process is otherwise required under s. 227.42, Stats.

(1m) APPLICATION. The provisions of this section do not apply to either of the following:

(a) Hearings to contest recoveries by the department of overpayments to providers. Requests for hearings and hearings under these circumstances are governed exclusively by s. HFS 108.02 (9) (e); or

(b) Contests by providers of the propriety of the amount of payment received from the department, including contests of claim payment denials. The exclusive procedure for these contests is as provided in s. HFS 106.03 (3) (b) 5, except as may be provided under the terms of the applicable provider agreement, pursuant to s. 49.45 (2) (a) 9., Stats.

(2) DUE PROCESS. The department shall assure due process in implementing any action described in sub. (1) by providing written notice, a fair hearing and written decision pursuant to s. 49.45 (2) (a) 14., Stats., or as otherwise required by law. In addition to any provisions of this section, the procedures implementing a fair hearing and a written decision shall comply with the provisions of ch. 227, Stats.

(3) WRITTEN NOTICE. The department shall begin actions described under sub. (1) by serving upon the provider written notice of the intended action or written notice of the action. Notice of intended action described under sub. (1) (a) and (b) shall include the following:

(a) A brief and plain statement specifying the nature of and identifying the statute, regulation or rule giving the department the authority to initiate the action;

(b) A short and plain statement identifying the nature of the transactions, occurrences or events which served as the basis for initiating the action; and

(c) A statement advising the provider of the right to a hearing and the procedure for requesting a hearing.

(4) REQUEST FOR HEARING. A provider desiring to contest a departmental action or inaction under sub. (1) may request a hearing on any matter contested. The request shall be in writing and shall:

(a) Be served upon the department of administration's division of hearings and appeals unless otherwise directed by the secretary;

(b) For requests for hearings on actions or intended actions by the department, be served within 15 days of the date of service of the department's notice of intended action or notice of action;

(c) For requests for hearings on inactions by the department, be served within 60 days from the date the provider first became aware of, or should have become aware of with the exercise of reasonable diligence, the cause of the appeal;

(d) Contain a brief and plain statement identifying every matter or issue contested; and

(e) Contain a brief and plain statement of any new matter which the provider believes constitutes a defense or mitigating factor with respect to non−compliance alleged in the notice of action.

Note: Hearing requests should be sent to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707.

(5) TIMING OF ACTIONS TAKEN AGAINST A PROVIDER. (a) Except as provided under par. (b), if no request for a hearing is timely filed, no action described in sub. (1) (a) and (b) may be taken by the department until 15 days after the notice of intended action has been served. Except as provided under par. (b), if a request for a hearing has been timely filed, no action described in sub. (1) (a) or (b) may be taken by the department until the hearing examiner issues a final decision.

(b) Actions described under sub. (1) (a) and (b) may be taken against a provider 15 days after service of the notice of intended action and without a prior hearing when the action is initiated by the department under s. HFS 106.06 (4), (5), (6), (8) or (28). If the provider prevails at the hearing, the provider shall be reinstated retroactive to the date of de−certification or suspension.

(6) FINAL DECISION. (a) If payment of claims to the provider is being withheld by the department under s. HFS 106.08 (1), a final decision shall be made by the department within 150 days of receipt of the hearing request.

(b) The hearing examiner's decision shall be the final decision of the department for contested actions under sub. (1) (a) and (b).

(7) EFFECT OF FAILURE TO APPEAR AT HEARING. (a) If the department fails to appear on the date set for a hearing on a contested action under sub. (1) (a) or (b), the hearing examiner may enter an order dismissing the department's action, pursuant to the motion of the provider or on its own motion.

(b) If the department fails to appear on the date set for a hearing on a contested action under sub. (1) (c), the hearing examiner may enter an order granting the relief sought by the provider upon due proof of facts which show the provider's entitlement to the relief.

(c) If the provider fails to appear on the date set for a hearing on a contested action under sub. (1) (a) or (b), the hearing examiner may enter an order dismissing the provider's appeal upon due proof of facts which show the department's entitlement to the remedy or relief sought in the action.

(d) If the provider fails to appear on the date set for a hearing on a contested action under sub. (1) (c) the hearing examiner may enter an order dismissing the provider's appeal, pursuant to the motion of the department or on its own motion.

(e) The department of administration's division of hearings and appeals may by order reopen a default arising from a failure of either party to appear on the date set for hearing. The order may be issued upon motion or petition duly made and good cause shown. The motion shall be made within 20 days after the date of the hearing examiner's default order.

(8) DATES OF SERVICE. The date of service of a written notice required under sub. (3) 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. The date of service of a request for hearing under sub. (4) shall be the date on which the division of hearings and appeals receives the request.

History: Cr. Register, December, 1979, No. 288, eff. 2−1−80; r. and recr. Register, February, 1986, No. 362, eff. 3−1−86; am. (1) (c) and (4) (b), r. and recr. (5) (a) and (b), r. (5) (c), cr. (8), Register, February, 1988, No. 386, eff. 3−1−88; renum. from HSS 106.10, r. (1m), Register, February, 1993, No. 446, eff. 3−1−93.

HFS 106.13 Discretionary waivers and variances. A provider or recipient may apply for and the department shall consider applications for a discretionary waiver or variance of any rule in chs. HFS 102 to 105, 107 and 108, excluding ss. HFS 107.02 (1) (b), (2) (e) to (j) and (3) (a) and (b) and (d) to (h), 107.03 (1) to (8) and (10) to (18), and 107.035. Waivers and variances shall not be available to permit coverage of services that are either expressly identified as non−covered in ch. HFS 107 or are not expressly mentioned in ch. HFS 107. The following requirements and procedures apply to applications under this section:

(1) REQUIREMENTS FOR A DISCRETIONARY WAIVER OR VARIANCE. A discretionary wavier or variance may be granted only if the department finds all of the following are met:

(a) The waiver or variance will not adversely affect the health, safety or welfare of any recipient;

(b) Either:

1. Strict enforcement of a requirement would result in unreasonable hardship on the provider or on a recipient; or

2. An alternative to a rule, including a new concept, method, procedure or technique, new equipment, new personnel qualifications or the implementation of a pilot project is in the interests of better care or management;

(c) The waiver or variance is consistent with all applicable state and federal statutes and federal regulations;

(d) Consistent with the MA state plan and with the federal health care financing administration and other applicable federal program requirements, federal financial participation is available for all services under the waiver or variance; and

(e) Services relating to the waiver or variance are medically necessary.

(2) APPLICATION FOR A DISCRETIONARY WAIVER OR VARIANCE. (a) A request for a waiver or variance may be made at any time. All applications for a discretionary waiver or variance shall be made in writing to the department, specifying the following:

1. The rule from which the waiver or variance is requested;

2. The time period for which the waiver or variance is requested;

3. If the request is for a variance, the specific alternative action which the provider proposes;

4. The reasons for the request; and

5. Justification that sub. (1) would be satisfied.

Note: Discretionary waiver or variance requests should be sent to the Division of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701.

(b) The department may require additional information from the provider or the recipient prior to acting on the request.

(c) The terms of a discretionary waiver or variance may be modified by the department at any time to ensure that the requirements of sub. (1) and the conditions or limitations established under this paragraph are met during the duration of the waiver or variance. The department may impose any conditions or limitations on the granting of a discretionary waiver or variance necessary to ensure that the requirements of sub. (1) are met during the duration of the waiver or variance or to ensure compliance with rules not waived or varied. The department may limit the duration of any discretionary waiver or variance.

(d) The department may revoke a discretionary waiver or variance at any time if it determines that the terms, conditions or limi-

tations established under par. (c) or any of the requirements under sub. (1) are not met, if it determines that there is evidence of fraud or MA program abuse by the provider or recipient, or if any of the facts upon which the waiver or variance was originally based is no longer true. The department may also revoke a waiver or variance at any time upon request of the applicant. The department shall mail a written notice at least 10 days prior to the effective date of the revocation or modification to the provider or recipient who originally requested the waiver or variance.

(e) The denial, modification, limitation or revocation of a discretionary waiver or variance may be contested under s. HFS 106.12 or 104.01 (5) by the provider or recipient who requested the discretionary waiver or variance, provided that the sole issue in any fair hearing under this paragraph is whether the department acted in an arbitrary and capricious manner or otherwise abused its discretion in denying, modifying, limiting or revoking a discretionary waiver or variance.

History: Cr. Register, February, 1993, No. 446, eff. 3−1−93.