CR 89-162

CERTIFICATE

STATE OF WISCONSIN)
) SS
DEPARTMENT OF HEALTH AND SOCIAL SERVICES)

I, Patricia A. Goodrich, Secretary of the Department of Health and Social Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to administration of the Office of Health Care Information were duly approved and adopted by this Department on February 12, 1990.

I further certify that this copy has been compared by me with the original on file in the Department and that this copy is a true copy of the original, and of the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 12th day of February, 1990.

SEAL:

Patricia A. Goodrich, Secretary
Department of Health and Social Services FOR P.G.

4-1-90

CR89-162

ORDER OF THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
REPEALING, RENUMBERING, AMENDING, REPEALING AND RECREATING, AND CREATING RULES

To repeal HSS 120.14 and subch. II (title) of ch. HSS 120; to renumber HSS 120.03 (1m) to (12), 120.04 to 120.13, 120.15 and 120.16; to amend HSS 120.03 (19), as renumbered, 120.06 (4) (e) and (f), as renumbered, 120.07 (2) and (3) (c) 2 b and c, as renumbered, 120.08 (2), as renumbered, 120.10 (1) (a) and (d), as renumbered, 120.11 (title) and (1) and (2), as renumbered, 120.12 (1), as renumbered, 120.13 (2), (3) and Note, as renumbered, 120.20 (1) (a), (Table), (3) (b) and (6) (d) and (e), as renumbered, 120.22 (3) (a) 5 and (b), as renumbered, 120.24 (title), (intro.) and (Table) (titles), as renumbered, 120.26 (2) (c), (3), (4) and (5) (d) (intro.) and (e), as renumbered, and 120.27 (2) (a) and (c) and (3), as renumbered; and to create HSS 120.03 (14), 120.04, 120.05, 120.06 (4) (g), 120.07 (3) (c) 2 d, subch. II (title), 120.21, 120.23, 120.25 and 120.26 (5) (i), relating to the Wisconsin Office of Health Care Information.

Analysis Prepared by the Department of Health and Social Services

Chapter 153, Stats., established an Office of Health Care Information in the Department to collect and disseminate information about hospital service utilization, charges, revenues, expenditures, mortality and morbidity rates, health care coverage and uncompensated health care services. Section 153.75, Stats., directs and authorizes the Department to promulgate rules for administration of the Office. Given the scope of ch. 153, Stats., the rules are being promulgated in phases. These are the phase 3 rules.

The first set of rules, stating what inpatient discharge data hospitals are to report and how and by when they are to report it and providing for the confidentiality of reported data, went into effect on February 1, 1989. The second set of rules, which became effective July 1, 1989, required hospitals to report revenue and expense data, per unit charges for each of several charge elements and the number of times a charge was made for each charge element in a 12-month period; report actual and anticipated uncompensated health care; and provide notice to the public of any rate increase before that increase takes place. The rules also permitted the Board on Health Care Information to designate a contractor to collect, analyze and disseminate health care information on behalf of the Office.

This third set of rules identifies the methods and criteria used to assess hospitals fees to pay for the operation of the Board and Office; requires hospitals to use and insurers to accept the uniform patient billing form; and requires hospitals to report additional inpatient data elements, selected outpatient surgical data, and asset, liability and fund balance data.

The Department's authority to create these rules is set forth in ss. 153.05 (1) (e), 153.40 (1) and (5) and, 153.75 (1) (b), (e) and (k), and (2) (a) and (c), Stats., as affected by 1989 Wisconsin Act 18. The rules interpret ch. 153, Stats., as affected by 1989 Wisconsin Act 18.

SECTION 1. HSS 120.03 (1m) to (12) are renumbered HSS 120.03 (2) to (13) and (15) to (19).

SECTION 2. HSS 120.03 (14) is created to read:

HSS 120.03(14) "Person" means any individual, partnership, association or corporation, the state or a political subdivision or agency of the state or of a local unit of government.

SECTION 3. HSS 120.03 (19), as renumbered, is amended to read:

HSS 120.03(19) "Uniform patient billing form" ~~has the meaning specified in s. 153.01(9), Stats., namely,~~ means, for a hospital inpatient discharges, the uniform billing form UB-82/HCFA-1450 ~~developed by the national uniform billing committee~~ or, for hospital outpatient discharges, the health insurance claim form HCFA-1500 or the uniform billing form UB-82/HCFA 1450.

SECTION 4. HSS 120.04 to 120.095 are renumbered HSS 120.06 to 120.12.

SECTION 5. HSS 120.04 and 120.05 are created to read:

HSS 120.04 ASSESSMENTS TO FUND THE OPERATIONS OF THE OFFICE AND THE BOARD. (1) DEFINITION. In this section, "state fiscal year" means the 12-month period beginning July 1 and ending the following June 30.

(2) ESTIMATION OF EXPENDITURES. The office shall by October 1 of each year estimate the total expenditures for the office and the board for the current state fiscal year from which the office shall deduct the following:

(a) The estimated total amount of monies to be received by the office from user fees, gifts, grants, bequests, devises and federal funds for that state fiscal year; and

(b) The unencumbered balances of the total amount of monies received through assessments, user fees, gifts, grants, bequests, devises and federal funds from the prior state fiscal year.

(3) CALCULATION OF ASSESSMENTS. (a) The office shall annually assess hospitals, as a group, the net amount determined under sub. (2) in order to fund the operations of the office and the board at the expenditure level authorized in s. 20.435 (1) (hg), Stats., and to fulfill the requirements of ch. 153, Stats., and this chapter.

(b) The assessment for an individual hospital shall be based on the proportion of that hospital's gross private-pay patient revenue reported to the office for its most recently concluded entire fiscal year, which is that fiscal year ending 120 days prior to July 1 each year, compared to the total assessment for hospitals as a group.

(4) PAYMENT OF ASSESSMENTS. (a) Payment deadline. Each hospital shall pay the amount it has been assessed on or before December 31 each year. Payment of the assessment is on time if it is mailed in a properly addressed envelope, postmarked before midnight of December 31 of the year in which due, with postage prepaid, and is received by the office not more than 5 days after the prescribed date for making the payment. A payment which fails to satisfy these requirements solely because of a delay or administrative error of the U.S. postal service shall be considered to be on time.

Note: Send all assessment fees to the Department of Health and Social Services, Division of Health, License Renewal, Drawer 296, Milwaukee, Wisconsin, 53293-0296. Make the check or money order payable to the Department of Health and Social Services.

(b) Forfeitures. If the assessment is not paid by December 31, the department shall directly assess a forfeiture of $25 for each day after December 31 that the assessment is not paid, subject to a maximum forfeiture equal to the amount of the assessment due or $500, whichever is greater. The department shall send a notice of the forfeiture assessed to the alleged violator and shall include a notice of the appeal process under s. HSS 120.12 (2). If the department determines pursuant to an appeal that the sole reason the payment was not timely was a delay or administrative error by the U.S. postal service, the department shall reimburse to the appellant any forfeiture paid.

HSS 120.05 UNIFORM PATIENT BILLING FORM. (1) USE. All hospitals in Wisconsin shall use the uniform patient billing form for all inpatient and outpatient care provided by them.

(2) ACCEPTANCE. All private pay patients and payers who are insurers shall accept the uniform patient billing form as the only billing form for payment purposes. On an individual case basis, any private pay patient or payer who is an insurer may request additional medical record or billing information from a hospital to justify payment of a bill.

SECTION 6. HSS 120.06 (4) (e) and (f), as renumbered, are amended to read:

HSS 120.06 (4) (e) Date of discharge; ~~and~~

(f) Date of principal ~~procedures.~~ procedure; and

SECTION 7. HSS 120.06 (4) (g) is created to read:

HSS 120.06 (4) (g) Encrypted case identifier.

SECTION 8. HSS 120.07 (2), as renumbered, is amended to read:

HSS 120.07 (2) PATIENT CONFIDENTIALITY. Any information identifying a physician and which would permit the identification of specific patients shall be considered confidential and may not be released, except under s. HSS ~~120.04~~ 120.06.

SECTION 9. HSS 120.07 (3) (c) 2 b and c, as renumbered, are amended to read:

HSS 120.07 (3) (c) 2 b. The request is accompanied by a signed and notarized statement from the physician or a person designated by the physician waiving the 30-day calendar day comment period provided in par. (b); ~~or~~

c. The request is made by a payer for aggregated or nonidentifiable patient care data and the payer is responsible for paying the charges for that care~~.~~; or

SECTION 10. HSS 120.07 (3) (c) 2 d is created to read:

HSS 120.07 (3) (c) 2 d. The request is made by a hospital for its own data.

SECTION 11. HSS 120.08 (2), as renumbered, is amended to read:

HSS 120.08 (2) In addition to the reports under sub.(1), the office shall respond to requests by individuals, agencies of government and organizations in the private sector for public use data, data to fulfill statutory mandates for epidemiological purposes or to minimize the duplicate collection

of similar data elements, and information that identifies a physician pursuant to s. HSS ~~120.05~~ 120.07. The board shall designate the form in which the data for the requests shall be made available. The office shall charge the requester the total actual and necessary cost of producing the requested data.

SECTION 12. HSS 120.10 (1) (a) and (d), as renumbered, are amended to read:

HSS 120.10 (1) (a) A person ~~as defined in s. HSS 123.03 (36)~~, a trust, a multiple employer trust, a multiple employer welfare association, a third party administrator or a labor organization that purchases health benefits, which provides health care benefits or services for more than 500 of its full-time equivalent employes, or members in the case of a labor organization, either through an insurer or by means of a self-funded program of benefits;

(d) ~~Any~~ A person ~~as defined in s. HSS 123.03(36)~~ that provides health care services and has 100 or more full-time equivalent employes.

SECTION 13. Subchapter II (title) of HSS 120 is repealed.

SECTION 14. HSS 120.10 to 120.13 are renumbered HSS 120.13, 120.20, 120.22 and 120.24.

SECTION 15. HSS 120.14 is repealed.

SECTION 16. HSS 120.15 and 120.16 are renumbered HSS 120.26 and 120.27.

SECTION 17. HSS 120.11 (title) and (1) and (2), as renumbered, are amended to read:

HSS 120.11 (title) PENALTIES AND FORFEITURES. (1) PENALTIES. (a) Civil. In accordance with s. 153.85, Stats., whoever violates the patient confidentiality provisions defined in s. HSS ~~120.04~~ 120.06, shall be liable to the patient for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation.

(b) Criminal. In accordance with s. ~~53.90 (1)~~ 153.90 (1), Stats., whoever intentionally violates s. HSS ~~120.04~~ 120.06 may be fined not more than $10,000 or imprisoned for not more than 9 months or both.

(2) FORFEITURES. In accordance with s. 153.90(2), Stats., whoever violates ch. 153, Stats., or this chapter, except for s. HSS 120.04 or 120.06, shall forfeit not more than $100 for each violation. Except as stated in s. 153.90 (2), Stats., each day of a violation constitutes a separate offense.

SECTION 18. HSS 120.12 (1), as renumbered, is amended to read:

HSS 120.12 (1) DETERMINATION, NOTICE OF VIOLATION AND FORFEITURE ASSESSMENT. If the office determines that a hospital has failed to submit the required information, failed to submit the information by the due date, failed to submit the information in the proper form or failed to submit corrected information, the ~~office shall notify the hospital in writing, of this determination and the basis for it.~~ department may directly assess forfeitures under s. 153.90 (2), Stats., and shall send a notice of the forfeiture assessment to the alleged violator. The notice shall specify the alleged violation of the statute or rule and the amount of the forfeiture assessed, shall explain how the forfeiture amount was calculated and shall include a notice of the appeal process under sub. (2).

SECTION 19. HSS 120.13 (2), (3) and Note, as renumbered, are amended to read:

HSS 120.13 (2) FORMAT. All written information or communications submitted on behalf of a hospital to the office shall be signed by the ~~hospital's~~ chief executive officer of the hospital or the designee of the chief executive officer.

(3) TIMING. Except as stated in ss. HSS ~~120.05~~ 120.07 (3) (b) and ~~120.06~~ 120.08 (3), all written communications, including documents, reports and information required to be submitted to the office shall be submitted by 1st class or registered mail or by delivery in person. The date of submission is the day the written communication is postmarked or delivered in person.

Note: Send all communications, except the actual payment of assessments under s. HSS 120.04 (3), to the Director, Office of Health Care Information, P.O. Box 309, Madison, Wisconsin 53701-0309, or deliver them to 1 West Wilson Street, Room 272, Madison, Wisconsin.

SECTION 20. Subchapter II (title) of HSS 120 is created to read:

Subchapter II - Hospital Reporting Requirements

SECTION 21. HSS 120.20 (1) (a), (Table), (3) (b) and (6) (d) and (e), as renumbered, are amended to read:

HSS 120.20 (1) (a) Each hospital shall report to the office information on all inpatient discharges from the hospital, using the data elements available on uniform patient billing forms. The data shall include the elements listed in Table ~~120.11~~ 120.20.

TABLE ~~120.11~~ 120.20
REQUIRED DATA ELEMENTS

DATA ELEMENT	UNIFORM PATIENT BILLING FORM ITEM
Patient control number, if applicable	3
Type of bill	4
Federal tax number of the hospital	6
Encrypted case identifier	10
Patient zip code	11
Patient date of birth	12
Patient sex	13
Date of admission	15
Type of admission	17
Source of admission	18
Patient status	21
Date of discharge	22
Race and ethnicity	27
Condition codes, if applicable	35-39
Patient medical record or chart number	45
Adjusted ~~Total~~ total charges and components of those charges	51-53
Primary and secondary sources of payment	57
Principal and ~~up to 4~~ other diagnoses	77-81
Principal and ~~up to 2~~ other procedures, if applicable	84-86
Date of principal ~~procedures~~ procedure, if applicable	84-86
Attending physician license number	92
Other physician license number, if applicable	93

(3) (b) A hospital with ~~fewer than 50 approved under s. HSS 123.30, or a hospital with~~ fewer than 600 annual patient discharges, as determined by the department's most recently published hospital directory, may submit extracts on a paper form acceptable to the office for calendar years 1989 and 1990. If a hospital elects to submit data on an electronic medium, the hospital shall submit the data in accordance with par.(a).

(6) (d) After receipt of data revisions and additional records, ~~The~~ the office shall aggregate each hospital's data ~~after its receipt of data revisions and additional records~~ and shall send a written copy to the hospital. ~~Hospitals~~ Each hospital shall review the aggregated data for accuracy and completeness and shall supply to the office within 10 working days after receipt of the data any corrections or additions to the data at the patient discharge level.

(e) Within the same 10-working day period under par. (d), ~~The~~ the chief executive officer or designee of each hospital shall ~~sign~~ submit to the office a statement, subscribed under oath or affirmation before a notary public, affirming that the data submitted to the office have been verified pursuant to subs. (4) and (5); ~~and~~ that any corrections to the data have been verified pursuant to pars. (a) to (d); and that the data are accurate and complete to the best of his or her knowledge.

SECTION 22. HSS 120.21 is created to read:

HSS 120.21 HOSPITAL RESPONSIBILITY TO REPORT OUTPATIENT SURGICAL DATA. (1) REPORTING RESPONSIBILITY. Each hospital shall report to the office information on specific outpatient discharges from a hospital outpatient department or a hospital-affiliated ambulatory surgical center as described in 42 CFR 416.120. The office, upon recommendation by the board, shall determine which outpatient discharges are to be reported by annually specifying in a technical manual a list of surgical procedures for which information is to be collected.

(2) DATA ELEMENTS COLLECTED. (a) For each outpatient discharged from a hospital where the outpatient received a surgical procedure listed in the technical manual, the hospital shall report information using the data elements available on the uniform patient billing form. The following data elements shall be reported:

1. Patient control number, if applicable;

2. Type of bill;

3. Federal tax number of the hospital;

4. Encrypted case identifier;

5. Patient zip code;

6. Patient date of birth;

7. Patient sex;

8. Date of admission;

9. Type of admission;

10. Source of admission;

11. Patient status;

12. Date of discharge;

13. Condition codes, if applicable;

14. Race and ethnicity;

15. Patient medical record or chart number;

16. Adjusted total charges;

17. Primary and secondary sources of payment;

18. Principal and other diagnoses;

19. Principal and other procedures;

20. Date of principal procedure;

21. Attending physician license number; and

22. Other physician license number, if applicable.

(b) Each hospital shall prepare for submission to the office an extract of the uniform patient billing form containing data elements specified in this subsection. The information to be reported on each data element shall be specified in a technical manual issued by the office.

(c) After collection of each full calendar year of data, the office shall analyze the completeness and accuracy of the reporting and usefulness of each data element. Based on this analysis, the office may recommend to the board for its approval changes in the rules to provide that:

1. Certain data elements not be collected in subsequent years due to significant problems in collecting these data elements;

2. Additional uniform patient billing form data elements be collected; or

3. New data elements defined by the office be added to the uniform patient billing form.

(3) SUBMISSION DATES. (a) Each hospital shall submit the data specified in sub. (2) for all specified outpatient discharges occurring on or after July 1, 1990.

(b) Outpatient surgical data shall be submitted to the office on a quarterly basis. Calendar quarters shall begin on January 1 and end on March 31, begin on April 1 and end on June 30, begin on July 1 and end on September 30, and begin on October 1 and end on December 31. For discharges occurring in calendar year 1990, data for each calendar quarter shall be submitted to the office within 60 calendar days following the end of a calendar quarter. For discharges occurring in calendar year 1991 and in subsequent calendar years, the data shall be submitted within 45 calendar days following the end of a calendar quarter.

(c) An extension of the time limits specified under par. (b) may be granted by the office only when need for additional time is adequately justified by the hospital. Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension may be granted for up to 30 calendar days.

(4) ACCEPTABLE MEDIA FOR DATA SUBMISSION. (a) Except as provided in pars. (b) and (c), each hospital shall submit an extract of the uniform patient billing form data on a magnetic diskette or magnetic tape to the office. The office shall specify in a technical manual:

1. Physical specifications for the data submittal media; and

2. A recommended format for data submission.

(b) A hospital that qualifies for submitting its inpatient discharge data on paper under s. HSS 120.20 (3) (b) shall qualify for paper submittal of its outpatient surgical data for calendar years 1990 and 1991.

(c) A hospital that does not meet the requirement in par. (b) may submit outpatient surgical data on a paper form acceptable to the office if the hospital reimburses the office for all the actual and necessary costs of converting the data to an electronic medium with physical specifications and format acceptable to the office.

(d) Beginning with 1992 calendar year data, all hospitals shall submit outpatient surgical data on electronic media with physical specifications, format and record layout prescribed in a technical manual issued by the office.

(e) Any group of hospitals that qualify for a waiver by the office for submitting its inpatient discharge data under s. HSS 120.20 (3) (e) shall qualify for a waiver by the office for submission of its outpatient surgical data.

(f) The office shall provide consultation to a hospital upon written request of the hospital to enable it to submit outpatient surgical data according to office specifications.

(5) REVIEW OF OUTPATIENT SURGICAL DATA BY HOSPITALS PRIOR TO DATA SUBMISSION. As provided under s. 153.40, Stats., prior to submitting outpatient surgical data to the office, a hospital shall review the data. The review shall consist of checks for accuracy and completeness which are designed by the office or designed by the hospital and approved by the office.

(6) VERIFICATION OF OUTPATIENT SURGICAL RECORD DATA BY PHYSICIAN PRIOR TO DATA SUBMISSION. (a) The surgeon performing the principal procedure shall confirm the validity of the outpatient's principal and secondary diagnoses and the primary and secondary surgical procedures specified in the patient's medical record within a calendar month after the patient is discharged from the hospital. The diagnoses and procedures shall be as defined in the uniform patient billing form manual. The physician shall use the procedures under par. (b) to fulfill this requirement.

(b) A hospital, with its medical staff, shall establish appropriate procedures and mechanisms to ensure verification by a physician. As provided under s. 153.40, Stats., if verification is not made on a timely basis for each calendar quarter, the hospital shall submit the outpatient surgical data noting the lack of verification by the physician.

(7) REVIEW OF OUTPATIENT SURGICAL DATA BY THE OFFICE AND HOSPITALS AFTER DATA SUBMISSION. (a) The office shall check the accuracy and completeness of submitted outpatient surgical data. All errors or probable errors shall be recorded on paper for each outpatient discharge. Acceptable data submissions shall be integrated into the case level data base. Unacceptable data or tapes shall be returned to the hospital with a paper copy of the information for revision and resubmission.

(b) All data revisions required as a result of the checks performed shall be corrected and resubmitted to the office within 10 working days after a hospital's receipt of the unacceptable data.

(c) Outpatient records data resubmitted by hospitals shall be grouped with the appropriate amendments or additions. Additional outpatient records data from the same calendar quarter as the revised data may be submitted with the revised data.

(d) After receipt of data revisions and additional records, the office shall aggregate each hospital's data and shall send a written copy to the hospital. Each hospital shall review the aggregated data for accuracy and completeness and shall supply to the office within 10 working days after receipt of the data any corrections or additions to the data at the patient discharge level.

(e) Within the same 10-working day period under par. (d), the chief executive officer or designee of each hospital shall submit to the office a statement, subscribed under oath or affirmation before a notary public, affirming that the data submitted to the office have been verified pursuant to subs. (5) and (6); that any corrections to the data have been verified pursuant to pars. (a) to (d); and that the data are accurate and complete to the best of his or her knowledge.

SECTION 23. HSS 120.22 (3) (a) 5, as renumbered, is amended to read:

HSS 120.22 (3) (a) 5. Gross revenue from service to patients, by source, which shall be the actual dollar values or a reasonable estimate based on a hospital's internal records. Inpatient and outpatient dollar values shall be listed separately for subpar. a; subpar. b; subpar. h; subpar. i; an aggregation of subpars. c, d, and e; an aggregation of subpars. f, g, ~~h~~ and ~~i~~ j; and an aggregation of subpars. ~~j and~~ k and l as follows:

a. Medicare, excluding medicare reimbursement through HMOs under 42 CFR pt. 417;

b. Medical assistance under ss. 49.43 to 49.497, Stats., excluding medical assistance reimbursement through HMOs under s. 49.45 (3) (b), Stats.;

c. General relief, as defined in s. 49.01 (5m), Stats.;

d. Programs under ss. 51.42 and 51.437, Stats.;

e. All other public programs;

f. Group and individual accident and health insurance and self-funded plans;

g. HMOs, except HMOs under ~~subpar.~~ subpars. h and i, and all other alternative health care payment systems;

h. HMOs reimbursed by medical assistance under s. 49.45 (3) (b), Stats.;

i. HMOs reimbursed by medicare under 42 CFR pt. 417;

~~i~~ j. Workers' compensation;

~~j~~ k. Self pay;

~~k~~ l. All other nonpublic sources; and

~~l~~ m. Total gross revenue from service to patients, by source, obtained by adding the total amounts in subpars. a to ~~k~~ l. This dollar value shall equal the dollar value in subd. 4;

SECTION 24. HSS 120.22 (3) (b), as renumbered, is amended to read:

HSS 120.22 (3) (b) Deductions from revenue obtained from service to patients. Deductions from revenue obtained from service to patients, which shall be the actual dollar values or a reasonable estimate based on a hospital's internal records, as follows:

1. For contractual adjustments, this includes the difference between billed and paid amounts. Inpatient and outpatient dollar values shall be listed separately for subpar. a; subpar. b; subpar. h; subpar. i; an aggregation of subpars. c, d, and e; an aggregation of subpars. f, g, ~~h~~ and ~~i~~ j; and subpar. ~~j~~ k:

a. Medicare, excluding medicare reimbursement through HMOs under 42 CFR pt. 417;

b. Medical assistance under ss. 49.43 to 49.497, Stats., excluding medical assistance reimbursement through HMOs under s. 49.45 (3) (b), Stats.;

c. General relief, as defined in s. 49.01 (5m), Stats.;

d. Programs under ss. 51.42 and 51.437, Stats.;

e. All other public programs;

f. Group and individual accident and health insurance and self-funded plans;

g. HMOs, except HMOs under ~~subpar.~~ subpars. h and i, and all other alternative health care payment systems;

h. HMOs reimbursed by medical assistance under s. 49.45 (3) (b), Stats.;

i. HMOs reimbursed by medicare under 42 CFR pt. 417;

~~i~~ j. Workers' compensation;

~~j~~ k. All other nonpublic sources; and

~~k~~ l. Total contractual adjustments, obtained by adding the amounts in subpars. a to k;

2. For other deductions from revenue, this includes the following uncollectible revenue:

a. Bad debts;

b. Charity care;

c. All other deductions; and

d. Total other deductions from revenue from service to patients, obtained by adding the amounts in subpars. a to c; and

3. Total deductions from revenue, obtained by adding the amounts in subds. 1 ~~k~~ l and 2 d;

SECTION 25. HSS 120.23 is created to read:

HSS 120.23 ASSET, LIABILITY AND FUND BALANCE DATA. (1) SUBMITTAL. (a) Except for the department-operated state mental health institutes and county-owned psychiatric or alcohol and other drug abuse hospitals, each hospital shall annually submit to the office an extract of the asset, liability and fund balance data from its final audited financial statements. In order to comply with this section, a hospital does not have to alter the way it otherwise records its financial data.

(b) If a hospital is jointly operated in connection with a nursing home, home health agency or other organization, and the asset, liability and fund balance data are not available from the hospital's final audited financial statements for the hospital unit alone, the hospital shall use data from its most recent medicare cost report to derive the required data for the hospital unit for subs. (2) (b), (c), (d) and (f), and (3) (b). If the assets and funds under subs. (2) (h) and (4) (a) relate directly to the hospital unit, a hospital shall report these data for the hospital unit only; otherwise a hospital shall report these data based on the total facility. For subs. (2) (a), (e) and (g), (3) (a), (c) and (d), and (4) (b) and (c), a hospital shall report these data based on the total facility if the hospital unit data cannot be separated from the total facility data.

(2) UNRESTRICTED ASSET CATEGORIES. The information reported on each extract shall include the dollar amounts for each of the following unrestricted asset categories:

(a) Current cash and short-term investments;

(b) Current receivables;

(c) Uncollectibles;

(d) Net receivables, obtained by subtracting the uncollectibles under par. (c) from the current receivables under par. (b);

(e) Other current assets;

(f) Buildings and equipment, including the following subcategories:

1. Gross plant assets, including:

a. Buildings;

b. Fixed equipment; and

c. Land;

2. Movable equipment;

3. Accumulated depreciation, including:

a. Buildings;

b. Fixed equipment; and

c. Movable equipment; and

4. Net plant and equipment assets, obtained by subtracting accumulated depreciation under subd. 3 from the sum of gross plant assets under subd. 1 and movable equipment under subd. 2.

(g) Long-term investments, reported at the lower of cost or market;

(h) Other unrestricted assets; and

(i) Total unrestricted assets. This is obtained by adding the current cash and short-term investments under par. (a), the net receivables under par. (d), the other current assets under par. (e), the net plant and equipment assets under par. (f) 4, the long-term investments under par. (g) and the other unrestricted assets under par. (h).

(3) UNRESTRICTED LIABILITIES AND FUND BALANCES. The information reported on each extract shall include the dollar amounts for each of the following unrestricted liabilities and fund balance categories:

(a) Current liabilities;

(b) Long-term debt;

(c) Other liabilities;

(d) Unrestricted fund balances; and

(e) Total unrestricted liabilities and fund balances, obtained by adding pars. (a) through (d).

(4) RESTRICTED HOSPITAL FUNDS. The information reported on each extract shall include the dollar amounts for each of the following restricted hospital fund balances:

(a) Specific purpose funds;

(b) Plant replacement and expansion funds; and

(c) Endowment funds.

SECTION 26. HSS 120.24 (title), (intro.) and Table 120.24 (titles), as renumbered, are amended to read:

HSS 120.24 (title) HOSPITAL CHARGES BY CHARGE ELEMENT. The charge elements listed in Table ~~120.13~~ 120.24 shall be reported to the office in accordance with s. HSS ~~120.14~~ 120.25.

TABLE 120.24
HOSPITAL CHARGE ELEMENTS

HOSPITAL CHARGE ELEMENT	UB-82 REVENUE CODE

SECTION 27. HSS 120.25 is created to read:

HSS 120.25 TIMING, EXTENSIONS, FORMAT AND REVIEW OF HOSPITAL CHARGE ELEMENT AND FISCAL DATA REPORTS. (1) CHARGES BY CHARGE ELEMENT. (a) By July 1, 1989, each hospital shall submit to the office:

1. The amount of the per unit charge for each of the hospital charge elements under s. HSS 120.24 as of that date and the amount one year previous to that date. The outpatient per unit charge shall be listed separately if it differs from the inpatient per unit charge; and

2. The number of times a charge occurred for each of the hospital charge elements under s. HSS 120.24 in the 12-month period of the hospital's most recently completed fiscal year and in the 12-month period previous to the most recently completed fiscal year. A hospital may estimate the volume of charges for each charge element, rounded to the nearest 100, except that if a charge occurred less than 50 times in a 12-month period, the hospital shall count the exact number of times that the charge occurred.

(b) By July 1, 1990 and annually thereafter, each hospital shall submit to the office:

1. The amount of the per unit charge for each of the hospital charge elements under s. HSS 120.24 as of that date. The outpatient per unit charge shall be listed separately if it differs from the inpatient per unit charge; and

2. The number of times a charge occurred for each of the hospital charge elements under s. HSS 120.24 for the 12-month period of the hospital's most recently completed fiscal year. A hospital may estimate the volume of charges for each charge element, rounded to the nearest 100, except that if a charge occurred less than 50 times in a 12-month period, the hospital shall count the exact number of times that the charge occurred.

(2) REVENUE AND EXPENSE DATA. (a) Except as provided in par. (b), by July 1, 1989, each hospital shall submit to the office the dollar amounts of the revenue and expense data included in its audited financial statements, as specified under s. HSS 120.22, for the hospital's fiscal years 1987, 1988 and 1989.

(b) If a hospital's 1989 fiscal year ends after March 1, 1989, the hospital shall submit the 1989 fiscal data to the office no later than 120 calendar days following the close of its 1989 fiscal year.

(c) For each subsequent fiscal year, the hospital shall annually submit to the office the dollar amounts of the revenue and expense data included in its audited financial statements, as specified under s. HSS 120.22, no later than 120 calendar days following the close of that fiscal year.

(d) If the exact audited financial data required for pars. (a), (b) and (c) are available from the department's Wisconsin annual survey of hospitals, a hospital may use the data from that source to submit the required audited revenue and expense data to the office.

(e) Except as provided in par. (b), by July 1, 1989, each hospital shall report to the office the total gross and net revenue figures required under s. HSS 120.22 (3) (a) 4 and (c) for its fiscal years 1987, 1988 and 1989; the dollar difference between the revenue figures for each of these fiscal years; and an explanation of the amount of the dollar difference that was due to a utilization change.

(f) For each subsequent fiscal year, each hospital shall annually submit to the office, no later than 120 calendar days following the close of the hospital's fiscal year, the following information for the fiscal year and the previous fiscal year:

1. The total gross and net revenue figures required under s. HSS 120.22 (3) (a) 4 and (c);

2. The dollar difference between the revenue figures for each of these fiscal years; and

3. The amount in subd. 2 attributable to a price change and the amount attributable to a utilization change.

(3) ASSET, LIABILITY AND FUND BALANCE DATA. (a) By May 1, 1990, each hospital shall submit to the office the dollar amounts of the asset, liability and fund balance data included in its audited financial statements, as specified under s. HSS 120.23, for the hospital's fiscal years 1988 and 1989.

(b) For each subsequent fiscal year, the hospital shall annually submit to the office, no later than 120 calendar days following the close of the hospital's fiscal year, the dollar amounts of the asset, liability and fund balance data included in its audited financial statements, as specified under s. HSS 120.23.

(c) If the exact audited financial data required for par. (a) are available from the department's Wisconsin annual survey of hospitals, a hospital may use the data from that source to submit the required audited asset, liability and fund balance data to the office.

(4) EXTENSION OF SUBMITTAL DEADLINES. (a) Except as provided in par. (b), the office may grant an extension of a deadline specified in this section for submission of a report only when need for additional time is adequately justified by the hospital. Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension for adequate justification may be granted for up to 30 calendar days.

(b) An extension of a deadline specified in this section for submission of a report by a department-operated state mental health institute may be granted for up to 90 calendar days upon written request.

(5) FORMAT FOR DATA SUBMISSION. Each hospital shall submit the charge element data under sub. (1) and fiscal data under sub. (2) and (3) to the office in a paper medium format provided by the office.

(6) REVIEW OF DATA BY OFFICE AND HOSPITALS AFTER DATA SUBMISSION. (a) The office shall check the accuracy and completeness of submitted charge element and fiscal data. Unacceptable data shall be returned to the hospital that submitted it with a paper copy of the information for revision and resubmission if the office has contacted the hospital and has determined that the data cannot be corrected by telephone. Data returned to a hospital shall be resubmitted to the office within 10 working days after the hospital's receipt of the unacceptable data.

(b) After the office has made any data revisions under par. (a) relating to the charge element and fiscal data for a particular hospital, the office shall send to the hospital a written copy of all data variables submitted by that hospital to the office or subsequently corrected by the office. The hospital shall review the data for accuracy and completeness and shall supply to the office within 10 working days after receipt of the data any corrections to the data.

(c) Within the same 10-working day period under par. (b), the chief executive officer of each hospital shall submit to the office a statement, subscribed under oath or affirmation before a notary public, affirming that any corrections to the data have been verified pursuant to par. (b), and that the data are accurate and complete to the best of his or her knowledge.

SECTION 28. HSS 120.26 (2) (c), (3), (4) and (5) (d) (intro.) and (e), as renumbered, are amended to read:

HSS 120.26 (2) (c) "~~Rate~~ Reportable rate increase" means an increase that raises a hospital's total gross revenue from continuing services to patients, as determined under s. HSS ~~120.12~~ 120.22 (3) (a) 4, not less than one-half percent within ~~the hospital's fiscal year~~ a 12-month period.

(3) TYPE OF NOTICE. A hospital shall publish a class 1 notice at least 10 days prior to instituting a reportable rate increase to inform interested persons of the increase. The notice shall be published in one or more newspapers of general circulation likely to give notice to the hospital's patients and payers.

(4) PUBLICATION OF NOTICE. If at any time ~~during a hospital's fiscal year~~ a hospital's cumulative rate increases meet the definition of a reportable rate increase in sub. (2) (c), the hospital shall publish a notice of ~~that~~ the most recent rate increase in accordance with sub. (5).

(5) (d) (intro.) An increase in the rate for any charge element under s. HSS ~~120.13~~ 120.24. If a rate for a charge element will not increase, the hospital is not required to list that charge element in the notice. The information about the increase shall be formatted as follows:

(e) The anticipated overall increase in a hospital's total gross revenue under s. HSS ~~120.12~~ 120.22 (3) (a) 4 that will result from rate changes in all reportable and unreportable charge elements for the following 12-month period, expressed as an annualized percentage.

SECTION 29. HSS 120.26 (5) (i) is created to read:

HSS 120.26 (5) (i) A hospital shall include footnotes in the notice to explain any rate increase or decrease reported. The explanatory footnotes shall be clearly separated from the required information and printed in type no larger than that required by par. (a) for the text of the notice.

SECTION 30. HSS 120.27 (2) (a) and (c) and (3), as renumbered, are amended to read:

HSS 120.27 (2) (a) By July 1, 1989 ~~and annually thereafter~~, each hospital shall submit its uncompensated health care services plan to the office for its most recently completed fiscal year.

(c) ~~For all~~ A hospital shall submit every subsequent uncompensated health care services plan ~~submissions, each hospital shall annually submit~~ to the office annually ~~the plan for its most recently completed fiscal year~~ in accordance with sub. (1) in a format prescribed by the office in a technical manual no later than 120 calendar days following the close of ~~that~~ the hospital's most recently completed fiscal year.

(3) HILL-BURTON UNCOMPENSATED SERVICES PROGRAM REQUIREMENTS. Any hospital that has a current obligation or obligations under 42 CFR pt. 124 shall annually report to the office on the same date as provided in sub. (2) the date or dates the obligation or obligations went into effect, the amount of the total federal assistance under obligation at the hospital and the date or dates the obligation or obligations will be satisfied.

The repeals and rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s. 227.22 (2), Stats.

Approved by the Board on Health Care Information

Date: February 12, 1990

By: Ronald H Dix
Ronald H. Dix
Chairperson

Wisconsin Department of Health and Social Services

Date: February 12, 1990

By: John Torgerson FOR
Patricia A. Goodrich FOR P-G.
Secretary

Seal:

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES
1 West Wilson Street, Madison, Wisconsin 53702

Tommy G. Thompson
Governor

Patricia A. Goodrich
Secretary

Mailing Address:
Post Office Box 7850
Madison, WI 53707

February 12, 1990

Mr. Bruce E. Munson
Revisor of Statutes
7th Floor - 30 on the Square
Madison, WI 53702

Dear Mr. Munson:

As provided in s. 227.20, Stats., there is hereby submitted a certified copy of HSS 120, administrative rules relating to administration of the Office of Health Care Information.

These rules are also being submitted to the Secretary of State as required by s. 227.20, Stats.

Sincerely,

John Torgerson FOR P.G.

Patricia A. Goodrich
Secretary

Enclosure