Chapter HSS 105

MEDICAL ASSISTANCE: PROVIDER CERTIFICATION

Note: Chapter HSS 105 as it existed on February 28, 1986 was repealed and a new chapter HSS 105 was created effective March 1, 1986.

HSS 105.01 Introduction. (1) PURPOSE OF THE CHAPTER. This chapter identifies the terms and conditions under which providers of health care services are certified for participation in the medical assistance program (MA).

(2) DEFINITIONS. In this chapter:

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

(b) 1. "Institutional provider" means a provider group or organization which is:

a. Composed of more than one individual performing services; and

b. Licensed or approved by the appropriate state agency or certified for medicare participation, or both.

2. Institutional providers include: hospitals, home health agencies, portable x-ray providers, rehabilitation agencies, independent clinical laboratories, rural health clinics, outpatient mental health clinics, operations by boards authorized under s. 51.42, Stats., skilled nursing facilities and intermediate nursing facilities.

(c) "Non-institutional provider" means a provider, eligible for direct reimbursement, who is in single practice rather than group practice, or a provider who, although employed by a provider group, has private patients for whom the provider submits claims to MA.

(d) "Provider assistant" means a provider such as a physical therapist assistant whose services must be provided under the supervision of a certified or licensed professional provider, and who, while required to be certified, is not eligible for direct reimbursement from MA.

(3) GENERAL CONDITIONS FOR PARTICIPATION. In order to be certified by the department to provide specified services for a reasonable period of time as specified by the department, a provider shall:

(a) Affirm in writing that, with respect to each service for which certification is sought, the provider and each person employed by the provider for the purpose of providing the service holds all licenses or similar entitlements as specified in chs. HSS 101 to 108 and required by federal or state statute, regulation or rule for the provision of the service;

(b) Affirm in writing that neither the provider, nor any person in whom the provider has a controlling interest, nor any person having a controlling interest in the provider, has, since the inception of the medicare, medicaid, or title 20 services program, been convicted of a crime related to, or been terminated from, a federal-assisted or state-assisted medical program;

(c) Disclose in writing to the department all instances in which the provider, any person in whom the provider has a controlling interest, or any person having a controlling interest in the provider has been sanctioned by a federal-assisted or state-assisted medical program, since the inception of medicare, medicaid or the title 20 services program;

(d) Furnish the following information to the department, in writing:

1. The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

2. The names and addresses of all persons who have a controlling interest in the provider; and

3. Whether any of the persons named in compliance with subd. 1 or 2, is related to another as spouse, parent, child or sibling; and

(e) Execute a provider agreement with the department.

(4) PROVIDERS REQUIRED TO BE CERTIFIED. The following types of providers are required to be certified by the department in order to participate in the MA program:

(a) Institutional providers;

(b) Non-institutional providers;

(c) Provider assistants; and

(d) Group billing providers.

(5) PERSONS NOT REQUIRED TO BE INDIVIDUALLY CERTIFIED. The following persons are not required to be individually certified by the department in order to participate in the MA program:

(a) Technicians or support staff for a provider, including:

1. Dental hygienists;

2. Medical record librarians or technicians;

3. Hospital and nursing home administrators, clinic managers, and administrative and billing staff;

4. Nursing aides, assistants and orderlies;

5. Home health aides;

6. Personal care workers;

7. Dieticians;

8. Laboratory technologists;

9. X-ray technicians;

10. Patient activities coordinators;

11. Volunteers; and

12. All other persons whose cost of service is built into the charge submitted by the provider, including housekeeping and maintenance staff; and

(b) Providers employed by or under contract to certified institutional providers, including but not limited to physicians, therapists, nurses and provider assistants. These providers shall meet certification standards applicable to their respective provider type.

(6) NOTIFICATION OF CERTIFICATION DECISION. Within 60 days after receipt by the department or its fiscal agent of a complete application for certification, including evidence of licensure or medicare certification, or both, if required, the department shall either approve the application and issue the certification or deny the application. If the application for certification is denied, the department shall give the applicant reasons, in writing, for the denial.

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

HSS 105.02 Requirements for maintaining certification. Providers shall comply with the requirements in this section in order to maintain MA certification.

(1) CHANGE IN PROVIDER STATUS. Providers shall report to the department in writing any change in licensure, certification, group affiliation, corporate name or ownership by the time of the effective date of the change. The department may require the provider to complete a new provider application and a new provider agreement when a change in status occurs. A provider shall immediately notify the department of any change of address but the department may not require the completion of a new provider application or a new provider agreement for a change of address.

(2) CHANGE IN OWNERSHIP. (a) *Non-nursing home provider.* In the event of a change in the ownership of a certified provider, except a nursing home, the provider agreement shall automatically terminate, except that the provider shall continue to maintain records required by subs. (4), (6) and (7) unless an alternative method of providing for maintenance of these records has been established in writing and approved by the department.

(b) *Nursing home provider.* In the event of a change in the ownership of a nursing home, the provider agreement shall automatically be assigned to the new owner.

(3) RESPONSE TO INQUIRIES. A provider shall respond as directed to inquiries by the department regarding the validity of information in the provider file maintained by the department or its fiscal agent.

(4) MAINTENANCE OF RECORDS. Providers shall prepare and maintain whatever records are necessary to fully disclose the nature and extent of services provided by the provider under the program. Records to be maintained are those enumerated in subs. (6) and (7). All records shall be retained by providers for a period of not less than 5 years from the date of payment by the department for the services rendered, unless otherwise stated in chs. HSS 101 to 108. In the event a provider's participation in the program is terminated for any reason, all MA-related records shall remain subject to the conditions enumerated in this subsection and sub. (2).

(5) PARTICIPATION IN SURVEYS. Nursing home and hospital providers shall participate in surveys conducted for research and MA policy purposes by the department or its designated contractors. Participation involves accurate completion of the survey questionnaire and return of the completed survey form to the department or to the designated contractor within the specified time period.

(6) RECORDS TO BE MAINTAINED BY ALL PROVIDERS. All providers shall maintain the following records:

(a) Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by MA;

(b) MA billings and records of services or supplies which are the subject of the billings, that are necessary to fully disclose the nature and extent of the services or supplies; and

(c) Any and all prescriptions necessary to disclose the nature and extent of services provided and billed under the program.

(7) RECORDS TO BE MAINTAINED BY CERTAIN PROVIDERS. (a) *Specific types of providers.* The following records shall be maintained by hospitals, skilled nursing facilities (SNFs), intermediate care facilities (ICFs) and home health agencies, except that home health agencies are not required to maintain records listed in subds. 5, 11 and 14, and SNFs, ICFs and home health agencies are not required to maintain records listed in subd. 4:

1. Annual budgets;

2. Patient census information, separately:

a. For all patients; and

b. For MA recipients;

3. Annual cost settlement reports for medicare;

4. MA patient logs as required by the department for hospitals;

5. Annual MA cost reports for SNFs, ICFs and hospitals;

6. Independent accountants' audit reports;

7. Records supporting historical costs of buildings and equipment;

8. Building and equipment depreciation records;

9. Cash receipt and receivable ledgers, and supporting receipts and billings;

10. Accounts payable, operating expense ledgers and cash disbursement ledgers, with supporting purchase orders, invoices, or checks;

11. Records, by department, of the use of support services such as dietary, laundry, plant and equipment, and housekeeping;

12. Payroll records;

13. Inventory records;

14. Ledger identifying dates and amounts of all deposits to and withdrawals from MA resident trust fund accounts, including documentation of the amount, date, and purpose of the withdrawal when withdrawal is made by anyone other than the resident. When the resident chooses to retain control of the funds, that decision shall be documented in writing and retained in the resident's records. Once that decision is made and documented, the facility is relieved of responsibility to document expenditures under this subsection; and

15. All policies and regulations adopted by the provider's governing body.

(b) *Prescribed service providers.* The following records shall be kept by pharmacies and other providers of services requiring a prescription:

1. Prescriptions which support MA billings;

2. MA patient profiles;

3. Purchase invoices and receipts for medical supplies and equipment billed to MA; and

4. Receipts for costs associated with services billed to MA.

(8) PROVIDER AGREEMENT DURATION. The provider agreement shall, unless terminated, remain in full force and effect for a maximum of one year from the date the provider is accepted into the program. In the absence of a notice of termination by either party, the agreement shall automatically be renewed and extended for a period of one year.

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

HSS 105.03 Participation by non-certified persons. (1) REIMBURSEMENT FOR EMERGENCY SERVICES. If a resident of Wisconsin or of another state who is not certified by MA in this state provides emergency services to a Wisconsin recipient, that person shall not be reimbursed for those services by MA unless the services are covered services under ch. HSS 107 and:

(a) The person submits to the fiscal agent a provider data form and a claim for reimbursement of emergency services on forms prescribed by the department;

(b) The person submits to the department a statement in writing on a form prescribed by the department explaining the nature of the emergency, including a description of the recipient's condition, cause of emergency, if known, diagnosis and extent of injuries, the services which were provided and when, and the reason that the recipient could not receive services from a certified provider; and

(c) The person possesses all licenses and other entitlements required under state and federal statutes, rules and regulations, and is qualified to provide all services for which a claim is submitted.

(2) REIMBURSEMENT PROHIBITED FOR NON-EMERGENCY SERVICES. No non-emergency services provided by a non-certified person may be reimbursed by MA.

(3) REIMBURSEMENT DETERMINATION. Based upon the signed statement and the claim for reimbursement, the department's professional consultants shall determine whether the services are reimbursable.

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

HSS 105.04 Supervision of provider assistants. Provider assistants shall be supervised. Unless otherwise specified under ss. HSS 105.05 to 105.49, supervision shall consist of at least intermittent face-to-face contact between the supervisor and the assistant and a regular review of the assistant's work by the supervisor.

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

HSS 105.05 Certification of physicians and assistants. (1) PHYSICIANS. For MA certification, physicians shall be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 1, 2, 3, 4, 5, and 14.

(2) PHYSICIAN ASSISTANTS. For MA certification, physician assistants shall be certified and registered pursuant to ss. 448.05 and 448.07, Stats., and chs. Med 8 and 14.

Note: For covered physician services, see s. HSS 107.06.

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

HSS 105.06 Certification of dentists. For MA certification, dentists shall be licensed pursuant to s. 447.05, Stats.

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

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

HSS 105.07 Certification of general hospitals. For MA certification, hospitals shall be approved pursuant to s. 50.35, Stats., and ch. H 24 [HSS 124], shall either have a medicare provider agreement or be accredited by the joint commission on the accreditation of hospitals (JCAH), and shall have a utilization review plan that meets the requirements of 42 CFR 405.1035. In addition:

(1) Hospitals providing outpatient psychotherapy shall meet the requirements specified in s. HSS 105.22 (1) (2) and (3);

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

(3) Hospitals providing day treatment services shall meet the requirements specified in s. HSS 105.24;

(4) Hospitals participating in the peer review organization (PRO) review program shall meet the requirements of 42 CFR 405.1035 and any additional requirements established under state contract with the PRO.

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

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

HSS 105.08 Certification of skilled nursing facilities. For MA certification, skilled nursing facilities shall be licensed pursuant to s. 50.03, Stats., and ch. HSS 132.

Note: For covered nursing home services, see s. HSS 107.09.

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

HSS 105.09 Medicare bed requirement. (1) MEDICARE BED OBLIGATION. Each county shall have a sufficient number of skilled nursing beds certified by the medicare program pursuant to ss. 49.45 (6m) (g) and 50.02 (2), Stats. The number of medicare-certified beds required in each county shall be determined by the department, based on factors including but not limited to the number of persons over 65 in the county and the number of medicare-eligible persons transferred from hospitals to skilled nursing facilities in the county for convalescent stays.

(2) PENALTY. (a) If a county does not have sufficient medicare-certified beds as determined under sub. (1), each SNF within that county which does not have one or more medicare-certified beds shall be subject to a fine to be determined by the department of not less than $10 nor more than $100 for each day that the county continues to have an inadequate number of medicare-certified beds.

(b) The department may not enforce penalty in par. (a) if the department has not given the SNF prior notification of criteria specific to its county which shall be used to determine whether or not the county has a sufficient number of medicare-certified beds.

(c) If the number of medicare-certified beds in a county is reduced so that the county no longer has a sufficient number of medicare-certified beds under sub. (1), the department shall notify each SNF in the county of the number of additional medicare-certified beds needed in the county. The department may not enforce the penalty in par. (a) until 90 days after this notification has been provided.

(3) EXEMPTIONS. (a) In this subsection, a "swing-bed hospital" means a hospital approved by the federal health care financing administration to furnish skilled nursing facility services in the medicare program.

(b) Homes which are certified ICF/MR are exempt from this section.

(c) The department may exempt the skilled nursing facilities in a county from the requirements of this section if it determines that there is adequate accessibility to medicare-certified beds for persons residing in the county.

(d) A skilled nursing facility located within a county determined by the department to have an inadequate number of medicare-certified beds may apply to the department for exemption from the requirements of this section. The department may grant an exemption based on but not limited to:

1. Availability of a swing-bed hospital operating within a 30 mile radius of the nursing home; or

2. Availability of an adequate number of medicare-certified beds in an adjacent county or a regional facility.

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

HSS 105.10 Certification of SNFs and ICFs with deficiencies. If the department finds a facility deficient in meeting the standards specified in s. HSS 105.08, 105.09, 105.11 or 105.12, the department may nonetheless certify the facility for MA under the conditions specified in s. HSS 132.21 and 42 CFR 442, Subpart C.

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

HSS 105.11 Certification of intermediate care facilities. For MA certification, intermediate care facilities shall be licensed pursuant to s. 50.03, Stats., and ch. HSS 132.

Note: For covered nursing home services, see s. HSS 107.09.

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

HSS 105.12 Certification of ICFs for mentally retarded persons or persons with related conditions. For MA certification, institutions for mentally retarded persons or persons with related conditions shall be licensed pursuant to s. 50.03, Stats., and ch. H 34 [HSS 134].

Note: For covered ICF/MR services, see HSS 107.09.

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

HSS 105.29 Certification of speech and hearing clinics. For MA certification, speech and hearing clinics shall be currently accredited by the American speech and hearing association (ASHA) pursuant to the guidelines for "accreditation of professional services programs in speech pathology and audiology" published by ASHA.

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

HSS 105.30 Certification of speech pathologists. For MA certification, speech pathologists shall:

(1) Possess a current certification of clinical competence from the American speech and hearing association;

(2) Have completed the educational requirements and work experience necessary for such a certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate of clinical competence under sub. (1).

Note: For covered speech pathology services, see. s. HSS 107.18.

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

HSS 105.31 Certification of audiologists. For MA certification, audiologists shall:

(1) Possess a certificate of clinical competence from, and current membership in, the American speech and hearing association (ASHA);

(2) Have completed the educational requirements and work experience necessary for the certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate.

Note: For covered audiology services, see s. HSS 107.19.

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

HSS 105.32 Certification of optometrists. For MA certification, optometrists shall be licensed and registered pursuant to ss. 449.04 and 449.06, Stats.

Note: For covered vision care services, see s. HSS 107.20.

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

HSS 105.33 Certification of opticians. For MA certification, opticians shall practice as described in s. 449.01 (2), Stats.

Note: For covered vision care services, see s. HSS 107.20.

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

HSS 105.34 Certification of rehabilitation agencies. For MA certification, rehabilitation agencies providing outpatient physical therapy or speech pathology shall be certified to participate in medicare and shall meet the requirements of 42 CFR 405.1702 to 405.1726.

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

HSS 105.35 Certification of rural health clinics. For MA certification, a rural health clinic shall be:

(1) Certified to participate in medicare;

(2) Licensed as required under all other local and state laws; and

(3) Staffed with persons who are licensed, certified, or registered in accordance with appropriate state laws.

Note: For covered rural health clinic services, see s. HSS 107.29.

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

HSS 105.36 Certification of family planning clinics or agencies. For MA certification, family planning clinics or agencies shall meet the following conditions:

(1) GENERAL. In order to qualify for MA reimbursement, family planning clinics shall certify to the department that:

(a) An MA card has been shown before services are provided;

(b) Services are prescribed by a physician or are provided by a nurse midwife as provided under s. 411.15, Stats.; and

(c) No sterilization procedures are available to persons who are mentally incompetent, institutionalized or under the age of 21.

(2) PRINCIPLES OF OPERATION. (a) Family planning services shall be made available:

1. Upon referral from any source or upon the patient's own application;

2. Without regard to race, nationality, religion, family size, martial status, maternity, paternity, handicap or age, in conformity with the spirit and intent of the civil rights act of 1964, as amended, and the rehabilitation act of 1973, as amended;

3. With respect for the dignity of the individual; and

4. With efficient administrative procedures for registration and delivery of services, avoiding prolonged waiting and multiple visits for registration. Patients shall be seen on an appointment basis whenever possible.

(b) Acceptance of family planning service shall be voluntary, and individuals shall not be subjected to coercion either to receive services or to employ or not to employ any particular method of family planning. Acceptance or nonacceptance of family planning services shall not be a prerequisite to eligibility for or receipt of any other service funded by local, state, or federal tax revenue.

(c) A variety of medically approved methods of family planning, including the natural family planning method, shall be available to persons to whom family planning services are offered and provided.

(d) The clinic shall not provide abortion as a method of family planning.

IOWA	ILLINOIS	MINNESOTA	MICHIGAN
Dubuque	Antioch	Duluth	Bessemer
Guttenberg	Durland	Hastings	Crystal Falls
Lansing	East Dubuque	Kingsdale	Iron Mountain
McGregor	Freeport	LaCrescent	Iron River
	Galena	Lake City	Ironwood
	Harvard	Markville	Kingsford
	Hebron	Minneapolis	Marenisco
	Richmond	Red Wing	Menominee
	Rockford	Rochester	Norway
	South Beloit	Rush City	Wakefield
	Stockton	St. Paul	Watersmeet
	Warren	Stillwater	
	Woodstock	Taylor Falls	
		Wabasha	
		Winona	
		Wrenshall	

5. Out-of-state providers at locations other than those in subd. 4 may apply to the department for border status certification, except that out-of-state nursing homes are not eligible for border status. Requests for border status shall be considered by the department on a case-by-case basis.

(b) *Review of border status certification.* The department may review border status certification annually. Border status certification may be cancelled by the department if it is found to be no longer warranted by medical necessity, volume or other considerations.

(2) LIMITATION ON CERTIFICATION OF OUT-OF-STATE PROVIDERS. (a) Providers certified in another state whose services are not covered in Wisconsin shall be denied border status certification in the Wisconsin program.

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

(b) Providers denied certification in another state shall be denied certification in Wisconsin, except that providers denied certification in another state because their services are not MA-covered in that state may be eligible for Wisconsin border status certification if their services are covered in Wisconsin.

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

HSS 105.49 Certification of ambulatory surgical centers. For MA certification, ambulatory surgical centers shall meet the requirements for participation in medicare as stated in 42 CFR 416.39.

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

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