Chapter HSS 1

UNIFORM FEE SYSTEM

Note: Chapter HSS 1 as it existed on August 31, 1978 was replaced and a new chapter HSS 1 was created effective September 1, 1978.

HSS 1.01 Purpose, definitions, exempted services. (1) STATEMENT OF INTENT. These rules, implementing ss. 46.03 (18), 46.10 and 51.30 (4) (b) 2., Stats., standardize on a statewide basis the determination of liability and ability to pay, and otherwise regulate billing and collection activities for care and services provided or purchased by the department, a county department of social services, or a board created under s. 51.42, 51.437, or 46.23, Stats.

Note: Boards operated under the provisions of s. 46.033, 46.034, 55.02, Stats., are included as well since authority is derived from the agencies specified above.

(2) DEFINITIONS. (a) "Administratively unfeasible" means that the total payments realized would approximate or be less than the cost of collections for a specified type of service.

(b) "Department" means the state department of health and social services.

(c) "Division" means one of the major subunits of the department.

(d) "Facility" means any agency, office, institution, clinic, etc., that delivers client services.

(e) "Family" means an adult, the adult's spouse, if any, and any other person(s) who meet(s) internal revenue service standards as their dependent(s). However, any person described by one of the following conditions shall not be included as a family member in determining the ability to pay of any given responsible party under these rules:

1. A family member who is receiving services in a full-care facility, or

2. A legal dependent living outside the household of the responsible party for whom there is a court-ordered support/maintenance obligation.

Note: An adult residing in the home of his or her parent(s) shall be considered a separate family in determining ability to pay under these rules.

(f) "Fee" means a single, cost-related, per unit charge or rate assigned to a purchased or provided service furnished by a provider of service calculated and/or approved according to the provisions of this rule for the purpose of establishing the liability of responsible parties and billing third-party payers.

Note: "Fee" in the context of these rules is different from the term, "sliding fee" as used in some human service agencies. "Fee" in these rules indicates the cost of service—regardless of ability to pay. "Sliding fee" usually relates to ability to pay.

(g) "Full financial information" means such information about a family's income, expenses, liquid assets, and insurance coverage as is necessarily and reasonably requested for the purpose of determining ability-to-pay and for billing all applicable insurance.

(h) "Income" means money, wages or salary, net income from nonfarm self-employment, net income from farm self-employment, social security, dividends, interest (on savings or bonds), income from estates or trusts, net rental income or royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers compensation, alimony (maintenance payments), child support, and veteran pensions.

(i) "Parent" means a child's adoptive or biological mother or father who has legal responsibility for the child.

(j) "Parental payment limit" means the dollar amount specified in s. 46.10 (14), Stats., for parental liability for services described in that section.

(k) "Payment approval authority" means an administrator of a division, the director of a county department of social services, or the program director of a board established under s. 51.42, 51.437, or 46.23, Stats., or a designee.

(l) "Secretary" means the secretary of the department of health and social services.

(m) "Student" means an individual who is attending a school, college, university, or a course of vocational or technical training.

(3) WHERE RULES APPLY. These rules apply to all client-specific care and services purchased or provided by the department, county departments of social services, and boards created under s. 51.42, 51.437, or 46.23, Stats., except as provided in section HSS 1.01 (4) of these rules.

(4) EXCEPTIONS. The following services are not subject to direct billing to responsible parties under these rules:

(a) Federal exemptions: any service for which the imposition of a charge is prohibited by federal law, regulation, or valid federal grant requirement, including educational services to handicapped pre-school age children with exceptional education needs under Title I of P.L. 89-313.

(b) Statutory or judicial exemptions: services exempted in ss. 46.03 (18) (a) and 46.10 (2m), Stats., services for handicapped children with exceptional education needs which local school districts must ensure be available under ss. 115.83 and 115.85, Stats., and any other care or service for which the imposition of a charge is prohibited by state law.

(c) Exemptions established by the department, pursuant to s. 46.03 (18) (a), Stats.:

1. Services offered and defined under the state plan for Title XX of the Social Security Act which are specifically exempted from fee charging in the plan.

2. Probation and parole services, court ordered supervision and other supervision services.

Note: In situations where this provision conflicts with the Title XX Plan and Regulations, the latter take precedence.

3. Purchases of education services by the divisions of corrections and vocational rehabilitation.

4. Sheltered employment, work activity, and adult non-medical day services programs for the handicapped.

5. Non-medical initial diagnosis and evaluation services.

6. Family planning services.

7. Advocacy.

(d) Further exemptions:

1. Any provider of a service may request that the service be exempted from these rules under the following procedures unless prohibited by law, if the secretary or designee finds that the benefit of the service in question will be significantly impaired if the imposition of a charge continues or that the imposition of a charge is administratively unfeasible.

2. Agencies seeking an exemption of a service not listed in HSS 1.04 (4) (c) shall submit a request containing documentation. At a minimum data must include a full review for 3 continuous months of the maximum monthly payment rates computed according to HSS 1.03 for all clients receiving the service.

3. Each request shall also include the following summary information:

a. Full description of the type of service (e.g. how it is provided, its intended purpose, etc.).

b. Per unit cost of service.

c. Units of service provided each month under review.

d. Total number of clients during the full period of review.

e. Number of clients in each of the Maximum Monthly Payment Rate levels.

(Note: For example 15 clients - 0
3 clients - $4 - $10/mo.
4 clients - $11 - $20/mo.
Etc.)

f. A statement indicating the potential recovery from third party payers and whether the services are eligible for federal financial participation under the state Title XX plan.

g. Documentation of extra administrative cost to operate the uniform fee system for this service.

h. Reason and evidence to sustain any contra-therapeutic claim for exemption.

4. Agencies providing services under contract with a county agency shall submit the supporting materials to the appropriate purchasing agency. If the county agency concurs with the request for exemption, the

request and any additional supporting information and rationale shall be forwarded by the county agency to the Secretary, Department of Health and Social Services - Subject: Uniform Fee Exemption.

5. Fee exemption, when approved, relates to all clients receiving the specified service from the service provider. The secretary may expand the fee exemption to include like services from all similar providers of service. Fee exemptions shall be communicated by letter to the appropriate county agency (ies).

(5) CROSS REFERENCE TO OTHER RULES. Rules governing fees for services provided under s. 46.25, Stats., shall be promulgated under (PW) of the Wis. Adm. Code pertaining to the bureau of child support.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (1), (3), (4) (b) and (5), ren. (2) (j) to (l) to be (2) (k) to (m), cr. (2) (j), ren. (4) (d) to be (4) (d) 1., cr. (4) (d) 2 to 5, Register, November, 1979, No. 287, eff. 1-1-80.

HSS 1.02 Liability for paying fees. (1) RESPONSIBLE PARTIES. Whenever a client receives a service which is subject to these rules, the client, the spouse of a married client, and the parents of a minor client shall be responsible for paying for the service in the manner set forth in these rules. These persons shall hereinafter be referred to as "responsible parties." Their legal obligation for the service received shall hereinafter be referred to as "liability."

(2) EXTENT OF LIABILITY. Liability for a service shall equal the fee, as determined pursuant to these rules, times the number of units of service provided, except as follows:

(a) For parties and services specified in s. 46.10 (14), Stats., liability of responsible parties listed therein and of insurance firms shall be as specified therein.

(b) Notwithstanding paragraph (a), when inpatient care for minors at facilities listed in s. 46.10 (14), Stats., exceeds one year, the liability of parents shall be the lower of the rate established in s. 46.10 (14), Stats., or their monthly payment rate as calculated under section HSS 1.03 (12) or (13) and adjusted as appropriate under section HSS 1.03 (14).

(3) RECORDING UNITS OF SERVICE TO ESTABLISH LIABILITY. Except as provided in subsection (5), facilities shall maintain records of all clients receiving fee-chargeable services using the following specified data. For each client receiving a fee-chargeable service, units of service shall be as follows unless an exception is granted by the secretary or a designee:

(a) Rounded to the next highest ¼ hour for outpatient, counseling and similar services.

(b) Rounded to the nearest whole hour for child day care, homemaker services, day services, or similar services.

(c) Per day for residential care services including those in the following settings: (Also see subsection (4) for additional provisions.)

1. Mental hygiene inpatient facilities

2. Foster homes

3. Group homes

4. Child caring institutions

5. Community based residential facilities

6. Juvenile correctional facilities

(d) For other services, supplies or materials, where the cost is the fee, an itemized statement describing the service and cost will suffice.

(4) ADDITIONAL PROVISIONS FOR RECORDING PER DAY UNITS OF SERVICE. (a) Except as otherwise stated, a charge shall be made for each day a patient or resident is physically at the institution or facility at midnight of the day. No charge shall be made for the day the patient or resident leaves.

(b) A charge shall be made if the patient or resident both enters and leaves during the same day.

(c) No charge shall be made for any day during which a patient or resident has been granted a leave or furlough or is on unauthorized absence for one or more overnights.

(d) A charge shall be made for each day during which a patient or resident of a state institution is confined at university of Wisconsin hospital and clinics as a charge of the department institution when admitted under s. 46.115, Stats. Patients or residents placed on authorized leave or furlough and sent to a general hospital overnight or longer at their own expense shall not be charged for institution care while so hospitalized.

(5) REPORTING EXCEPTION FOR SOCIAL SERVICES. For fee-chargeable services of the type that have no potential for third-party payment recovery, a simplified reporting system may be established to eliminate the reporting of units of service to the facility's or agency's billing unit for clients and other responsible parties who show a documented zero ability to pay according to HSS 1.03. However, agency records shall contain information specified in HSS 1.06.

(6) LESSER SPECIAL RATES. These procedures govern the computation of a "lesser special rate" for residential facilities subject to s. 46.10 (14), Stats., where "no liability may accrue for the difference between the lesser special rate and $4 per day."

(a) Inpatient facilities. While HSS 1.02 (2) (b) requires the application of a lesser special rate when care exceeds one year, it is also permissible to apply a lesser special rate during the first year of such care when it is virtually certain that care will exceed one year and not to do so would work a documentable hardship on the family. The earlier application of the lesser special rate shall be determined by the payment approval authority.

(b) Residential non-medical facilities. Where the family's monthly payment rate determined according to HSS 1.03 is less than $122, a lesser special rate shall be applied at the outset of services in lieu of the parental payment limit of $4.00 per day. Agencies may set lesser special rates in one of the following ways:

1. A monthly rate shall be the lesser of $122 or the family's monthly payment rate as determined according to HSS 1.03; however, the application of a monthly rate must not result in a parental payment of more than $4.00 per day of care for any month.

2. A daily rate may be used by charging a family the lesser of $4.00 per day or an amount consisting of their monthly payment rate multiplied by 12 with that product divided by 365.

(7) PARENTAL LIABILITY FOR NON-RESIDENTIAL SERVICES. (a) Parents are liable for the full cost of non-residential services; however, under certain conditions, HSS 1.03 (18) (a) limits parental billings for outpatient psychotherapy purchased or provided by county agencies to $120 per month. Billings for other non-residential services are limited to $4.00 per day. Claims for third parties are filed at the full cost of service. (See paragraph (b) on how health insurance recovery affects the billing amount to parents.) In billing parents, if the total charges in a calendar month exceed the monthly payment rate as calculated in HSS 1.03, the charges to the parents for that month shall be reduced to the monthly payment rate.

(b) Where the parental payment limit is $120 per month, the parents' payment obligation for a given month is credited by any insurance payments received for services during that month. Where the parental payment limit is $4.00 per day, the parents' payment obligation for a given day is credited by any insurance payments received for services on that day.

(8) DISCHARGE OF LIABILITY OTHER THAN BY MEANS OF FULL PAYMENT. At the end of a treatment episode, the liability of responsible parties remaining after recovery of benefits from all applicable insurance shall be deemed discharged if responsible parties provide persons with billing responsibility with full financial information and obtain a waiver as follows:

(a) For all care and service except inpatient mental hygiene, by having paid the lesser of the liability remaining after crediting third-party payments each month or the monthly payment rate as calculated in section HSS 1.03 (12) or (13) and adjusted, as appropriate, under section HSS 1.03 (14).

(b) For inpatient mental hygiene care and services, when liability remaining exceeds $1000 or discharge of liability at the maximum monthly payment rate would exceed 5 years, by entering into an agreement with the appropriate payment approval authority to pay a substantial portion of the liability outstanding as a lump sum.

(9) EXEMPTION FROM LIABILITY. If it is determined in the case of a particular family that the accomplishment of the purpose of a service would be significantly impaired by the imposition of liability, the accrual of liability during a period not to exceed 90 days may be voided in whole or in part by the appropriate payment approval authority. If the need to avoid imposition of liability continues, a further cancellation may be granted.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (1), (2) (b), ren. (3) and (4) to be (8) and (9) and am. (8) (a) and (9), cr. (3) to (7), Register, November, 1979, No. 287, eff. 1-1-80.

HSS 1.03 Billing rates and ability to pay. (1) APPLICABLE INSURANCE. Where applicable insurance exists, the insurer shall be billed an amount equal to the fee, as determined pursuant to these rules, times the number of units of service provided.

(2) CLIENTS RESIDING IN FACILITIES (MEDICAL OR NON-MEDICAL) WITH UNEARNED INCOME. A client receiving room and board with care or services and who is the beneficiary of monthly payments intended to meet maintenance needs and/or accrues unearned income (including but not limited to interest from assets such as savings and investments), shall be expected to pay the lesser of the monthly liability for that care or the total amount of unearned income that month less an amount sufficient to satisfy the client's unmet personal needs and any court-ordered payments or support of legal dependents. The monthly amount of interest income is determined by dividing the current annual interest income by 12. If payments of unearned income are made to a representative payee or guardian, that person shall be expected to pay from the resources of the client as specified for the client but subject to further possible reductions according to other prerequisite uses of the benefit payments a payee may be required or permitted to make as established by the payer. For clients in full-care, non-medical facilities receiving SSI benefits, no attempt shall be made to collect from any responsible party any remaining liability for those months that SSI payments are applied to the cost if such collections would reduce the SSI payment.

(3) CLIENTS RESIDING IN FACILITIES (MEDICAL OR NON-MEDICAL) WITH EARNED INCOME. Except for clients who are full time students or part-time students who are not full time employes, clients receiving room and board with care or services who have earned income shall be expected to pay any remaining liability for that care each month from earnings as follows: after subtraction of the first $65 of net earnings (after taxes) and any unmet court-ordered obligations or support of legal dependents, up to one-half the remaining amount of earnings.

(4) PAYMENT ADJUSTMENT FROM CLIENT'S EARNED INCOME. The appropriate payment approval authority may authorize the following modification to subsection (3) of this section for clients whose care-treatment plans provide for economic independence within less than one year: subtract up to $240 of net earnings after taxes and proceed under the provisions of subsection (3) of this section provided that any amounts subtracted beyond $65 per month under this subsection are used for the following purposes:

(a) Savings to furnish and initiate an independent living arrangement for the client upon release from the facility. Under this provision, earnings shall not be conserved beyond the point that the client would no longer meet the asset eligibility limits for SSI or Medicaid.

(b) Purchase of clothing and other reasonable personal expenses the client will need to enter an independent living arrangement.

(c) Repayment of previously incurred debts.

(5) PAYMENT ADJUSTMENT FROM CLIENT'S UNEARNED AND EARNED INCOME. When a client resides in a facility less than 15 days in any calendar month, payments expected under subsections (2) and (3) of this section may be prorated between the days the client spends in and out of the facility. A daily payment rate may be calculated by multiplying the monthly amount determined under subsections (2) and (3) of this section by 12 and dividing by 365. The daily payment rate times the days the client spends in the facility determines the amount of the payment expected from the client's income. The provisions for determining the client's "available income" in billing Medicaid shall take precedence over this procedure wherever applicable.

(6) CLIENTS RESIDING IN FACILITIES (MEDICAL OR NON-MEDICAL) WITH LIQUID ASSETS IN EXCESS OF ELIGIBILITY FOR SSI OR MEDICAID. Clients residing in facilities shall be expected to pay any remaining liability for that care until their assets are reduced to eligibility limits for SSI or Medicaid except as follows:

(a) As protected by law or an order of the court.

(b) As may be protected in full or in part by a written agreement approved by the appropriate payment approval authority upon presentation in writing by the client or client's guardian, trustee or advocate, any specific and viable future plans or uses for which the excess assets are intended. Such documentation shall include the extent to which the client's funds need to be protected for purposes of preventing further dependency of the client upon the public and/or of enhancing development of the client into a normal and self-supporting member of society.

(7) NOTIFICATION. The payment approval authority shall assure that clients and responsible parties are informed as early as administratively and clinically feasible of their rights and responsibilities under the uniform fee system. The department shall provide sample brochures for the various service categories to assist payment approval authorities with this requirement.

(8) REFUSAL TO PROVIDE FULL FINANCIAL INFORMATION. A responsible party who is informed of his or her rights and knowingly refuses to provide full financial information and authorizations for billing all applicable insurance shall not be eligible under section HSS 1.02 (8) to discharge liability other than by means of full payment.

(9) INTAKE PROCESS. In conjunction with appropriate notification, the intake process for each client who receives fee-chargeable or third-party billable services shall include sufficient time and capability to complete all necessary information for billing including an application for ability to pay considerations.

(10) FINANCIAL INFORMATION FORM (APPLICATION FOR ABILITY TO PAY PROVISIONS). (a) Except as otherwise provided in these rules, the Financial Information Form (DHSS 130) is mandatory when a responsible party chooses to be considered for ability to pay provisions.

Note: Form DHSS 130 may be ordered from:

Department of Health & Social Services
Forms Center - Room B364
1 West Wilson Street
Madison, Wisconsin 53702.

(b) County agencies may use their own forms in place of DHSS 130 subject to the prior approval of the department. Any substitute form (s) must be capable of fulfilling the same provisions as the current DHSS 130.

(11) BILLING ON THE BASIS OF ABILITY TO PAY. (a) A responsible party who provides full financial information and authorizations for billing all applicable insurance shall be billed on the basis of the family's ability to pay.

(b) For each family, ability to pay shall be determined in the following manner:

1. The annual gross income of family members shall be determined and totaled except that the earned income of any child who is a full time student or a part-time student but not a full time employe shall be excluded. Income from self-employment or rent shall be the total net income after expenses. The income of any family member in a residential setting is treated separately under this rule.

2. The monthly average income shall be computed by dividing the annual gross income by 12.

3. Monthly payments from court ordered obligations shall be subtracted from monthly average income.

4. From the remaining amount there shall be subtracted:

a. An amount determined by the department based on the bureau of labor statistics' most recent annual lower-level-budget monthly figure adjusted for a family of like size, and

b. The estimated amount of income taxes and social security or federal retirement obligations above the level determined in subparagraph a. for a family of like income and size.

5. The resulting amount equals the family's "monthly available income". A positive amount signifies ability to pay.

(12) MAXIMUM MONTHLY PAYMENT RATE. A family which provides full financial information shall be billed monthly an amount equal to monthly available income multiplied by 50% which billing amount shall be called the "maximum monthly payment rate".

Note: The department shall annually develop and distribute a schedule for converting from average-dollars-available-monthly to the billing amount, as an aid for facilities covered by these rules.

(13) MINIMUM PAYMENT. The appropriate payment approval authority may establish a minimum payment rate up to $25.00 per month across the board for all families receiving a fee chargeable service whose maximum monthly payment as calculated according to sub. (12) is less than the minimum rate. Where such minimum rates are used, all families shall be expected to pay the applicable minimum rate except where liability is waived according to HSS 1.02 (9) or where a minimum payment exceeds the available income of the responsible party(ies). Minimum charges under this section may also be set on a per unit basis (e.g. per hour, per day, etc.) provided such minimum charges do not accumulate to exceed $25.00 per month.

(14) ADJUSTMENTS. The maximum monthly payment rate calculated under section HSS 1.03 (12) or (13) is adjustable in the following situations:

(a) In cases where family members who contribute to the family income are not responsible parties for the liability being charged to the family, the maximum monthly payment rate shall not exceed the sum of the unearned and one-half the earned income of responsible party(s), less a percentage of earnings equal to that used by the Wisconsin AFDC program for work related expenses.

(b) When payment at the maximum monthly payment rate, as calculated in section HSS 1.03 (12) or (13), would create a documentable hardship on the family, (such as the forced sale of the family residence

or cessation of an education program), a lower maximum monthly payment rate may be authorized by the appropriate payment approval authority under the following provisions:

1. Hardship adjustments are normally restricted to situations where services extend more than one year, and sufficient relief is not afforded to the family through an extended or deferred payment plan.

2. Each hardship adjustment shall be documented by additional family financial information. Such documentation shall become part of the client's collection file as provided in HSS 1.06.

3. Responsible parties shall be informed in writing of approval or denial with approval taking the form of a written agreement.

4. Hardship adjustments shall be reviewed annually and, if necessary, renegotiated.

(15) EXTENDED PAYMENT PLANS. Agencies must have the capability to work out an extended payment plan with any responsible party who indicates that payment at their monthly payment rate would place a burden on their family. Such payment plans have the effect of the responsible party paying a lesser monthly amount over a longer period of time but with the total expected amount to equal the full application of the monthly payment rate under HSS 1.02 (8). Authority to approve extended payment plans may be placed at whatever staff level the payment approval authority determines is appropriate.

(16) SHORTCUTS TO DOCUMENT NO ABILITY TO PAY FOR SERVICES NOT COVERED BY THIRD-PARTY PAYERS. (a) Family income information in form DHSS 130 is not required where no family member receives earned income and the family is supported in full or in part by income maintenance benefits.

(b) The financial information form (DHSS 130) is not required for fee-chargeable services when zero ability to pay can be documented. The following families making application for services are automatically considered to have no ability to pay when the following financial information is documented on other forms required by the department.

1. Recipients of SSI.

2. When the family has no earned income and are recipients of AFDC, Medical Assistance, Food Stamps or General Relief.

3. Group-eligibles under the state Title XX plan who request services.

4. Families whose income is lower than the point at which payment begins according to the maximum monthly payment rate schedule for families of similar size.

(17) RELATIONSHIP TO EXTENT OF SERVICES. When full financial information is provided, the monthly payment rate established according to sub. (12) or (13) and adjusted according to sub. (14) (a) is the total ceiling amount that the family may be billed a month regardless of the number of family members receiving services, the number of agencies providing services, or the magnitude or extent of services received.

(18) EXCEPTIONS. (a) For outpatient psychotherapy purchased or provided by county agencies, parents who provide full financial information shall not be billed a total amount per child per month greater than

$120. For all other services, parents who provide full financial information shall not be billed more than $4.00 per day for each child who receives service. When a minor child and an adult from one family receive services, the parental payment limit shall not apply to billings for services to the adult.

(b) The appropriate payment approval authority may bill a responsible party a minimum payment for therapeutic reasons for a fee chargeable service. The therapeutic charge may be a per month amount or a per visit or per unit of service charge and may result in a higher amount than the maximum monthly payment rate. A charge for "no-show" is considered a therapeutic charge. Therapeutic charges may not exceed the maximum monthly payment by more than $25.00 per month. Therapeutic charges and minimum charge (s) established under sub. (13) may not total more than $25.00 per family nor may a therapeutic charge exceed the responsible party's available income.

(19) REDETERMINATION OF MAXIMUM MONTHLY PAYMENT RATE. The maximum monthly payment rate established upon entry into the system shall be reviewed at least once per year. A redetermination shall be made at any time during the treatment or payment period that a significant change occurs in available income. The redetermined maximum monthly payment rate may be applied retroactively or prospectively.

(20) PAYMENT PERIOD. Monthly billing to responsible parties with ability to pay shall continue until:

(a) Liability has been met or

(b) A waiver of remaining liability is obtained or

(c) Client records for inpatient mental health services are placed in inactive status as specified under section HSS 1.06 (3) (d) of these rules.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (2) to (6), renum. (7) to (14) to be (8), (11), (12), (14), (17) to (20) respectively and am. (8), (11), (14), (17), (18) (b) and (20), r. and recr. (18) (a), cr. (7), (9), (10), (13), (15) and (16), Register, November, 1979, No. 287, eff. 1-1-80.

HSS 1.04 Fee establishment, calculation and approval. (1) APPLICABILITY. With respect to client services for which responsible parties incur liability and may be billed, each facility operated by the department, a county department of social services, or a board established under s. 51.42, 51.437, or 46.23, Stats.; or an agency providing services pursuant to a contract in excess of $10,000 per year with the department, a county department of public welfare or social services, or a board established under s. 51.42, 51.437, or 46.23, Stats., shall establish a fee or set of fees as follows:

(a) *Facility fee or service fee.* The division, county department of social services, board established under s. 51.42, 51.437, or 46.23, Stats., or private firm in charge of the facility shall establish a uniform facility fee, except that if the facility provides 2 or more services of a disparate nature with associated wide differences in per-service cost, separate per-service fees shall be established.

(b) *Fee calculation.* Fees shall be determined in advance for each calendar year, except that divisions may determine fees in advance for each fiscal year. For purchased services, the contract rate and billable units to the purchaser should be identical to the fee and billable units to

the responsible party (s), wherever possible. Fees shall be determined by dividing either the number of patient days projected by the year in question, or, if the facility or service provides less than 24 hour care, the number of hours of billable client service projected for the year in question, into allowable anticipated facility or service-related expenditures for the year in question. For purchased services not easily converted to time units and where the contract or agreement specifies purchase units other than time, fees shall be set using the contract unit.

(c) *Expenditures.* Expenditures mean ordinary and necessary budgeted non-capital expenses and depreciation on capital equipment. Cost standards that govern purchase of care and services under s. 46.036, Stats., shall apply to expenditures for calculating the fee. Outlays associated with non-client-specific community service and with client services exempted under section HSS 1.01 (4) plus a pro-rata share of depreciation and associated administration or indirect costs are excluded. Where the facility establishes separate per-service fees, expenditures mean ordinary and necessary per-service expenses plus a pro-rata share of depreciation and indirect or administration costs.

(d) *Calculating fee (s).* A division, county department of social services, board established under s. 51.42, 51.437, or 46.23, or private firm (under contract to one of the above) responsible for the calculation of the facility or service fees shall complete form CD-142 [143] or the calculation of such unit rates. Budgeted costs shall be segregated among cost-centers based on groupings of programs which have significantly different costs. Since a single fee is acceptable for a facility, a single direct treatment cost-center may be used if the facility does not provide services of a disparate nature with associated wide discrepancies in cost. Multi-service facilities providing services outside the scope of the Uniform Fee System shall not include costs for those services in their calculations of fees. The following steps shall be completed in calculating the fee (s) for a facility:

Note: An example of services with costs of a disparate nature would be services provided by disciplines such as psychiatrists versus social workers.

1. Salaries of staff and costs of clinically-related consultants shall be divided among administration, exempt services and direct treatment/service cost-centers on the basis of time spent in each area. Salary of clerical staff, accounting staff, and other support service staff shall be listed as administration costs. Salaries or wages of dietary, maintenance, housekeeping, groundskeeping, laboratory, medical records, pharmacy, etc. shall be included under support services staff except where it can be shown that these administrative and support services are related to specific direct treatment/service cost-centers or the exempt service cost-center.

2. Fringe benefit costs shall be apportioned between administration, exempt services, and direct treatment cost-centers by multiplying total salary in each column by the fringe benefit percentage unless fringe benefits are included in item 1.

3. Budgeted costs for office supplies, depreciation or rent of buildings, other consultant costs, employee travel, food, linen, and all other approved costs shall be included in the administration cost column except where it can be shown that these costs are related to specific direct treatment/service cost-centers or the exempt service cost-center.

4. The facility's prorated share of the 51.42, 51.437, or 46.23 board expenses, identified with services provided to board-operated facilities shall be entered in the administration cost column. Note: For board-operated facilities only.

5. Federally or otherwise funded costs included in previous entries shall be deducted out for programs where there is a funding source prohibition on billing clients for services so funded.

6. Administration costs shall be prorated among the cost-centers on the basis of the ratio of days of care or hours of service or hours of exempt service in each cost-center to total days or hours provided by the facility in all cost-centers except where it can be shown that these costs should be allocated to the other cost-centers on some other basis.

7. Total budgeted costs in each treatment or service cost-center shall be divided by the total projected units of service as described in HSS 1.02 (for example, client days of care, projected hours of face to face service) to determine the fee. Where volunteers provide a direct client service equivalent to one performed by paid staff, the projected number of volunteer hours shall be included when projecting the total hours of billable face to face client service. Where volunteers provide a service with which there are no associated direct staff salaries, it shall not be necessary to calculate a fee for that service nor should such hours be included when calculating other facility or service fees.

Note: Forms CD-143 may be ordered from:
Department of Health & Social Services
Forms Center - Room B364
1 West Wilson Street
Madison, Wisconsin 53702.

(e) *Multiple therapist fees.* Where fees are computed according to professional disciplines (i.e. psychiatrist, psychologist, social worker, nurse, etc.), a fee for an hour of service provided by 2 or more professionals would be the sum of the hourly rates for each professional.

Note: Example: The fee for an hour of service provided by a psychologist and social worker would be the sum of the hourly rate computed for each discipline.

(f) *Group therapy fees.* Group therapy fees shall be computed by dividing the fee calculated according to (d) or (e) by the projected number of non-family-related clients per group.

Note: Examples: For group sessions conducted by one therapist with an average size of 7.

Group fee = Therapist fee ÷ 7

For group sessions conducted by more than one therapist with an average group size of 10.

Group fee = (Therapist 1 + Therapist 2 etc.) ÷ 10

(g) *Fee approval.* 1. Provided services. County departments of social services and boards established under s. 51.42, 51.437, or 46.23, Stats., shall submit fees for provided services for review and approval in compliance with procedures established by the department's division of community services. The division of community services shall inform agencies submitting fees of their acceptance or rejection except where another form of approval is set by law. Divisions shall approve rates for facilities they operate except where another form of approval is set by law.

2. Contracted services. The administrative unit authorized to enter into contracts or agreements for purchased services shall approve the fee(s) for such services before execution of the contract or agreement and the approved fee(s) shall be part of the contract.

3. Where 2 or more agencies purchase the same service(s) from the same provider, the agency with the largest dollar contract shall have final approval of the facility fee or service fee(s) in question.

(h) *Effective date of fee.* Fees in effect at any time shall remain in effect until new fees are determined and approved pursuant to these rules. No fees shall be modified without the prior consent of the fee-approving authority.

(2) EXCEPTIONS. (a) *Purchases totaling less than $10,000.* Facilities providing services pursuant to contracts or agreements of $10,000 or less with a division, a county department of social services, or a board established under s. 51.42, 51.437, or 46.23, Stats., shall establish fees which shall be equal to the "usual and customary charge." Each facility shall establish a uniform facility fee, except that if the facility provides 2 or more services of a disparate nature with associated wide differences in per-service cost, the facility shall establish separate per-service fees. The initial fee established under these rules shall be approved by the administrative unit authorized to enter into the contract or agreement before taking effect. Fees shall not be modified without the prior approval of the purchasing authority.

(b) *General hospitals and special hospitals.* The rates approved for reimbursement under the rate review process established by s. 146.60, Stats., shall be the fee for services rendered on and after January 1, 1979. Rates for hospitals not subject to rate review shall be determined and approved by the applicable provisions set forth in these rules. Public patient rates for university of Wisconsin hospital and clinics approved under s. 142.07 (1) (b) and (c), Stats., shall be the fee for those services.

(c) *Private practitioners.* For services provided by a private practitioner the fee shall be the usual and customary charge for such services when such charges are in accord with all laws or regulations governing such charges.

(d) *Statewide rates.* Where the department has established a statewide rate for a service, that rate shall be the fee.

(e) *County departments of social services.* In special circumstances with approval of the department, county departments of social services may use a fee of $12 per hour for services delivered by professional staff and $8 per hour for services provided by paraprofessionals instead of establishing fees under HSS 1.04 (1).

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (1) (intro.) and (a), renum. (1) (d) and (e) to be (1) (g) and (h), r. and recr. (1) (g), cr. (1) (d) to (f), Register, November, 1979, No. 287, eff. 1-1-80.

HSS 1.05 Billing and collections responsibility and practice. (1) BOARDS ESTABLISHED UNDER S. 51.42, 51.437, OR 46.23, STATS. (a) With respect to each service not provided in state facilities, the responsibility for billing and collections pursuant to these rules shall be delegated to a board established under ss. 51.42, 51.437, or 46.23, Stats., under authority established by s. 46.10 (16), Stats., subject to the conditions specified by the department. The board may further delegate responsibility

for billing and collection to a service provider by written agreement specifying the conditions of such delegation.

(b) Formal delegation approval is required for care received in county hospitals under s. 51.09, Stats., on and/or after January 1, 1975. Until such time as collections are delegated for these services, the department's bureau of collections will continue to manage these accounts. Delegation of collections for county hospitals will be granted to the program director of the appropriate 51.42 board upon submission of required form CD-143 [142] to the Secretary of the Department - Attention: Bureau of Collections. Where the board of trustees of the hospital is not the 51.42 board, application for delegated collection authority shall specify the role in the collection function and how any disposition of monies collected by the facility will be handled. When application is received, a representative of the bureau of collections will visit the facility in question to determine the adequacy of their capability to operate in accord with laws and rules relative to the collections function.

Note: Form CD-142 may be obtained from:
Department of Health & Social Services
Bureau of Collections
1 West Wilson Street
Madison, Wisconsin 53702.

(c) For services provided in Milwaukee county-operated facilities, the provisions of s. 46.10 (12), Stats., take precedence over s. 46.10 (16), Stats. Therefore, Milwaukee county may continue to collect for these services without additional delegation authority. However, if Milwaukee county chooses not to operate under s. 46.10 (12), Stats., the provisions of s. 46.10 (16), Stats., will apply according to (d) of this section.

(d) Collections for all other services purchased or provided by boards not mentioned in (1) or (2) [(b) or (c)] above are delegated to the program director of the board.

(e) Accounts collected by the department's bureau of collections for boards established under ss. 51.42, 51.437, or 46.23, Stats., shall be distributed according to s. 46.10 (8m), Stats.

(Note: Chapter 29, Laws of 1977, revises s. 46.10 (8m), Stats.)

(2) COUNTY DEPARTMENTS OF SOCIAL SERVICES. (a) Where services covered by these rules are delivered through a county department of social services, the county department of social servies shall have billing and collection responsibility for those services unless it delegates such responsibility to a provider agency or agencies by written agreement specifying the conditions of such delegation.

(b) Accounts collected by the department's bureau of collections for county departments of social services shall be distributed according to s. 46.03 (18) (g), Stats.

(3) REVOCATION OF DELEGATED AUTHORITY. All delegations under section HSS 1.05 (1) and (2) of these rules are subject to revocation should the department find violations of these rules or of generally recognized good accounting practices.

(4) STATE BUREAU OF COLLECTIONS. Except where responsibility for collections is delegated under sections HSS 1.05 (1) and (2), the bureau of collections of the department shall be responsible for the billing and

collection function. The bureau of collections shall also provide collection services for individual delinquent, or otherwise referred, client accounts.

(5) FURTHER DELEGATION. Agencies with delegated collection responsibility may contract out the billing and collection functions as part of a purchase of service agreement. Such contracts shall specifically provide that all billing and collections functions be carried out according to these rules. However, no contract may be negotiated with a private collections firm without written permission from the bureau of collections.

(6) APPROACH TO BILLING AND COLLECTIONS. (a) All billing and collection efforts shall strive toward what is fair and equitable treatment for both clients who receive service and taxpayers who bear unmet costs.

(b) Billing and collection activity shall consider the rights, dignity, and physical and mental condition of the client and other responsible parties. Responsible parties with no ability to pay and without applicable insurance shall not be pursued for payment.

(c) All billing and collection activity shall be pursued in a forthright and timely manner according to these rules:

1. Where applicable insurance exists, the insurance company shall be billed directly wherever possible by the unit with collection responsibility for the facility providing the service. Where a responsible party is covered by Medicare and private insurance, Medicare shall be billed for the full coverage it provides and the private insurance company shall be billed for any remaining amount. Medicaid, where applicable, is the payer of last resort. For services exempted by section HSS 1.01 (4), third-party reimbursement shall be pursued where applicable, but direct billings to the client or other responsible parties shall not occur. Agencies shall follow the claims processing procedures of third-party payers to assure payment of claims.

2. Responsible private parties shall be billed for liability not covered by insurance, according to applicable provisions of HSS 1.03.

(7) FIRST BILLINGS TO RESPONSIBLE PARTIES WHO HAVE AN ABILITY TO PAY OR WHO HAVE NOT PROVIDED FULL FINANCIAL INFORMATION. Where it is anticipated third-parties will pay less than the full liability, the first billing to responsible parties shall be sent during the calendar month following the month services were provided, except where an agreement to delay billing exists. A cover letter explaining the liability and arrangements for making payment shall accompany the first billing statement to the responsible person(s) billed.

(8) CONTENT OF BILLING STATEMENTS TO RESPONSIBLE PARTIES. The billing statement shall be designed to meet all the requirements of the uniform fee system in the laws, rules and this order and must allow for the following entries:

(a) Any balance brought forward from the last statement.

(b) Any payments received during the billing period.

(c) Any services provided during the billing period with charges showing liability and adjustments for parental maximums (except billings to *clients* for full care) and adjustments for maximum monthly payment rate (except for inpatient accounts).

(d) Total outstanding charges to date ((a) minus (b), plus (c)).

(9) MAILING BILLING STATEMENTS. When a statement or other correspondence is mailed to a responsible party, there shall be no information on the mailed item to indicate that the item is necessarily related to care or treatment for mental illness, developmental disability, alcoholism, drug abuse or any other condition treatable under the provisions of ch. 48, 51, 55, or 970, Stats.

(10) ADDRESSING BILLING STATEMENTS. Statements shall only be addressed to the following persons:

(a) The client.

(b) The client's spouse if the client is personally unable to pay the entire liability.

(c) The parents or guardian of a minor client.

(d) The guardian of the estate of a person adjudged incompenent under ch. 880, Stats.

(e) A person appointed representative payee of social security or SSI benefits of a client or responsibility party.

(f) A person, agency or firm specifically designated through an informed release of information by the client or a person named in s. 51.30 (5) (a) or (e), Stats.

(11) COORDINATION WHERE OTHER LIABILITY EXISTS. Before billing responsible parties, agencies shall determine if a responsible party has outstanding payment responsibility from any previous social or mental hygiene service. Where such payment responsibility exists, the agency currently providing service shall inform the first agency of the party's present status and coordinate the application of payments from the responsible party according to HSS 1.03 (17) and 1.05 (12). When charges are satisfied of the agency given priority, that agency shall notify the other agency to commence their billing.

(12) APPLICATION OF PAYMENTS. (a) Payments shall be applied to the oldest period of service for which a liability remains, except as provided in the following paragraphs of this subsection.

(b) When a responsible party has liability for inpatient mental health care and for some other type of service, payments shall not be applied to inpatient mental health liability until other liabilities have been satisfied according to these rules.

(c) Payment from one responsible party shall have no effect on decreasing the liability of other responsible parties except as total liability is decreased.

(d) When private insurers or government agencies make payments against claims or statements that specify dates of service, such payments shall be applied to liability for the period indicated.

(e) For clients residing in facilities, payments from client's own income shall be applied to the liability incurred during the month the income is received except that retroactive benefits may be applied to liability incurred back to the date of entitlement. The priority of payments for clients residing in facilities is as follows:

1. Payments from any responsible parent for a child under custody in accordance with ch. 48, Stats.

2. Payment from any unearned income of the client.

3. Payment from any earned income of the client.

4. Payment from any other responsible party.

5. Payment from any excess assets of the client.

(13) DELINQUENT ACCOUNT PROCEDURES. (a) An account is considered delinquent when a determination has been made that ability to pay currently exists, that no payment has been made over a period of 90 days, and that 3 or more contacts have been made to secure a payment.

(b) Follow-up of accounts. Each billing/collection unit shall have a procedure to review accounts periodically for follow-up. When no payment is made on the initial billing, a second billing showing accumulated monthly charges shall be sent during the next calendar month. A note shall be enclosed explaining the bill and the amount now due. No response after 30 days following the second billing suggests checking with the service staff to see if there are any known reasons why collection efforts should not be pursued. Options are to:

1. Continue the standard billing-follow-up approach.

2. Modify the approach by writing individualized letters or making telephone or other contacts.

3. Defer billing and follow-up for a period.

4. Recommend referral of the account for collection.

The Payment Approval Authority shall determine the course of action for unclear cases. Actions taken shall be documented in the client's collection file.

(c) Referral of accounts for collection. Agencies shall refer accounts for collection when they are considered delinquent as defined in subsection HSS 1.05 (7) [(13)], when the agency's own collection unit has completed required follow-up procedures.

1. The following channels shall be utilized, depending on their availability and potential for timely handling of the account:

a. District attorney or corporation counsel handling legal matters for the county department of social services, or 51.42, 51.437, or 46.23 board involved.

b. Office of administrative rules and hearings (collection and deportation counsel), Wisconsin department of health and social services through referral to the bureau of collections.

2. No referral may be made to a private collection agency or private law office without the written permission of the bureau of collections.

3. The following information shall be sent to the collection unit when referring an account for collection:

a. Statement of charges.

b. A summary of all correspondence and actions taken.

c. Information relating to ability to pay.

4. Referring agencies are responsible to follow-up on the status of referred accounts.

(d) Responsible parties involved shall be notified in writing when the agency plans to refer the account for collection.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; renum. (1) to be (1) (a), cr. (1) (b) to (e), renum. (2) to be (2) (a) and cr. (2) (b), renum. (5), (6) and (7) to be (6), (12) and (13), and am., cr. (5) and (7) to (11), Register, November, 1979, No. 287, eff. 1-1-80.

HSS 1.06 Record-keeping, reporting, confidentiality requirements, and disclosure authority. (1) CONFIDENTIALITY. Except as provided in statutes and these rules, information regarding a client and all interested parties, collected by a facility or agency subject to these rules, shall remain confidential.

(2) EXCEPTION. Confidentiality provisions shall not prohibit disclosure of information in the following situations:

(a) Disclosure of financial and service information without informed consent for services provided under ch. 51, Stats., may be made to the department, the program director of a board established under s. 51.42, 51.437, or 46.23, Stats., a qualified staff member designated by the program director or a county department of social services only under conditions specified in s. 51.30, Stats., and rules promulgated thereunder.

(b) Disclosure of financial and service information without informed consent for all other services under the uniform fee system may be made to the department, qualified staff members of a board established under s. 51.42, 51.437, or 46.23, Stats., or qualified staff members of a county department of social services when the information disclosed is for billing and collection purposes.

(c) Further disclosure of financial and service information obtained under (a) and (b) of this section may be made without informed consent by a board established under s. 51.42, 51.437, or 46.23 or a county department of social services to the county district attorney or corporation counsel for the purpose of enforcing the collection of delinquent accounts in the courts.

Note: The district attorney or corporation counsel must be seen as the legitimate counsel to the county agencies named in this section.

(d) Billings sent to the following persons shall not constitute unlawful re-disclosure of financial or service information when such information is obtained by the agency in accordance with s. 51.30 (4) (b) 2., Stats.:

1. The client.

2. The spouse of the client.

3. The parent, guardian or person acting in loco parentis for a minor client.

4. The representative payee for benefits owing to the client from social security or SSI.

5. The guardian of the estate of a person adjudged incompetent under ch. 880, Stats.

(e) Except where prohibited by a federal regulations relating to alcohol and drug treatment records, the persons named in s. 51.30 (5) (a) may consent in place of the client for the release of medical information in order to obtain insurance benefits owing to the client, the client's spouse or the parents of a client.

(3) CLIENT RECORDS. (a) *Records.* Clear, exact and auditable records shall be established and maintained for each client regardless of the client's financial status or services involved.

Note: [This does not mean that all of these records must be reported to the agency's billing unit; but, if necessary, the provider's records should include or allow for each client, the potential for reporting to the billing unit enough information to prepare a billing statement that establishes liability for and by each calendar month during which services are provided.]

Such information shall include:

1. Dates of service contacts.

2. Times and duration of such contacts.

3. The nature of the contact (professional service or paraprofessional service).

4. In the case of residential services, the actual days of care must be documentable.

(b) *Individual account control record.* Each billing and collection unit has broad flexibility to design a system that best fits the agency's needs and also satisfies the requirements of the uniform fee system. A record system is required that brings together all units of services provided for those clients whose accounts must be set up for billing a responsible party or third-party under the uniform fee system. For such cases, financial information forms and other information to prepare billings must be reported to the billing unit. The billing and collection unit is responsible for posting data to individual account control records from information received as soon as possible, including services provided and payments made as well as dates of service and dates of payments.

(c) *Client collection file.* There shall be a client collection file for every account billed. The file shall include:

1. Copies of financial information forms for all responsible parties who elect to be billed according to their ability to pay.

2. Updated information after each year (6 months for social service clients) concerning the family's ability to pay when billing extends for more than one year (6 months for social service clients).

3. Copies of all invoices sent to responsible parties.

4. Copies of all invoices sent to third-party payers.

5. Copies of all correspondence.

6. Documentation of all other actions taken on the account.

(d) *Active client record.* Records remain active as long as liability exists with the following exception: For inpatient mental health services, client records may be placed in inactive status when third-party sources have been exhausted and it has been determined the responsible parties have a permanent inability or unlikely future ability to pay.

(e) *Inactive client records.* Inactive client records shall be available for audit purposes and kept a minimum of 5 years with the following exception: Where liability for inpatient mental health services remains, client records shall be kept a minimum of 10 years after the last transaction is posted to the record.

(4) AGENCY RECORDS. Each agency or facility covered by these rules shall keep complete, clear, and exact records of allocation of staff time, service units delivered, and all revenues and gross expenditures.

(5) REQUIRED REPORTS. Each facility or agency covered by these rules shall submit to the department such reports on client liability, billings, and collections as the department may require.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (1), r. and recr. (2) (a) and (b), cr. (2) (c) to (e), r. and recr. (3) (a), ren. (3) (b) and (c) to be (3) (d) and (e), cr. (3) (b) and (c), Register, November, 1979, No. 287, eff. 1-1-80.