Chapter HSS 106

PROVIDER RIGHTS AND RESPONSIBILITIES

HSS 106.01 Introduction. In addition to other provisions of this rule relating to individual provider types, or the manner by which specified services are to be provided and paid for under the program, the participation of all providers certified under section HSS 105.01 to provide or claim reimbursement for services under the program shall be subject to the conditions set forth under this chapter.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.02 General requirements for the provision of health care services to recipients by providers. (1) REIMBURSABILITY OF SERVICES. (a) An individual or entity may claim reimbursement for covered services as defined in chapter HSS 107 when the individual or entity providing such service is properly licensed or is otherwise qualified, and is certified under section HSS 105.01 to participate as a provider in the program. Services defined under chapter HSS 107 as covered shall be reimbursable only if:

1. The recipient of the service was eligible to receive medical assistance benefits on the date such service was provided;

2. The provider complied with applicable state and federal procedural requirements relating to the delivery of the service and;

3. The service provided was appropriate and medically necessary for the condition of the recipient.

(b) If a provider determines that, to assure quality health care to a recipient, it is necessary to provide a non-covered service, nothing in this rule shall preclude the provider from furnishing such service, if before rendering the service, the provider advises the recipient that it is not covered under the program, and that the recipient, and not the program, shall be responsible for payment for the non-covered service.

(2) REFUSAL TO PROVIDE PROGRAM SERVICES TO RECIPIENTS. Provider shall not be required to provide services to a recipient if the recipient refuses or fails to present a currently valid medical assistance identification card. If a recipient fails, refuses, or is unable to produce a currently

valid identification card, the provider may contact the fiscal agent to confirm the eligibility of the recipient. The department shall require its fiscal agent to install and maintain adequate toll free telephone service to enable providers to verify the eligibility of recipients to receive benefits under the program.

(3) PROVIDER'S RESPONSIBILITY TO PREPARE, MAINTAIN, AND PROVIDE ACCESS TO RECORDS. (a) A provider shall prepare and maintain all records specified under section HSS 105.02(4) and the relevant paragraphs of section HSS 105.02(5) for purposes of maintaining the provider's certification and to fully disclose the nature and scope of services provided under the program. All such records shall be retained by the provider for a period of not less than 5 years, or 6 years in the case of rural health clinics. The 5 year period, or 6 years in the case of rural health clinics, shall commence on the date on which the provider received payment from the program for the service to which the records relate.

(b) Termination of a provider's participation in the program shall not terminate the provider's responsibility to retain the subject records unless an alternative arrangement for retention and maintenance has been established by the provider and approved by the department.

(c) The secretary of the department shall designate persons authorized to request access, inspect, audit or review the required records. Persons so authorized shall be issued credentials, including photographic identification, verifying the person's authorization.

(d) Upon the request of an authorized person and upon presentation of the authorized person's credentials, providers shall permit such persons at all reasonable times access to the records requested. Access for purposes of this section shall include the opportunity to inspect, review, audit and/or reproduce the subject records. All costs of reproduction of records shall be borne by the department. The department shall not use or disclose data or information relating to recipients and contained in a provider's records, except for purposes directly related to the administration of the program.

(4) NONDISCRIMINATION. Providers shall, in providing health care services to recipients, comply with the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), regulations promulgated thereunder and section 504 of the Federal Rehabilitation Act of 1973. Accordingly, providers may not exclude, deny or refuse to provide health care services to recipients on the grounds of race, color, national origin or handicap.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.03 Manner of preparation and submission of claims for reimbursement. (1) FORMAT. A provider shall utilize claim forms prescribed and furnished by the department. In lieu of using such claim forms, a provider may utilize magnetic tape billing if the format and content of such magnetic tape meets department specification, and the provider receives the department's prior written approval. The department shall, upon request, provide a provider with written format and content specifications required for magnetic tape billings and shall advise the provider of procedures required to obtain departmental approval of magnetic tape billing.

(2) CONTENT. A provider shall make all reasonable attempts to insure that the information contained on the provider's claim forms is complete and accurate. Providers preparing claims shall utilize, where applicable, procedure codes specified by the department for identifying the services that are the subject of the claim. The department shall inform affected providers of the name and source of the designated procedure code. Every claim submitted shall be signed by the provider, or the provider's authorized agent.

(3) TIMELINESS. A claim may not be submitted until the recipient has received the service which is the subject of the claim. A claim shall be submitted to the fiscal agent within one year of the date such service was provided. Payment shall not be made for any claim submitted after that one year period, except where the provider demonstrates to the satisfaction of the department that unusual circumstances or circumstances beyond the provider's control prevented timely submission of the claim.

(4) HEALTH CARE SERVICES REQUIRING PRIOR AUTHORIZATION. Claims for service requiring prior authorization shall be denied where prior authorization was not obtained before the date of service delivery. Claims rejected due to lack of the provider's timely receipt of prior authorization may be paid under the following circumstances:

(a) Where the provider's initial request for prior authorization was denied and the denial was either rescinded in writing by the department or overruled by administrative order rendered pursuant to the recipient's petition for administrative review of the department's denial of prior authorization.

(b) Where the service requiring prior authorization was provided within a period of retroactive eligibility, i.e., before the recipient became eligible, and the provider applies to and receives from the department retroactive authorization for the service.

(5) PERSONS OR ENTITIES ELIGIBLE TO RECEIVE PAYMENT ON CLAIMS. (a) Payment for a service shall be made directly to the provider furnishing the service or to the provider organization which provides or arranges for the availability of such service on a prepayment basis, except that payment may be made:

1. To the employer of an individual provider if such provider is required as a condition of employment to turn over fees derived from such service to the employer, or to a facility;

2. To a facility if a service was provided in such hospital, clinic or other facility, and there exists a contractual agreement between the individual provider and such facility under which the facility prepares and submits the claim for reimbursement for the service provided by the individual provider.

(b) An employer or facility submitting claims for services provided by a provider in its employ or under contract as provided for in paragraph (a) above must apply for and receive certification from the department to submit claims and receive payment on behalf of the performing provider. Any claim submitted by an employer or facility so authorized must identify the provider number of the individual provider who actually provided the service or item that is the subject of such claim.

(c) No payment which under paragraph (a) must be made directly to an individual provider or provider organization providing the service, may be made to anyone else under a reassignment or power of attorney [except to an employer or facility as defined in subparagraphs 1 and 2 of paragraph (a)], but nothing in this paragraph shall be construed:

1. To prevent the making of such a payment in accordance with an assignment from the person or institution providing the service involved if such service is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent juristiction, or;

2. To preclude an agent of such provider from receiving any payment if, and only if, such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for services in connection with the billing or collection of payments due such person or institution under the program is unrelated, directly or indirectly, to the amount of such payments or the claims therefore, and is not dependent upon the actual collection of any such payment.

(6) ASSIGNMENT OF MEDICARE PART B BENEFITS. A provider providing a covered service to a recipient eligible to receive Part B Benefits under Medicare (Title XVIII) shall accept assignment of the recipient's Part B Medicare benefits, if the service provided is, in whole or in part, reimbursable under Medicare Part B coverage.

(7) THIRD PARTY LIABILITY FOR COST OF SERVICES. (a) The department shall make reasonable efforts to identify third party resources legally liable to contribute in whole or in part to the cost of services provided a recipient under the program. For purposes of this section, "third party" means an individual, institution, corporation, public or private agency that is liable to pay all or part of the cost of injury, disease or disability of an applicant for a recipient of medical assistance.

(b) If the department identifies a third party insurer (either public or private) that provides health or accident coverage for a recipient, such insurance coverage shall be identified on the recipient's medical assistance card. The department shall prepare and distribute to a provider, code conversion information which indicates whether other insurance coverage is available.

(c) If the existence of a third party source of insurance is identified, the provider shall, before submitting a claim, seek to obtain from that third party, payment for the service. If third party coverage appears unlikely or uncertain, or if the third party denies coverage for all or a portion of the cost of the service, the provider may then submit a claim to the extent payment for the service remains unpaid.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.04 Payment on claims for reimbursement. (1) AMOUNT AND TIMELINESS. The department shall reimburse a provider for a properly provided covered service, according to provider payment schedule entitled "Terms of Provider Reimbursement." Payment shall issue on a claim for a covered service, properly completed and submitted by the provider, within 30 days of receipt of such claim.

(2) NON-LIABILITY OF RECIPIENTS. A provider shall accept payments made by the department in accordance with subsection (1) above as

payment in full for services provided a recipient. A provider shall not attempt to impose an additional charge or receive payment from a recipient, relative or other person for services provided, or to impose direct charges upon a recipient in lieu of obtaining payment under the program, except under the following conditions:

(a) A service desired, needed, or requested by a recipient is not covered under the program and the recipient is advised of this fact before receiving such services.

(b) If an applicant is determined to be eligible retroactively under 49.46 (1) (b), Stats., and a provider bills the applicant directly for services rendered during the retroactive period, the provider shall, upon notification of the recipient's retroactive eligibility, submit claims under this section for covered services provided during the retroactive period. Upon receipt of payment from the program for such services, the provider shall reimburse in full the recipient or other person who has made prior payment to the provider. A provider shall not be required to reimburse the recipient or other person in excess of the amount reimbursed by the program.

(c) A nursing home resident recipient chooses a private room in the nursing home and the provisions of HSS 107.09 (3) (i) are met.

(3) RETURN OF OVERPAYMENT. If a provider receives a payment under the program to which the provider was not entitled or in an amount greater than that to which the provider was entitled, the provider shall promptly return to the department the amount of such erroneous or excess payment. In lieu of returning such overpayment, a provider may notify the department in writing of the nature, source and amount of the overpayment and request that the excess payment be deducted from future amounts owing the provider under the program. The department shall honor such a request if the provider is actively participating in the program and is claiming and receiving reimbursement in amounts sufficient to allow recovery of the overpayment within a reasonable period of time, as agreed to by the department and the provider.

(4) REQUEST FOR CLAIM PAYMENT ADJUSTMENT. If a provider contests the propriety of the amount of payment received from the department for services claimed, the provider shall notify the fiscal agent of its concerns, requesting reconsideration and payment adjustment. The fiscal agent shall within 30 days of receipt of such request respond in writing, and advise what, if any, payment adjustment will be made. The fiscal agent's response shall identify the basis for approval or denial of the payment adjustment requested by the provider. This action shall constitute final departmental action with respect to payment of the claim (s) in question.

(5) DEPARTMENTAL RECOUPMENT OF EXCESS PAYMENTS. (a) If the department finds a provider has received payment under the program to which the provider was not entitled or in an amount greater than that to which the provider was entitled, the department may recover the amount of such improper or excess payment by any of the following methods:

1. By offset or appropriate adjustment against other amounts owing the provider for covered services;

2. If the amount owing the provider at the time of the department's finding is insufficient to recover in whole the amount of the improper or excessive payment, by offset or credit against amounts determined to be owing the provider for subsequent services provided under the program.

3. By requiring the provider to pay directly to the department the amount of the excess or erroneous payment.

(b) No recovery by offset, adjustment, or demand for payments shall be made by the department under paragraph (a) unless the department gives the provider prior written notice of its intent to recover the amount determined to have been erroneously or improperly paid. The notice shall set forth the amount of the intended recovery, shall identify the claim or claims in question, and shall summarize the basis for the department's finding that the provider has received amounts to which the provider was not entitled or in excess of that to which the provider was entitled.

(c) The department shall not be required to provide prior written notice under paragraph (b) above where the payment was made as a result of a computer processing or clerical error, or where the provider has requested or authorized the recovery to be made. In such case the department or its fiscal agent shall provide written notice of any payment adjustments made on the next remittance advice issued the provider. Such notice shall specify the amount of the adjustment made and the claim or claims which were the subject of the adjustments.

(d) If the provider chooses to contest the propriety of a proposed recovery, the provider shall within 20 days after receipt of the department's notice of intent to recover, request a hearing on the matter. Such a request shall be in writing and shall briefly identify the basis for contesting the proposed recovery. Receipt of a timely request for hearing shall preclude the department from making the recovery proposed while the hearing proceeding is pending. The department shall schedule a hearing on the contested recovery within 20 days of receipt of provider's request for hearing. If a timely request for hearing is not received, the department may recover from current or future obligations of the program to the provider that amount specified in the notice of intent to recover. All hearings on contested recoveries shall be held in accordance with the provisions of ch. 227, Stats. All notices under this section shall be in writing and shall be conclusively presumed to have been received within 5 days after evidence of mailing.

(e) If the provider contests the propriety of adjustments made under paragraph (c) above, the provider shall within 30 days of receipt of the remittance advice, request in writing a hearing on the matter. Such written request shall be accompanied by a copy of the remittance advice reflecting the adjustment and by a brief summary statement of the basis for contesting the adjustment. The department shall schedule a hearing on the contested adjustment within 20 days of receipt of the provider's request for hearing. All hearings on contested adjustments shall be held in accordance with the provisions of ch. 227, Stats.

(6) SUPPORTING DOCUMENTATION. The department may refuse to make payment and may recover previous payments made, on claims where the provider has failed or refused to prepare, maintain or provide authorized department personnel access to records required under section HSS

105.02(4) or (5) for purposes of disclosing and substantiating the nature, scope and necessity of services which are the subject of the claims.

(7) GOOD FAITH PAYMENT. A claim denied for recipient eligibility reasons may qualify for a good faith payment if the service provided was provided in good faith to a recipient with a medical assistance identification card which the provider saw on the date of service and which was apparently valid for the date of service.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.05 Voluntary termination of program participation. (1) PROVIDERS OTHER THAN NURSING HOMES. (a) Any provider, other than a skilled nursing or intermediate care facility, may at any time terminate participation in the program. A provider electing to terminate program participation shall within 30 days notify the department in writing of such election and of the effective date of termination from the program.

(b) A provider may not claim reimbursement for services provided recipients on or after the effective date specified in the termination notice. If the provider's notice of termination fails to specify an effective date, the provider's certification to provide and claim reimbursement for services under the program shall be terminated on the date on which notice of termination is received by the department.

(2) SKILLED NURSING AND INTERMEDIATE CARE FACILITIES. (a) A provider certified under section HSS 105.01 of this rule as a skilled nursing or intermediate care facility may terminate participation in the program upon advance written notice of not less than 30 days, to the department and to the facility's resident recipients or their legal guardians. Such notice shall specify the effective date of the facility's termination of program participation.

(b) A skilled nursing or intermediate care facility electing to terminate program participation may claim and receive reimbursement for services for a period of not more than 30 days after and including the effective termination date. Services furnished during the 30 day period shall be reimbursable provided that:

1. The recipient was not admitted to the facility after the date on which written notice of program termination was given the department.

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

(3) Voluntary termination of a provider's program participation under this section shall not serve to terminate the provider's responsibility to retain and provide access to records as required under section HSS 106.02(3) unless an alternative arrangement for retention, maintenance and access has been established by the provider and approved by the department.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.06 Involuntary termination, suspension or denial of eligibility for program participation. The department may suspend or terminate the certification of any person, partnership, corporation, association, agency, institution or other entity participating as a health care

provider under the program, if after reasonable notice and opportunity for a hearing the department finds:

(1) The provider has repeatedly and knowingly failed or refused to comply with federal or state statute, rule or regulation applicable to the delivery of, or billing for, services under the program.

(2) The provider has repeatedly and knowingly failed or refused to comply with the terms and conditions of its provider agreement.

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

(a) Inappropriate;

(b) Unnecessary or in excess of the recipient needs;

(c) Detrimental to the health or safety of the recipient; or

(d) Of grossly inferior quality.

Findings precipitating departmental action under this section shall be based upon the written findings of a peer review committee established by the department for the purpose of review and evaluation of health care services provided under the program.

(4) The licensure, certification, authorization, or other official entitlement required under state or federal law as a prerequisite to the provider's certification to participate in the program has been suspended, terminated, expired or revoked.

(5) Provider has provided a service to a recipient during a period in which provider's licensure, certification, authorization or other entitlement to provide the service was terminated, suspended, expired, or revoked.

(6) Provider has been convicted of a criminal offense related to the provision of or claiming reimbursement for services under Medicare (Title XVIII, Social Security Act), or under this or any other state's medical assistance program. For purposes of this section, "convicted" means that a judgment of conviction has been entered by a federal, state, or local court, irrespective of whether an appeal from that judgment is pending.

(7) Provider knowingly made or caused to be made a false statement or misrepresentation of material fact in connection with provider's application for certification or recertification.

(8) Provider has concealed, failed or refused to disclose any material change in licensure, certification, authorization, or ownership which if known to the department would have precluded the provider from certification.

(9) Provider at the time of application for certification under section HSS 105.01 or after receiving such certification, knowingly misrepresented, concealed or failed to disclose to the department full and complete information as to the identity of each person holding an ownership or control interest.

(10) Provider at the time of application for certification under section HSS 105.01 or after receiving such certification knowingly misrepresented, concealed or failed to disclose to the department an ownership or control interest the provider held in corporation, partnership, sole proprietorship, or other entity certified under the program.

(11) The provider has made or caused to be made false statements or misrepresentation of material facts in records required under section HSS 105.02(3), (4), or (5) and maintained by provider for purposes of identifying the nature and scope of services provided under the program.

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

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

(14) The provider has knowingly made or caused to be made a false statement or misrepresentation of a material fact in a claim.

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

(16) The provider has offered or paid to another person, solicited or received from another person, any remuneration in cash or in kind in consideration for a referral of a recipient for the purpose of procuring the opportunity to provide covered services to the recipient, payment for which may be made in whole or in part under the program.

(17) The provider has in addition to claiming reimbursement for services provided a recipient, imposed a charge on the recipient for such services or has attempted to procure payment from the recipient in lieu of claiming reimbursement through the program contrary to provisions of HSS 106.04(2).

(18) Provider has refused to provide, or has denied services to recipients on the basis of the recipient's race, color or national origin in violation of the Civil Rights Act of 1964.

(19) Provider has refused to provide, or has denied services to a handicapped recipient, solely on the basis of handicap in violation of Section 504 of the Federal Rehabilitation Act of 1973.

(20) A provider providing skilled nursing or intermediate care services has failed or refused to establish and maintain an accounting system which insures full and complete accounting of its resident recipients' personal funds; or has engaged in, caused, or condoned serious mismanagement or misappropriation of such funds.

(21) The provider has failed or refused to repay amounts that have been determined to be owed the department either under section HSS

106.04(5) or pursuant to a judgment of a court of competent jurisdiction, as a result of erroneous or improper payments made to the provider under the program.

(22) The provider failed or refused to purge a contempt order issued under s.885.12, Stats. as a result of the provider's refusal to obey a subpoena under s.49.45(3)(h)1, Stats.

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

(a) Terminated from participation in the program within the preceeding 5 years.

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

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

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

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.07 Effects of termination under section HSS 106.06. (1) Upon the termination of a provider under section HSS 106.06, a person with direct management responsibility for said provider at the time of the occurrence which served as the basis for such termination may be barred from future participation as a provider for a period not to exceed 5 years.

(2) Upon termination of a corporate provider under section HSS 106.06, officers and persons owning directly or indirectly 5% or more of the stock or other evidences of ownership in the corporation at the time of the occurence which served as the basis for such termination, may be barred from future participation as a provider for a period of not to exceed 5 years.

(3) Upon the termination of a sole proprietorship or partnership provider under section HSS 106.06, an owner or partner in partnership at the time of the occurrence which served as the basis for the termination, may be barred from participation as a provider for a period not to exceed 5 years.

(4) The secretary shall notify the appropriate state licensing agency of the suspension or termination of any provider licensed by the agency,

and of the act or acts which served as the basis for the provider's suspension or termination.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.08 Payment on claims during pendency of proceedings under section HSS 106.06. (1) Where termination action is initiated against a provider by the department under subsection (7), (11), (12), (13), (14), or (21) of section HSS 106.06, the department may withhold issuance of payments on the provider's claims while proceedings are pending on such action, except that if a final administrative decision has not been issued within 90 days of the initiation of such action and the delay has not been caused by the subject provider, payment may no longer be withheld and shall be issued to the provider.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.09 Pre-payment review of and prior authorization for claims. (1) The department shall establish committees of qualified professional health personnel to review the appropriateness and quality of services furnished recipients. Such committees shall perform health care services evaluation and review within the meaning of s. 146.37, Stats.

(2) If the department has cause to suspect that a provider is prescribing or providing services which are not necessary for or which are in excess of the medical needs of recipients, or which are not in conformity with applicable professional practice standards, the department may before issuing payment for the claims, refer such claims to the appropriate health care review committee. The committee shall review and evaluate the medical necessity, appropriateness and propriety of the services of the claims. Denial or issuance of payment for the claims shall take into consideration the findings and recommendation of the committee.

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

(4) A provider shall be notified by the department of the institution of the pre-payment review process under sub. (2). Claims which undergo pre-payment review shall be evaluated by the committee, and payment shall be issued or denied within 60 days of the date on which the claims were submitted to fiscal agent by the provider.

(5) If a health care review committee established under sub. (1) finds that a provider has engaged in the delivery of services which are inappropriate or not medically necessary, the department may require the provider to request and receive from the department authorization for the delivery of services under the program.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

HSS 106.10 Procedure, pleadings and practice. (1) SCOPE. The provisions of this section shall govern procedure and practice relating to

administrative actions by the department to enforce program participation requirements, or to effect involuntary termination under section HSS 106.06 for non-compliance with program requirements. They shall be construed to comply with the provisions of ch. 227, Stats. and to secure the just, prompt, and inexpensive determination of every action.

(2) COMMENCEMENT OF ACTION. The department shall commence actions under this rule by serving upon the provider and filing with the office of administrative hearings and rules, written notice of the intended action. Such notice shall include the following:

(a) A brief and plain statement specifying the nature of and identifying the statute, regulation, or rule according the department the authority to commence the action.

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

(c) A statement advising the provider of the right to a hearing and the manner by which a hearing may be requested and effected.

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

(a) Be served upon the department and the office of administrative hearings and rules within 20 days of the date of service of the department's notice of intended action.

(b) Contain a short and plain statement identifying every matter or issue contested.

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

(4) CONTESTED ACTIONS; NOTICE OF HEARING. Upon receipt of a timely request for hearing, the office of administrative hearings and rules shall schedule and mail notice of hearing to the department and to the provider. Such notice shall be mailed to the parties at least 10 working days before the scheduled hearing and shall include:

(a) A statement of the time, place, and nature of the hearing, including whether the matter constitutes a class 1, 2, or 3 proceeding within the meaning of ch. 227, Stats.

(b) A statement of the legal authority and jurisdiction under which the hearing is to be held, and in the case of a class 2 proceeding, reference to the particular statutes and rules involved.

(c) A short and plain statement of the nature of the action and a statement of the contested issues.

(5) EFFECT OF FAILURE TO REQUEST A HEARING. The failure of the provider to submit a timely request for hearing shall constitute a default. Accordingly, the findings of the department which served as the basis for the action shall be construed as being admitted by the provider, and

the administrative remedy or relief sought by the department via the action may be effected.

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

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

(c) The office of administrative hearing and rules may by order reopen a default arising from a failure of either party to appear on the date set for hearing. Such an order may be issued upon motion or petition duly made and good cause shown. The motion shall be made within 20 days after the date of the hearing examiner's default order.

(7) PRIOR HEARING REQUIREMENT; EXCEPTION. (a) Departmental action may be taken against a provider without a prior hearing where such action is initiated on the basis of the department's finding that:

1. The health or safety of a recipient is in imminent danger as a result of the provider's failure to comply with applicable state or federal law relating to the provision of health care services.

2. The licensure, certification, authorization or other official entitlement required under state or federal law as a prerequisite to the provider's certification has been suspended, terminated, or revoked.

(b) If departmental action is taken under any of the grounds specified under paragaph (a), the department shall immediately provide the provider with notice of the action. The notice shall satisfy the requirements of section HSS 106.10(2). The provider shall be entitled to and may demand and receive a hearing on the actions within 10 days (excluding weekends) of the date of such notice.

(8) MOTIONS. (a) Unless made during the course of a hearing or prehearing conference, all motions shall be made in writing, shall state with particularity the grounds therefore, and shall set forth the relief or order sought. A notice of motion is not required, since notice is satisfied by service of a copy of the motion.

(b) Briefs, affidavits, or other documentation in support of a motion shall be served and filed with the motion.

(9) SERVICE. Unless otherwise provided by law, all orders, notices, and other papers may be served personally, or by first class, certified or registered mail. All papers filed by a party with the office of administrative hearings and rules shall be served by that party on all parties appearing in a proceeding. The filing of any paper required to be served constitutes a certification by the party or attorney effecting the filing, that a copy of such paper has been timely served on all parties required to be served, except as the person effecting the filing may otherwise state in writing, and no affidavits, certification, or admission of service need be filed with the office of administrative hearings and rules.

(10) FILING. All pleadings, motions, or other relevant material required to be filed with the office of administrative hearings and rules

shall be submitted to: Office of Administrative Hearings and Rules, state department of health and social services, Madison, Wisconsin 53702.

(11) HEARING EXAMINERS. The office of administrative hearings and rules shall appoint a hearing examiner to preside over every contested action. An examiner so appointed shall preside at all hearings relating to the action and may:

(a) Administer oaths and affirmations.

(b) Sign and issue subpoenas.

(c) Rule on offers of proof and receive relevant evidence.

(d) Take depositions or have deposition taken when provided by law.

(e) Supervise and regulate the course of hearings.

(f) Dispose of procedural requests or similar matters.

(g) Prepare a written decision which shall include findings of fact, conclusions of law, order and opinion.

(12) PREHEARING CONFERENCE. (a) The hearing examiner may direct the parties to appear at a pre-hearing conference to consider:

1. The clarification of issues.

2. The necessity or desirability of amendments to the pleadings.

3. Obtaining admissions of fact and documents which will avoid unnecessary proof.

4. Limitations of the number of witnesses.

5. Such other matters as will aid disposition of the action.

(b) A prehearing conference may be held by telephone.

(13) MANDATORY DISCLOSURE. At a prehearing conference, parties shall file and exchange lists of their witnesses, and shall identify documentary and other physical evidence which they intend to utilize at the hearing. Following the prehearing conference, the parties remain under a continuing obligation to file and exchange lists of additional witnesses and additional evidentiary matter which they intend to utilize at the hearing. With the exception of rebuttal matter, witnesses or evidence not so submitted prior to 3 working days before the hearing will not be permitted to testify or be received at the hearing, unless good cause for the failure of submission is shown.

(14) DISCOVERY. Parties shall have available substantially all the means of discovery that are available to parties to judicial proceedings as set forth in ch. 804, Stats., to the extent that the same are not inconsistent with or prohibited by these rules, Wisconsin Statutes or the Wisconsin Administrative Code. Motions to compel discovery shall be directed to the hearing examiner.

(15) CONDUCT OF HEARINGS. (a) *Open to public.* All hearings shall be open to the public except that the hearing examiner may order a closed

hearing where necessary to protect the identity of or the confidentiality of information relating to recipients or providers.

(b) *Representation.* A provider is entitled to appear in person or by or with counsel or other person authorized by the Wisconsin Supreme Court.

(c) *Continuances.* The hearing examiner may continue a hearing to another time or place, or order a future hearing on the examiner's own motion or upon the motion of any party and a showing of good cause. If the hearing examiner determines that additional evidence is necessary for proper resolution of the matter, the examiner may:

1. Continue the matter to a later date and order the party to produce additional evidence; or

2. Close the hearing and hold the record open to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to all parties and each party shall have the opportunity for rebuttal.

(d) *Evidence.* As prescribed by s. 227.08 (1), Stats., parties to a hearing shall not be bound by common law or statutory rules of evidence. All testimony having reasonable probative value, shall be admitted, but immaterial, irrelevant, or unduly repetitious testimony shall be excluded. All evidence of the parties, including documents and records, may be offered and made a part of the record. Every party shall be afforded the opportunity to inspect and rebut evidence introduced or offer countervailing evidence. Documentary evidence may be offered and received in the form of copies or excerpts if the original is not readily available.

(e) *Witnesses.* A witness shall be examined first on direct examination by the party calling the witness, unless the witness is an adverse witness, in which case the person may be questioned as if on cross-examination by the party calling the person.

1. Cross-examination shall not be limited to matters to which the witness testified on direct examination, subject to the hearing examiner's discretion.

2. A person examining or cross-examining a witness shall not approach the witness stand except to show the witness an exhibit.

3. Examination and cross-examination shall be confined to questioning the witness and shall not be interspersed with argument or commentary on the testimony, except to the extent that argument relates to evidentiary questions to be resolved by the hearing examiner.

(f) *Briefs.* The hearing examiner may direct that the parties prepare and submit briefs on any issue related to the proceedings and may impose a briefing schedule.

(g) *Stipulation of facts; settlements.* The parties may agree upon and file at any time before the conclusion of the submission of testimony at hearing, written stipulation of fact. Any settlement between the parties relating to the disposition of a contested action shall not be effective unless or until approved by the secretary of the department.

(16) DECISION. Within 30 days of final hearing or, where applicable, the post-hearing brief deadline, the hearing examiner who presided at the hearing shall prepare a decision including findings of fact, conclusions of law, order and opinion. The hearing examiner's decision shall be the final decision of the department with respect to the action contested.

(17) SERVICE OF DECISION. Every decision when made, signed, and filed, shall be served by personal delivery or by mailing of a copy to each party to the proceedings or to the party's attorney of record.

(18) PETITION FOR REHEARING. (a) A petition for rehearing shall not be a prerequisite for appeal or review. Any party to a contested action, including the department, which deems itself aggrieved by a final decision may within 20 days after service of the decision, file a written petition for rehearing which shall specify in detail, the grounds for relief and supporting authorities.

(b) The filing of a petition for rehearing shall not suspend or delay the effective date of the decision or order, and the decision or order shall take effect on the date set by the order and shall continue in effect unless the petition is granted or until the order is superceded, modified or set aside as provided by law.

(c) Procedures relating to petition for rehearing shall comply with s. 227.12, Stats. A rehearing shall be granted only on the basis of the grounds specified in s. 227.12 (3), Stats.

(19) TRANSCRIPTS. Stenographic, electronic or other record of oral proceedings shall be made. A written transcript of the record shall be prepared only as deemed necessary by the office of administrative hearings and rules and shall not be prepared at the specific request of any persons unless needed by such person for purposes of judicial review or other valid reason. If a transcript has been prepared by the office of administrative hearings and rules for its own use, copies may be furnished to all interested parties upon payment of a fee of 10 cents per page. If no transcript of the record has been prepared by the office of administrative hearings and rules and a specific request for a transcript is made, the party making the request shall be responsible for all reasonable costs of transcription of the record and preparation of the transcript. A party seeking judicial review of a decision shall pay the cost of preparing the transcript submitted to the reviewing court. Notwithstanding other provisions of this subsection, any party who on the basis of a verified petition can establish to the satisfaction of the office of administrative hearings and rules the need for a transcript and the financial inability to pay for a copy, may be furnished a copy free of cost.

(20) WAIVER AND VARIANCE. In order to get a waiver or variance from compliance with a statute or regulation the provider must file a written request with the division of health, detailing the deficiency, the statute or regulation violated, and stating the reasons why the provider cannot comply.

(a) The division may grant the waiver or variance, order an investigation, set the matter for a hearing or deny the request if it is without merit.

(b) Hearings shall be held in conformance with the above procedures.

(c) The final decision on waiver or variance shall be made by the division. If the request for waiver or variance is denied the provider shall be given a reasonable opportunity to file a plan of correction and remedy the defect before action is taken by the division to suspend, revoke or refuse to renew its license or certification.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.