Chapter HSS 120

OFFICE OF HEALTH CARE INFORMATION

Subchapter I — General Provisions
HSS 120.01 Authority and purpose (p. 81)
HSS 120.02 Applicability (p. 81)
HSS 120.03 Definitions (p. 81)
HSS 120.04 Assessments to fund the operations of the office and the board (p. 83)
HSS 120.05 Uniform patient billing form (p. 85)
HSS 120.06 Patient confidentiality (p. 85)
HSS 120.07 Release of physician identifiable data (p. 87)
HSS 120.08 Data dissemination (p. 88)
HSS 120.09 Administrative and technical information (p. 89)
HSS 120.10 Selection of a contractor (p. 89)
HSS 120.11 Penalties and forfeitures (p. 90)
HSS 120.12 Notice of violation and opportunity for appeal (p. 90)
HSS 120.13 Communications addressed to the office (p. 91)

Subchapter II — Hospital Reporting Requirements
HSS 120.20 Hospital responsibility to report inpatient data (p. 91)
HSS 120.21 Hospital responsibility to report outpatient surgical data (p. 94)
HSS 120.22 Hospital financial data (p. 98)
HSS 120.23 Hospital charges by charge element (p. 100)
HSS 120.24 Data for annual survey of hospitals (p. 103)
HSS 120.25 Uncompensated health care services (p.104)
HSS 120.26 Publication of a price increase notice (p. 105)

Subchapter III — Freestanding Ambulatory Surgery Center Reporting Requirements
HSS 120.30 Freestanding ambulatory surgery center responsibility to report patient surgical data (p. 107)

Subchapter IV — Other Health Care Provider Reporting Requirements
HSS 120.40 Other health care provider responsibility to report profile and charge information (p. 110)

Subchapter I — General Provisions

HSS 120.01 Authority and purpose. This chapter is promulgated under the authority of s. 153.75, Stats., to implement ch. 153, Stats. Its purpose is to provide definitions and procedures to be used by the department to administer the office of health care information. The office is responsible for collecting, analyzing and disseminating information about health care providers in language that is understandable to lay persons.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; am. Register, June, 1989, No. 402, eff. 7-1-89; r. and recr. Register, January, 1991, No. 421, eff. 2-1-91; renum. (intro.) and am., r. (1) and (2), Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.02 Applicability. This chapter applies to all health care providers in Wisconsin.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; am. Register, January, 1991, No. 421, eff. 2-1-91; am. Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.03 Definitions. In this chapter:

(1) "Bad debts" means claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

(2) "Board" means the board on health care information established under s. 15.195 (6), Stats.

(3) "Calculated variable" means a data element that is computed or derived from an original data item or derived using another data source.

(4) "Charge element" means any service, supply or combination of services or supplies that is specified in the categories for payment under the charge revenue code for the uniform patient billing form.

(5) "Charity care" means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. "Charity care" does not include any of the following:

(a) Care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care;

(b) Contractual adjustments in the provision of health care services below normal billed charges;

(c) Differences between a hospital's charges and payments received for health care services provided to the hospital's employes, to public employes or to prisoners;

(d) Hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy; or

(e) Bad debts.

(6) "Contractor" means a person under contract to the office to collect, process, analyze or store data for the purposes of this chapter.

(7) "Contractual adjustment" means the difference between a hospital's normal charges for patient services and the discounted charge or payment received by the hospital from the payer.

(8) "Data element" means an item of information from a uniform patient billing form record.

(9) "Department" means the Wisconsin department of health and social services.

(10) "Facility level data base" means data pertaining to a health care facility, including aggregated utilization, staffing or fiscal data for the facility but not including data on an individual patient or data on an individual health care professional.

(11) "Freestanding ambulatory surgery center" means any distinct entity that is operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with the federal health care financing administration under 42 CFR 416.25 and 416.30 to participate as an ambulatory surgery center, and meets the conditions set forth in 42 CFR 416.25 to 416.49. "Freestanding ambulatory surgery center" does not include a hospital-affiliated ambulatory surgical center as described in 42 CFR 416.120 (b).

(12) "Health care provider" means an individual or institutional provider of health care services and equipment in the state of Wisconsin who is certified or eligible for certification under ch. HSS 105.

(13) "Health maintenance organization" or "HMO" means a health care plan that makes available to its participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

(14) "Hospital" has the meaning specified in s. HSS 124.02 (6).

(15) "Medical assistance" or "MA" means the assistance program operated by the department under ss. 49.43 to 49.497, Stats., and chs. HSS 101 to 108.

(16) "Medicare" means the health insurance program operated by the U.S. department of health and human services under 42 USC 1395 to 1395 ccc and 42 CFR ch. IV, subch. B.

(17) "Office" means the office of health care information.

(18) "Other alternative health care payment system" means a negotiated health plan other than an HMO or an indemnity health care plan.

(19) "Patient" has the meaning specified in s. 153.01 (7), Stats., namely, a person who receives health care services from a health care provider.

(20) "Payer" means a party responsible for payment of a hospital charge, including but not limited to, an insurer or a federal, state or local government.

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

(22) "Physician" means a person licensed under ch. 448, Stats., to practice medicine or osteopathy.

(23) "Public program" means any program funded with government funds.

Note: Examples of public programs are general relief under s. 49.01 (5m), Stats., primary care under s. 146.93, Stats., medicare under 42 USC 1395 and 42 CFR subchapter B, medical assistance (medicaid) under ss. 49.43 to 49.497, Stats., and chs. HSS 101 to 108 and CHAMPUS under 10 USC 1071 to 1103.

(24) "Public use data" means data from the office's comprehensive discharge data base or the office's facility level data base that does not identify a specific patient, physician, other individual health care professional or employer and is available to the general public. "Public use data" includes data on a magnetic tape, other medium or form.

(25) "Uncompensated health care services" means charity care and bad debts.

(26) "Uniform patient billing form" means, for hospital inpatient discharges, the uniform billing form UB-82/HCFA-1450 or, for hospital outpatient discharges or freestanding ambulatory surgery center discharges, the health insurance claim form HCFA-1500 or the uniform billing form UB-82/HCFA-1450.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. (1) to be (1m), cr. (1), (2m), (2r), (3m), (10m) and (11m), Register, June, 1989, No. 402, eff. 7-1-89; renum. (1m) to (12) to be (2) to (13) and (15) to (19) and am. (19), cr. (14), Register, March, 1990, No. 411, eff. 4-1-90; cr. (9m) and am. (19), Register, January, 1991, No. 421, eff. 2-1-91; renum. (9m) to (19) to be (11), (14), (17) and (19) to (26) and am. (24), cr. (10), (12), (13), (15), (16) and (18), Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.04 Assessments to fund the operations of the office and the board. (1) DEFINITION. In this section, "state fiscal year" means the 12-month period beginning July 1 and ending the following June 30.

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

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

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

(3) CALCULATION OF ASSESSMENTS. (a) The office shall annually assess hospitals and freestanding ambulatory surgery centers in order to fund the operations of the office and the board as authorized in s. 153.60, Stats. The office shall calculate net expenditures and resulting assessments separately for hospitals, as a group, and freestanding ambulatory surgery centers, as a group, based on the collection, analysis and dissemination of information related to each group.

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

(c) The assessment for an individual freestanding ambulatory surgery center shall be based on the freestanding ambulatory surgery center's proportion of the number of reported surgical procedures for all freestanding ambulatory surgery centers for the most recently concluded calendar year.

(4) PAYMENT OF ASSESSMENTS. (a) *Payment deadline.* Each hospital shall pay the amount it has been assessed on or before December 1 each year and beginning in 1991, each freestanding ambulatory surgery center shall pay the amount it has been assessed on or before December 1, of each year. Payment of the assessment is on time if it is mailed in a properly addressed envelope, postmarked before midnight of December 1 of the year in which due, with postage prepaid, and is received by the office not more than 5 days after the prescribed date for making the payment. A payment which fails to satisfy these requirements solely because of a delay or administrative error of the U.S. postal service shall be considered to be on time.

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

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

trative error by the U.S. postal service, the department shall reimburse to the appellant any forfeiture paid.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90, r. and recr. (3), am. (4) (a), Register, January, 1991, No. 421, eff. 2-1-91.

HSS 120.05 Uniform patient billing form. (1) USE. All hospitals and freestanding ambulatory surgery centers in Wisconsin shall use the uniform patient billing form for all inpatient and outpatient care provided by them.

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

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90; am. (1), Register, January, 1991, No. 421, eff. 2-1-91.

HSS 120.06 Patient confidentiality. (1) NONRELEASE OF PATIENT IDENTIFIABLE DATA. No data that identifies a patient may be released by the office, except as provided in sub. (3). The identification of a patient shall be protected by all necessary means, including the use of calculated or aggregated variables.

(2) RELEASE OF PATIENT IDENTIFIABLE DATA. A patient identifiable record obtained under ch. 153, Stats., and this chapter is not a public record under s. 19.35, Stats. The office may not release any data that would permit the identification of a patient, except as specified in sub. (3). Procedures to ensure the protection of patient confidentiality shall include the following:

(a) Requests for patient identifiable data shall be made in writing to the office. A request shall include the requester's name, address, reason for the request and supporting written evidence necessary to comply with sub. (3);

(b) Upon receiving a request for patient identifiable data, the office shall, as soon as practicable and without delay, either fill the request, as provided in sub. (3), or notify the requester in writing of the office's denial of the request in whole or in part and the reasons for the denial; and

(c) A record requester whose written request has been denied by the office may appeal the decision in accordance with procedures pursuant to ss. 19.31 to 19.39, Stats.

(3) ACCESS TO PATIENT IDENTIFIABLE DATA. Only the following may have access to patient identifiable data maintained by the office, in accordance with s. 153.50, Stats.:

(a) The patient or a person granted permission in writing by the patient for release of the patient's records;

(b) A health care provider, the agent of a health care provider or the department to ensure the accuracy of the information in the data base;

(c) The department for:

1. Epidemiological investigation purposes; or

2. Eliminating the need to maintain duplicative data bases; or

(d) Other entities that enter into a written agreement with the office, in accordance with the following conditions:

1. The entity shall have a statutory mandate for obtaining patient identifiable data for:

a. Epidemiological investigation purposes; or

b. Eliminating the need to maintain duplicative data bases, as stated under s. 153.45 (2), Stats.;

2. The office may review and approve specific requests by the entity for patient identifiable data to fulfill its statutory mandate. This review shall include the requester providing the office with written statutory evidence that the requester is entitled to have access to patient identifiable data from the office; and

3. The entity shall identify for the office any statutes that require it to uphold the patient confidentiality provisions specified in this section or stricter patient confidentiality provisions than those specified in this section. If these statutory requirements do not exist, the entity shall agree in writing to uphold the patient confidentiality provisions in this section.

Note: Examples of other entities include the centers for disease control of the U.S. public health service and cancer registries in other states.

(4) DATA ELEMENTS CONSIDERED CONFIDENTIAL. Data elements from the uniform patient billing form that identify a patient shall be considered confidential, except as stated in sub. (3). These elements are the following:

(a) Patient medical record or chart number;

(b) Patient control number;

(c) Patient date of birth;

(d) Date of admission;

(e) Date of discharge;

(f) Date of principal procedures;

(g) Encrypted case identifier; and

(h) Insured's policy number.

(5) AGGREGATION OF SMALL NUMBERS. (a) In this subsection, "small number" means any number that is not large enough to be statistically significant, as determined by the office.

(b) To ensure that the identity of patients is protected when information generated by the office is released, any data element category containing small numbers shall be aggregated using procedures developed by the office and approved by the board. The procedures shall follow commonly accepted statistical methodology.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.05, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.04 and am. (4) (e) and (f), cr. (4) (g), Register, March, 1990, No. 411, eff. 4-1-90; am. (3) (b), (4) (f) and (g), cr. (4) (h), Register, January, 1991, No. 421, eff. 2-1-91; am. (3) (b), Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.07 Release of physician identifiable data. (1) PHYSICIAN IDENTIFIABLE DATA THAT MAY NOT BE RELEASED. (a) *Public use data.* As specified under s. 153.45 (1), Stats., public use data shall protect the identification of a physician by all necessary means, including the use of calculated or aggregated variables.

(b) *Patient identifiable data.* Any information identifying a physician that would permit the identification of a patient shall be considered confidential and may not be released, except under s. HSS 120.06.

(2) PHYSICIAN IDENTIFIABLE DATA THAT MAY BE RELEASED. (a) *Physician profile data.* The office shall release physician profile data collected under s. HSS 120.40 to any person who requests the data.

(b) *Billing or paid claim data.* Except as provided in sub. (1) (a) and (b), the office shall release physician identifiable data collected from uniform patient billing forms, other billing forms or paid claims to any person who requests the data, other than data in the form of mortality and morbidity reports under s. 153.25, Stats.

(3) REVIEW PERIOD BY PHYSICIANS. The following conditions apply to the release of physician identifiable data under sub. (2) (b):

(a) Requests for data that identifies a physician shall be made in writing to the office, indicating the physician's name or Wisconsin physician license number;

(b) The following procedures apply to persons requesting data who wish to re-release data that identifies a physician:

1. Except as stated in par. (c), prior to the release of data that identifies a physician, the office shall notify the physician of the request by 1st class mail using the last known address maintained by the Wisconsin department of regulation and licensing. The notification shall include a statement that the physician may submit written comments on the data to the office. If the physician's comments are received by the office not more than 30 calendar days from the date of the postmark on the notification from the office, the office shall release the requested data and the comments received to the requester. If the office receives the physician's comments after the data is released, the office shall make the comments available to anyone requesting them;

2. The review and comment period by the physician does not apply if a request is identical to a previous request and the office has at the time of release the physician's prior written comments on file. The office shall notify the physician about the request and shall release the physician's written comments to the requester with the requested data; and

3. Prior to the release of physician identifiable data to the requester, the requester shall sign an agreement stating that if the data is re-released by the requester, the physician's written comments shall be appended to it; or

(c) The following procedures apply to persons requesting data who do not wish to re-release data that identifies a physician:

1. The review and comment period by the physician, as stated in par. (b), does not apply provided that the requester executes a written agreement with the office assuring the office that the data will not be re-released; and

2. One of the following applies:

a. The request is made by the department to fulfill epidemiological investigation purposes or to eliminate the need to maintain duplicative data bases, as stated under s. 153.50, Stats.;

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

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

d. The request is made by a health care provider for the health care provider's own data.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.06, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.05 and am. (2), (3) (c) 2. b. and c., cr. (3) (c) 2. d., Register, March, 1990, No. 411, eff. 4-1-90; am. (3) (c) 2. d., Register, January, 1991, No. 421, eff. 2-1-91; r. and recr. (1) to (3) (intro.), am. (3) (c) 2. d., Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.08 Data dissemination. (1) The office shall prepare quarterly and annual reports as specified in ss. 153.10 to 153.35, Stats. The office shall make these reports available to the public at a charge which meets the cost of printing, copying and mailing a report to the requester.

(2) In addition to the reports under sub. (1), the office shall respond to requests by individuals, agencies of government and organizations in the private sector for public use data, data to fulfill statutory mandates for epidemiological purposes or to minimize the duplicate collection of similar data elements, and information that identifies a physician pursuant to s. HSS 120.07. The board shall designate the form in which the data for these requests shall be made available. The office shall charge the requester the total actual and necessary cost of producing the requested data.

(3) The office shall prepare special studies or analyses upon request. Prior to the release of any special studies or analyses conducted by the office pertaining to morbidity or mortality data in which a physician or hospital is identified, the office shall notify the identified physician or hospital of the request by 1st class mail using the last known address. The physician or hospital may submit written comments on the data to the office. If the physician's or hospital's comments are received by the office not more than 30 calendar days from the date of the postmark on the notification from the office, the office shall release the requested data and the comments received to the requester. If the office receives the physician's or hospital's comments after the data is released, the office shall make the comments available to anyone requesting them.

(4) Prior to the release of a subfile or special report under s. HSS 120.07 (2) (b), the office shall include with the subfile or insert in the special report a statement cautioning the user or reader about the meaning and significance of the data.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.07, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.06 and am. (2), Register, March, 1990, No. 411, eff. 4-1-90; am. (4), Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.09 Administrative and technical information. The office shall conduct throughout the state a series of training sessions for data submitters to explain its policies and procedures and to provide assistance in implementing the requirements of ch. 153, Stats. and this chapter.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.08, Register, June, 1989, No. 402, eff. 7-1-89; am. Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.10 Selection of a contractor. (1) DEFINITION. In this section, "major purchaser, payer or provider of health care services" means any of the following:

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

(b) An insurer that writes accident and health insurance and is among the 20 leading insurers for either group or individual accident and health insurance, as specified in the market shares table of the most recent annual Wisconsin insurance report of the state commissioner of insurance. "Major purchaser, payer or provider of health care services" does not include an insurer that writes only disability income insurance;

(c) A trust, a multiple employer trust, a multiple employer welfare association or a third party administrator, including an insurer, that administers health benefits for more than 29,000 individuals; or

(d) A person that provides health care services and has 100 or more full-time equivalent employes.

(2) ELIGIBLE CONTRACTORS. (a) If the board decides under s. 153.05 (6), Stats., to designate a contractor for the provision of data processing services for the office, including the collection, analysis and dissemination of health care information, the contractor shall be a public or private organization that does not have a potential conflict with the purposes of the office as specified under s. 153.05 (1), Stats.

(b) A contractor may not be:

1. A major purchaser, payer or provider of health care services in Wisconsin, except as provided in par. (c);

2. A subcontractor of an organization in subd. 1;

3. A subsidiary or affiliate of an organization in subd. 1 in which a controlling interest is held and may be exercised by that organization either independently or in concert with any other organization in subd. 1; or

4. An association of major purchasers, payers or providers of health care services.

(c) The department is exempt from the requirement under par. (b) regarding eligibility to contract and may offer a bid if the board decides to bid the contract for services under s. 153.07 (2), Stats., and this section.

(3) CONFIDENTIALITY. The office may grant the contractor authority to examine confidential materials and perform other functions autho-

rized by the office. The contractor shall comply with all confidentiality requirements established under this chapter. The release of confidential information by the contractor without the written consent of the office shall constitute grounds for the office to terminate any agreement between the contractor and the office.

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. HSS 120.08 and am. (1) (a) and (d), Register, March, 1990, No. 411, eff. 4-1-90.

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

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

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

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.11, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.09 and am. Register, March, 1990, No. 411, eff. 4-1-90.

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

(2) APPEAL PROCESS. (a) *Request for a hearing.* Whoever wishes to challenge a determination of the office that ch. 153, Stats. or this chapter has been violated may request a hearing as specified under s. 227.44, Stats. A written request for a hearing shall be submitted no later than 30 calendar days after notification of the determination to both the office and the department's office of adminstrative hearings. Hearing requests based on multiple violations shall be adjudicated within one hearing. A request for a hearing is considered submitted on the date that the office and the office of adminstrative hearings receive it. If it is not received by both offices on the same date, the later of the 2 dates shall be used to determine if the request was filed on time.

Note: The request for a hearing should be submitted to the Director, Office of Health Care Information, P.O. Box 309, Madison, Wisconsin 53701-0309 and the Office of Administrative Hearings, P.O. Box 7875, Madison, Wisconsin 53707-7875.

(b) *Start of hearing process.* The department shall start the hearing process within 45 days after receiving a request unless all parties to a hearing

consent to an extension of this period. The hearing process is considered started when a prehearing conference is held.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.12, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.095 and am. (1), Register, March, 1990, No. 411, eff. 4-1-90; am. (1), Register, January, 1991, No. 421, eff. 2-1-91; am. (1) and (2) (a), Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.13 Communications addressed to the office. (1) FORMAT. All written information or communications submitted by or on behalf of a health care provider to the office shall be signed by the individual health care professional or the chief executive officer of the facility or the designee of the individual health care professional or the chief executive officer of the facility.

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

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

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.10 and am. (2) and (3), Register, March, 1990, No. 411, eff. 4-1-90; am. (2), Register, January, 1991, No. 421, eff. 2-1-91; r. (1), renum. (2) and (3) to be (1) and (2) and am. (1), Register, March, 1992, No. 435, eff. 4-1-92.

Subchapter II — Hospital Reporting Requirements

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

TABLE 120.20
REQUIRED DATA ELEMENTS

DATA ELEMENT	UNIFORM PATIENT BILLING FORM ITEM
Patient control number, if applicable	3
Type of bill	4
Federal tax number of the hospital	6
Encrypted case identifier	10
Patient zip code	11
Patient date of birth	12
Patient sex	13
Date of admission	15
Type of admission	17
Source of admission	18
Patient status	21
Date of discharge	22
Race and ethnicity	27
Condition codes, if applicable	35 - 39
Patient medical record or chart number	45

Adjusted total charges and components of those charges	51 - 53
Primary and secondary sources of payments	57
Insured's policy number	68
Principal and other diagnoses	77 - 81
Principal and other procedures, if applicable	84 - 86
Date of principal procedure, if applicable	84 - 86
Attending physician license number	92
Other physician license number, if applicable	93

(b) Each hospital shall prepare for submission to the office an extract of the uniform patient billing form containing data elements specified in this subsection. The information reported on each extract shall include the following:

1. Individual data elements; and

2. Aggregations of revenue related data elements, except that hospitals are not required to report the total charges for a patient that had accumulated a hospital stay of more than 100 calendar days. The aggregations will be specified in a technical manual issued by the office.

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

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

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

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

(2) SUBMISSION DATES. (a) Each hospital shall submit the data specified in sub. (1) for all inpatient discharges occurring on or after January 1, 1989.

(b) Data shall be submitted to the office on a quarterly basis. Calendar quarters shall begin on January 1 and end on March 31, begin on April 1 and end on June 30, begin on July 1 and end on September 30, and begin on October 1 and end on December 31. For discharges occurring in calendar year 1989, data for each calendar quarter shall be submitted to the office within 60 calendar days following the end of a calendar quarter. For discharges occurring in calendar year 1990 and in subsequent calendar years, the data shall be submitted within 45 calendar days following the end of a calendar quarter.

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

the office at least 10 calendar days prior to the date that the data are due. An extension may be granted for up to 30 calendar days.

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

1. Physical specifications for the data submittal media; and

2. A recommended format for data submission.

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

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

(d) Beginning with 1991 calendar year data, all hospitals shall submit information on electronic media with physical specifications, format and record layout prescribed in a technical manual issued by the office.

(e) Any group of 6 or more hospitals or any group of hospitals which in the aggregate have more than 30,000 patient discharges per year may request in writing a waiver from the office format, record layout or electronic data submission requirements under par. (a) or (d) if the hospitals have a common alternative electronic media, format and record layout for the required data.

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

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

(5) VERIFICATION OF PATIENT MEDICAL RECORD DATA BY PHYSICIAN PRIOR TO DATA SUBMISSION. (a) The physician who maintains primary responsibility for determining a patient's continued need for acute care and readiness for discharge, even when this physician has referred the patient to one or more consulting physicians for specialized treatment, shall verify, within a calendar month after the patient is discharged from the hospital, that the patient's principal and secondary diagnoses and the primary and secondary procedures were as specified in the patient's medical record. The diagnoses and procedures shall be as defined in the uniform patient billing form manual. The physician shall use the procedures under par. (b) to fulfill this requirement.

(b) Hospitals, with their medical staffs, shall establish appropriate procedures and mechanisms to ensure verification by the physician. As stated in s. 153.40, Stats., if verification is not made on a timely basis for

each calendar quarter, the hospital shall submit the data noting the lack of verification.

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

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

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

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

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

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.04, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.11 and am. (1) (a), Table, (3) (b) and (6) (d) and (e), Register, March, 1990, No. 411, eff. 4-1-90; am. Table, (5) (a) and (6) (e), Register, January, 1991, No. 421, eff. 2-1-91.

HSS 120.21 Hospital responsibility to report outpatient surgical data. (1) REPORTING RESPONSIBILITY. Each hospital shall report to the office information relating to any outpatient surgical procedure falling within the following general types, as required by the department:

(a) Operations on the integumentary system;

(b) Operations on the musculoskeletal system;

(c) Operations on the respiratory system;

(d) Operations on the cardiovascular system;

(e) Operations on the hemic and lymphatic systems;

(f) Operations on the mediastinum and diaphragm;

(g) Operations on the digestive system;

(h) Operations on the urinary system;

(i) Operations on the male genital system;

(j) Operations on the female genital system;

(k) Obstetrical procedures;

(l) Operations on the endocrine system;

(m) Operations on the nervous system;

(n) Operations on the eye and ocular adnexa; and

(o) Operations on the auditory system.

(2) DATA ELEMENTS COLLECTED. (a) Each hospital shall report information on specific outpatient discharges required under sub. (1) from a hospital outpatient department or a hospital-affiliated ambulatory surgery center as described in 42 CFR 416.120, using the data elements available on the uniform patient billing form. The following data elements shall be reported:

1. Patient control number, if applicable;

2. Type of bill;

3. Federal tax number of the hospital;

4. Encrypted case identifier;

5. Patient zip code;

6. Patient date of birth;

7. Patient sex;

8. Type of admission;

9. Race and ethnicity;

10. Patient medical record or chart number;

11. Adjusted total charges and components of those charges;

12. Primary and secondary sources of payment;

13. Insured's policy number;

14. Principal and other diagnoses;

15. Principal and other procedures;

16. Date of principal procedure;

17. Attending physician license number; and

18. Other physician license number, if applicable.

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

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

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

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

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

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

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

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

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

1. Physical specifications for the data submittal media; and

2. A recommended format for data submission.

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

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

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

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

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

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

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

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

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

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

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

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

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

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90.; r. and recr. (1) and (2) (a)(intro), r. (2) (a) 8., 10. to 13., renum. (2) (a) 9. and 14. to 22. to be 8. to 12. and 14. to 18. and am. 11., a. (2) (a) 13., am. (6) (a) and (7) (e), Register, January, 1991, No. 421 eff. 2-1-91.

HSS 120.22 Hospital financial data. (1) REPORTING REQUIREMENT. (a) All hospitals shall report financial data to the office in accordance with this section and with instructions from the office that are based on guidelines from the 2nd edition (1990) of the *Audits of Providers of Health Care Services* published by the American institute of certified public accountants, generally accepted accounting principles and the national annual survey of hospitals conducted by the American hospital association.

(b) The data to be reported shall include the following revenue and expenses:

1. Net revenue from service to patients;

2. Other revenue;

3. Total revenue;

4. Payroll expenses;

5. Nonpayroll expenses;

6. Total expenses;

7. Nonoperating gains and losses;

8. Net income;

9. Gross revenue from service to patients and its sources;

10. Deductions from gross revenue from service to patients and its sources, including contractual adjustments, charity care and other noncontractual deductions; and

11. Expenses for education activities approved by medicare under 42 CFR 412.113 (b) and 412.118 as excerpted from total expenses.

(c) The data to be reported shall include the following asset, liability and fund balance data:

1. Unrestricted assets;

2. Unrestricted liabilities and fund balances; and

3. Restricted hospital funds.

(d) The data to be reported shall include for the current fiscal year and the previous fiscal year:

1. Total gross revenue figures;

2. Total net revenue figures;

3. The dollar difference between gross and net revenue figures; and

4. The amount of the dollar difference between gross and net revenue figures attributable to a price change, the amount attributable to a utilization change and the amount attributable to any other cause.

(2) SOURCE OF DATA. (a) Except for the department-operated state mental health institutes, each hospital shall submit to the office an extract of the data requested by the office from its final audited financial statements. If the data requested does not appear on the audited financial statements, the hospital shall gather the data from medicare cost

reports, notes to the financial statements or other internal hospital financial records. A hospital does not have to alter the way it otherwise records its financial data in order to comply with this section.

(b) A department-operated state mental health institute shall submit to the office an extract of the data requested by the office from either its audited or unaudited financial statements. Data from audited financial statements shall be used if they are available. If the data requested does not appear on the financial statements, the hospital shall gather the data from medicare cost reports, notes to the financial statements or other internal hospital financial records.

(3) REPORTING RESPONSIBILTY. (a) *Revenue and expense data.* 1. Except for a department-operated state mental health institute, each hospital shall submit data specified under sub. (1) (b).

2. If a hospital is jointly operated in connection with a nursing home, home health agency or other organization, the hospital shall submit the required data from sub. (1) (b) for the hospital unit only.

3. A department-operated state mental health institute shall submit at least the dollar amounts for the items under sub. (1) (b) that are available from the state fiscal system.

(b) *Asset, liability and fund balance data.* 1. Except for a department-operated state mental health institute or a county-owned psychiatric or alcohol and other drug abuse hospital, each hospital shall submit data specified under sub. (1) (c).

2. If a hospital is jointly operated in connection with a nursing home, home health agency or other organization, the hospital shall report the required data from sub. (1) (c) for the hospital unit only. If the hospital unit data cannot be separated from the total facility data, the hospital shall report the data for the total facility.

3. Department-operated state mental health institutes and county-owned psychiatric or alcohol and other drug abuse hospitals are not required to submit any data specified under sub. (1) (c).

(c) *Trend data.* Each hospital shall submit all data required under sub. (1) (d).

4. SUBMISSION SCHEDULE. (a) *Due date.* For each fiscal year, a hospital shall annually submit to the office, no later than 120 calendar days following the close of the hospital's fiscal year, the dollar amounts of the financial data, as specified in this section.

(b) *Extension of submittal date.* 1. Except as provided in subd. 2, the office may grant an extension of a deadline specified in this section for submission of hospital financial data only when need for additional time is adequately justified by a hospital. Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension for adequate justification may be granted for up to 30 calendar days.

2. The office may grant an extension of a deadline specified in this section for submission of hospital financial data by a department-operated

state mental health institute for up to 90 calendar days upon written request.

(5) FORMAT FOR DATA SUBMISSION. Each hospital shall submit to the office the financial data specified in this section in a format provided by the office.

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

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

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

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.12 and am. (3) (a) 5. and (b), Register, March, 1990, No. 411, eff. 4-1-90; renum. (1) to be (1) (a) and am., cr. (1) (b), Register, January, 1991, No. 421, eff. 2-1-91; r. and recr. Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.23 Asset, liability and fund balance data. History: Cr. Register, March, 1990, No. 411, eff. 4-1-90; r. and recr. (2) (f), Register, January, 1991, No. 421, eff. 2-1-91; r. Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.23 Hospital charges by charge element. (1) The charge elements listed in Table 120.23 (1) shall be reported to the office if required under sub. (2).

TABLE 120.23
HOSPITAL CHARGE ELEMENTS

CHARGE ELEMENT	UB-82 REVENUE CODE
ROOM AND BOARD — PRIVATE	
General classification	110
Medical/surgical/gynecology	111
Obstetrics	112
Pediatric	113
Psychiatric	114
Hospice	115
Detoxification	116
Oncology	117
Other	119
ROOM AND BOARD — SEMI PRIVATE TWO BED	
General classification	120

Medical/surgical/gynecology	121
Obstetrics	122
Pediatric	123
Psychiatric	124
Hospice	125
Detoxification	126
Oncology	127
Other	129
NURSERY	
General classification	170
Newborn	171
Premature	172
Neonatal intensive care unit	175
Other	179
INTENSIVE CARE	
General classification	200
Surgical	201
Medical	202
Pediatric	203
Psychiatric	204
Post intensive care unit	206
Burn care	207
Trauma	208
Other	209
CORONARY CARE	
General classification	210
Myocardial infarction	211
INCREMENTAL NURSING CHARGE RATE	
General classification	230
Nursery	231
Intensive care	233
Coronary care	234
OTHER IMAGING SERVICES	
Mammography, excluding physician fees	401
EMERGENCY ROOM	
General classification — based on highest volume, excluding physician fees	450
LABOR ROOM/DELIVERY	
General classification	720
Labor	721
Delivery	722
Circumcision	723
Birthing center	724
Other	729
PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS	

General classification	900
Electroshock treatment	901
Milieu therapy	902
Play therapy	903
Other	909
PSYCHIATRIC/PSYCHOLOGICAL SERVICES	
General classification	910
Rehabilitation	911
Day care	912
Night care	913
Individual therapy	914
Group therapy	915
Family therapy	916
Biofeedback	917
Testing	918
Other	919

(2) The office may require that each hospital annually submit to the office:

(a) The amount of the per unit charge for each of the hospital charge elements under sub. (1) as of July 1 of each year. The outpatient per unit charge shall be listed seperately if it differs from the inpatient per unit charge; and

(b) The number of times a charge occurred for each of the hospital charge elements under sub. (1) for the 12-month period of the hospital's most recently completed fiscal year. A hospital may estimate the volume of charges for each charge element, rounded to the nearest 100, except that if a charge occurred less than 50 times in a 12-month period, the hospital shall count the exact number of times that the charge occurred.

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

(4) Each hospital shall submit the charge element data to the office in a format provided by the office.

(5) (a) The office shall check the accuracy and completeness of submitted charge element data. Unacceptable data shall be returned to the hospital that submitted it with information for revision and resubmission if the office has contacted the hospital and has determined that the data cannot be corrected by telephone. Data returned to the hospital shall be resubmitted to the office within 10 working days after the hospital's receipt of the unacceptable data.

(b) After the office has made any revisions under par. (a) in the data for a particular hospital, the office shall send to the hospital a written copy of all data variables submitted by that hospital to the office or sub-

sequently corrected by the office. The hospital shall review the data for accuracy and completeness and shall supply to the office within 10 working days after receipt of the data any corrections to the data.

(c) Within the same 10-working day period under par. (b), the chief executive officer or designee of each hospital shall submit to the office a signed statement affirming that any corrections to the data have been made, and that the data are accurate and complete to the best of his or her kowledge.

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. from. HSS 120. 13 and am. (intro.), Register, March, 1990, No. 411, eff. 4-1-90; renum. from HSS 120.24 and am., cr. (2) to (5), Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.24 Data for annual survey of hospitals. (1) REPORTING REQUIREMENT. (a) All hospitals shall submit to the office data requested by the department for the American hospital association's annual survey of hospitals, as required by this section.

(b) The survey information to be reported by a hospital shall be limitied to the following:

1. Type of hospital control;

2. Type of service that best describes the hospital;

3. Accreditation and certification;

4. Existence of contracts with prepaid health plans, including health maintenance organizations, and other alternative health care payment systems;

5. Provision of selected inpatient, ancillary and other services;

6. Location of services provided;

7. Utilization of selected services;

8. Number of beds and inpatient utilization for the total facility, including beds set up and staffed, admissions, discharges and days of care;

9. Inpatient utilization by government payers for the total facility;

10. Number of beds and utilization by selected inpatient services;

11. Swing-bed utilization, if applicable, including number of swing beds, admissions and days of care;

12. Long-term care utilization, if applicable, including beds set up and staffed, discharges and days of care;

13. Medical staff information, including availability of contractual arrangements with physicians in a paid capacity, total number of active or associate medical staff by selected specialty and number of board certified medical staff by selected speciality; and

14. Number of personnel on a hospital's payroll, including hospital personnel, trainees and nursing home personnel by occupational category and by full-time or part-time status.

(2) SUBMISSION SCHEDULE. (a) *Due date.* Each hospital by December 7th of each year shall submit to the office the information required under this section. The office may change the due date. If the office changes the

due date, the office shall notify each hospital of the change at least 30 days before the data are due.

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

(3) FORMAT FOR DATA SUBMISSION. Each hospital shall submit to the office the data specified in this section in a format provided by the office.

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

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

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

History: Cr. Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.25 Uncompensated health care services. (1) PLAN. Every hospital shall submit to the office a written plan for providing uncompensated health care services as required under sub. (2). The plan shall include at least the following elements:

(a) A set of definitions describing terms used throughout the plan;

(b) The procedures used to determine a patient's ability to pay for health care services received and to verify financial information from the patient;

(c) The number of patients obtaining uncompensated health care services from the hospital in its recently completed fiscal year, and the total accrued charges for those services, as determined by:

1. The number of patients whose accrued charges were attributed to charity care in that fiscal year;

2. The total accrued charges for charity care, based on revenue foregone at full established rates, in that fiscal year;

3. The number of patients whose accrued charges were determined to be a bad debt expense in that fiscal year; and

4. The total bad debt expense, as obtained from the hospital's final audited financial statements in that fiscal year;

(d) The projected number of patients anticipated to obtain uncompensated health care services from the hospital in its ensuing fiscal year, and the projected charges for those services, as determined by:

1. The hospital's projected number of patients anticipated to obtain charity care for that fiscal year;

2. The hospital's projected total charges attributed to charity care for that fiscal year;

3. The hospital's projected number of patients whose charges will be a bad debt expense for that fiscal year;

4. The hospital's projected total bad debt expense for that fiscal year; and

5. A rationale for the hospital's projections under subds. 1 to 4, considering the hospital's total patients and total accrued charges for the recently completed fiscal year; and

(e) The hospital's procedure to inform the public about charity care available at that hospital.

(2) SUBMISSION SCHEDULE. (a) *Due date.* For each fiscal year, a hospital shall annually submit to the office, no later than 120 calendar days following the close of the hospital's fiscal year, an uncompensated health care plan in accordance with sub. (1) and in a format prescribed by the office.

(b) *Extension of submittal date.* The office may grant an extension of a deadline specified in this section for submission of hospital uncompensated health care data only when need for additional time is adequately justified by a hospital. Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension for adequate justification may be granted for up to 30 calendar days.

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

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90; am. (1) (b) (intro.), (2) (c) and (6) (c), Register, January, 1991, No. 421, eff. 2-1-91; r. and recr. Register, March, 1992, No. 435, eff. 4-1-92.

HSS 120.26 Publication of a price increase notice. (1) USE. The procedures set out in this section shall be used by a hospital to provide notice to the public of a price increase.

(2) DEFINITIONS. In this section:

(a) "Affidavit of publication" means a sworn statement in writing affirming the publication of the notice issued by the editor, publisher, printer or proprietor of any newspaper, or by the printer or proprietor's lead worker or principal clerk.

(b) "Class 1 notice" has the meaning specified in s. 985.07 (1), Stats., namely, a notice requiring at least one insertion.

(c) "Reportable price increase" means a price increase that raises a hospital's total gross revenue from continuing services to patients, as determined under s. HSS 120.22 (1) (b) 9, not less than one percent within a 12-month period.

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

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

(5) CONTENTS OF NOTICE. A hospital shall include in a notice of price increase at least the following elements:

(a) A bold heading entitled, "NOTICE OF HOSPITAL PRICE INCREASE FOR (name of hospital)" printed in capital letters of not less than 18 point type size. The text of the notice shall be printed in not less than 10 point type size. Any numbers printed in the notice shall be expressed as numerals;

(b) The address of the hospital;

(c) Beginning and ending dates of a hospital's fiscal year;

(d) An increase in the price for any charge element under s. HSS 120.23. If the price for a charge element will not increase, the hospital is not required to list that charge element in the notice. The information about the increase shall be formatted as follows:

1. Name of the charge element;

2. Previous per unit price of the charge element;

3. New per unit price of the charge element;

4. Amount of price change between subds. 2 and 3; and

5. Percentage change between subds. 2 and 3;

(e) The anticipated overall increase in a hospital's total gross revenue under s. HSS 120.22 (1) (b) 9 that will result only from price changes in all reportable and unreportable charge elements for the following 12-month period, expressed as an annualized percentage;

(f) The date the price increase will go into effect;

(g) The date and annualized percentage of each price increase within the 12 months prior to this price increase;

(h) The date of the last price increase if there was no increase specified under par. (g); and

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

(6) AFFIDAVIT OF PUBLICATION. Within 2 weeks after the date on which a price increase notice is published, the hospital shall submit to the office an affidavit of the publication annexed to a copy of the notice, clipped from the paper in which it was published, that specifies the date of insertion and the name of the newspaper.

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.15 and am. (2) (c), (3), (4), (5) (d) (intro.) and (e), cr. (5) (i), Register, March, 1990, No. 411, eff. 4-1-90; am. (1), (2) (c), (3) to (5) (a), (d) to (i) and (6), Register, January, 1991, No. 421, eff. 2-1-91; corrections made under s. 13.93 (2m) (b) 7, Stats., Register, March, 1992, No. 435.

HSS 120.27 Uncompensated health care services. History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.16 and am. (2) (a) and (c) and (3), Register, March, 1990, No. 411, eff. 4-1-90; r. Register, March, 1992, No. 435, eff. 4-1-92.

Subchapter III — Freestanding Ambulatory Surgery Center Reporting Requirements

HSS 120.30 Freestanding ambulatory surgery center responsibility to report patient surgical data. (1) REPORTING RESPONSIBILITY. Each freestanding ambulatory surgery center shall report to the office information relating to any surgical procedure falling within the following general types, as required by the department:

(a) Operations on the integumentary system;

(b) Operations on the musculoskeletal system;

(c) Operations on the respiratory system;

(d) Operations on the cardiovascular system;

(e) Operations on the hemic and lymphatic systems;

(f) Operations on the mediastinum and diaphragm;

(g) Operations on the digestive system;

(h) Operations on the urinary system;

(i) Operations on the male genital system;

(j) Operations on the female genital system;

(k) Obstetrical procedures;

(l) Operations on the endocrine system;

(m) Operations on the nervous system;

(n) Operations on the eye and ocular adnexa; and

(o) Operations on the auditory system.

(2) DATA ELEMENTS COLLECTED. (a) Each freestanding ambulatory surgery center shall report information on specific patient discharges required under sub. (1), using the data elements available on the uniform patient billing form. The following data elements shall be reported:

1. Federal tax number of the freestanding ambulatory surgery center;

2. Encrypted case identifier;

3. Patient zip code;

4. Patient date of birth;

5. Patient sex;

6. Type of admission;

7. Race and ethnicity;

8. Patient medical record or chart number;

9. Adjusted total charges;

10. Primary and secondary sources of payment;

11. Insured's policy number;

12. Principal and other diagnoses;

13. Principal and other procedures;

14. Date of principal procedure; and

15. Attending physician license number.

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

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

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

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

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

(3) SUBMISSION DATES. (a) Each freestanding ambulatory surgery center shall submit the data specified in sub. (2) for all specified patient discharges occurring on or after January 1, 1991.

(b) Patient surgical data shall be submitted to the office on a quarterly basis. Calendar quarters shall begin on January 1 and end on March 31, begin on April 1 and end on June 30, begin on July 1 and end on September 30, and begin on October 1 and end on December 31. For discharges

occurring in calendar year 1991, data for each calendar quarter shall be submitted to the office within 60 calendar days following the end of a calendar quarter. For discharges occurring in calendar year 1992 and in subsequent calendar years, the data shall be submitted within 45 calendar days following the end of a calendar quarter.

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

(4) ACCEPTABLE MEDIA FOR DATA SUBMISSION. (a) Each freestanding ambulatory surgery center shall submit an extract of the uniform patient billing form data on a magnetic diskette, magnetic tape or on a paper form acceptable to the office. The office shall specify in a technical manual:

1. Physical specifications for the data submittal media; and

2. A recommended format for data sumission.

(b) Beginning with calendar year 1993, if a freestanding ambulatory surgery center submits its patient surgical data on a paper form acceptable to the office, the freestanding ambulatory surgery center shall reimburse the office for all the actual and necessary costs of converting the data to an electronic medium with physical specifications and format acceptable to the office.

(c) The office shall provide consultation to a freestanding ambulatory surgery center upon written request of the freestanding ambulatory surgery center to enable it to submit patient surgical data according to office specifications.

(5) REVIEW OF PATIENT SURGICAL DATA BY FREESTANDING AMBULATORY SURGERY CENTERS PRIOR TO DATA SUBMISSION. As provided under s. 153.40, Stats., prior to submitting patient surgical data to the office, a freestanding ambulatory surgery center shall review the data. The review shall consist of checks for accuracy and completeness which are designed by the office or designed by the freestanding ambulatory surgery center and approved by the office.

(6) VERIFICATION OF PATIENT SURGICAL RECORD DATA BY PHYSICIAN PRIOR TO DATA SUBMISSION. (a) The surgeon performing the principal procedure shall verify, within a calendar month after a patient is discharged from the freestanding ambulatory surgery center, that the patient's principal and secondary diagnoses and the primary and secondary surgical procedures were as specified in the patient's medical record. The diagnoses and procedures shall be as defined in the uniform patient billing form manual. The physician shall use the procedures under par. (b) to fulfill this requirement.

(b) A freestanding ambulatory surgery center, with its medical staff, shall establish appropriate procedures and mechanisms to ensure verification by a physician. As provided under s. 153.40, Stats., if verification is not made on a timely basis for each calendar quarter, the freestanding

ambulatory surgery center shall submit the patient surgical data noting the lack of verification by the physician.

(7) REVIEW OF PATIENT SURGICAL DATA BY THE OFFICE AND FREESTANDING AMBULATORY SURGERY CENTERS AFTER DATA SUBMISSION. (a) The office shall check the accuracy and completeness of submitted patient surgical data. All errors or probable errors shall be recorded on paper for each patient discharge. Acceptable data submissions shall be integrated into the case level data base. Unacceptable data or tapes shall be returned to the freestanding ambulatory surgery center with a paper copy of the information for revision and resubmission.

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

(c) Patient records data resubmitted by freestanding ambulatory surgery centers shall be grouped with the appropriate amendments or additions. Additional patient records data from the same calendar quarter as the revised data may be submitted with the revised data.

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

(e) Within the same 10-working day period under par. (d), the chief executive officer or designee of each freestanding ambulatory surgery center shall submit to the office a signed statement affirming that the data submitted to the office have been verified pursuant to subs. (5) and (6); that any corrections to the data have been made; and that the data are accurate and complete to the best of his or her knowledge.

History: Cr. Register, January, 1991, No. 421, eff. 2-1-91.

Subchapter IV — Other Health Care Provider Reporting Requirements

HSS 120.40 Other health care provider responsibility to report profile and charge information. (1) APPLICABILITY. This section applies to the following health care providers:

(a) Chiropractors licensed under s. 446.02, Stats.;

(b) Counselors, alcohol and other drug abuse, certified under s. HSS 105.23;

(c) Dentists licensed under ch. 447, Stats.;

(d) Nurse anesthetists licensed under s. 441.06, Stats., and certified by either the council of certification of nurse anethetists or the council on recertification of nurse anethetists;

(e) Nurse midwives licensed under s. 441.15, Stats.;

(f) Nurse practitioners licensed under s. 441.06, Stats., and certified under s. HSS 105.20 (1);

(g) Nurses, psychiatric, licensed under s. 441.06, Stats., and who meet the qualifications for a registered nurse under s. HSS 61.96 (1) (b);

(h) Occupational therapists certified under ch. 448, Stats.;

(i) Optometrists licensed under ch. 449, Stats.;

(j) Physical therapists licensed under ch. 448, Stats.;

(k) Physicians licensed under ch. 448, Stats., to practice medicine or osteopathy;

(l) Physician assistants certified under ch. 448, Stats.;

(m) Podiatrists licensed under ch. 448, Stats., to practice podiatry or podiatric medicine or surgery;

(n) Psychologists licensed under ch. 455, Stats.; and

(o) Other health care providers certified or eligible for certification under ch. HSS 105.

(2) REPORTING RESPONSIBILITY. (a) *Profile information.* Following the consultation required under par. (c), the office may require each health care provider under sub. (1) to report to the office, as specified under subs. (3) and (4), the following historical profile and qualification information:

1. Name of the provider and address or addresses of main practice or employment;

2. Date of birth;

3. License or certification information, if applicable, including date of initial licensure or certification;

4. Specialty, board certification and recertification information, if applicable;

5. Active status;

6. Formal education and training;

7. Whether the provider renders services to medicare and medical assistance patients and, if applicable, whether the provider has signed a medicare participation agreement indicating that she or he accepts assignment on all medicare patients;

8. Whether the provider participates in a voluntary partnercare program specified under s. 71.55 (10), Stats., in which assignment is accepted for low-income elderly;

9. Current names and addresses of facilities at which the provider has been granted priveleges, if applicable; and

10. Licensure or certification revocation or suspension information, if applicable.

(b) *Charge information.* Following the consultation required under par. (c), the office may require each health care provider specified in sub. (1)

to report to the office the ususal and customary charges for frequently occurring procedures.

(c) *Required consultation.* The office shall consult with each applicable health care provider group under sub. (1), through a technical advisory committee or trade association, before the office collects data directly from that health care provider group.

(3) SOURCE OF DATA. (a) *Wisconsin department of regualtion and licensing.* The information requested about each health care provider in this section shall be obtained through data already contained in the data base maintained by the Wisconsin department of regualtion and licensing. If the information requested in sub. (2) is not available from the Wisconsin department of regulation and licensing, or if the information is not available at the desired time interval, the office shall require the health care provider to submit that information directly to the office or the office's designee in a format prescribed by the office.

(b) *Health care provider.* If a health care provider specified in sub. (1) is not in the data base maintained by the Wisconsin department of regualtion and licensing, the office shall require the health care provider to submit the information in sub. (2) directly to the office or the office's designee in a format prescribed by the office.

(4) SUBMISSION SCHEDULE. (a) *Due date.* The office shall require that information requested under sub. (2) be submitted at least on a biennial basis according to a schedule developed by the office. The office may require that the requested information be submitted on an annual basis according to a schedule developed by the office.

(b) *Extension of submittal date.* The office may grant an extension of a deadline specified in this section for submission of health care provider information only when need for additional time is adequately justified by a health care provider specified in sub. (1). Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension for adequate justification may be granted for up to 30 calendar days. Health care providers who have been granted an extension shall submit their data directly to the office.

Note: Health care providers who are required to send their information directly to the office should use the following address: Office of Health Care Information, P.O. Box 309, Madison, Wisconsin 53701-0309, or deliver the communications to Room 272, 1 West Wilson, Madison, Wisconsin.

History: Cr. Register, March, 1992, No. 435, eff. 4-1-92.