Chapter HSS 1

UNIFORM FEE SYSTEM

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

HSS 1.01 Purpose, definitions, exempted services. (1) INTENT. This chapter, implementing ss. 46.03 (18), 46.10, 48.837 (7), 48.839 (1) and 51.30 (4) (b) 2., Stats., standardizes on a statewide basis the determination of liability and ability to pay, and otherwise regulates billing and collection activities for care and services provided or purchased by the department, a county department of social services, or a board created under s. 51.42, 51.437, or 46.23, Stats.

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

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

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

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

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

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

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

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

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

(f) "Fee" means a single, cost-related, per unit charge or rate assigned to a purchased or provided service furnished by a provider of service calculated and/or approved according to the provisions of this rule for the

purpose of establishing the liability of responsible parties and billing third-party payers.

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

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

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

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

(j) "Parental payment limit" means an amount set by the department according to s. HSS 1.03 (21) as a maximum daily or monthly billing amount to parents as an ability to pay ceiling for care or services to minors.

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

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

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

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

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

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

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

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

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

2. Probation and parole services, court ordered supervision and other supervision service provided to adults.

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

3. Purchases of education services by the division of corrections.

4. Sheltered employment, work activity, and adult non-medical day services programs for the handicapped except, transportation related to these services.

5. Non-medical initial diagnosis and evaluation services.

6. Family planning services.

7. Advocacy.

(d) Further exemptions:

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

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

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

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

b. Per unit cost of service.

c. Units of service provided each month under review.

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

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

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

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

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

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

4. Agencies providing services under contract with a county agency shall submit the supporting materials to the appropriate purchasing agency. If the county agency concurs with the request for exemption, the request and any additional supporting information and rationale shall be forwarded by the county agency to the Secretary, Department of Health and Social Services - Subject: Uniform Fee Exemption.

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

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (1), (3), (4)(b) and (5), renum. (2) (j) to (l) to be (2) (k) to (m), cr. (2) (j), renum. (4) (d) to be (4) (d) 1., cr. (4) (d) 2 to 5, Register, November, 1979. No. 287, eff. 1-1-80; am. (2) (j), (4) (c) 1. and (d) 2., r. (5), Register, December, 1980, No. 300, eff. 1-1-81; correction in (3) under s. 13.93 (2m) (b) 4, Stats., Register, September, 1984, No. 345; am. (1), (2) (g) and (4) (c), Register, September, 1984, No. 345, eff. 10-1-84.

HSS 1.02 Liability for paying fees. (1) RESPONSIBLE PARTIES. Whenever a client receives a service which is subject to this chapter, the client, the spouse of a married client, the parents of a minor client, and any other persons specified by statute as having liability payable according to ss. 46.03 (18), 46.10, 48.837 (7) and 48.839 (1), Stats., shall be responsible for paying for the service in the manner set forth in this chapter.

Note: Chapter 81, Laws of 1981, added proposed adoptive parents (s. 48.837 (7), Stats.) and guardians of foreign children (s. 48.839 (1), Stats.) to those liable to pay for services that clients receive which are subject to this chapter.

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

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

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

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

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

1. Mental hygiene inpatient facilities

2. Foster homes

3. Group homes

4. Child caring institutions

5. Community based residential facilities

6. Juvenile correctional facilities

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

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

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

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

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

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

(6) DISCHARGE OF LIABILITY OTHER THAN BY MEANS OF FULL PAYMENT. Except where statutes require payment of full liability, the liability of responsible parties remaining after recovery of benefits from all applicable insurance shall be considered discharged if responsible parties provide department or agency staff who have billing responsibility with full financial information and pay according to the following provisions:

(a) For adult inpatient care and services, when liability remaining exceeds $1,000 or discharge of liability at the maximum monthly payment rate would exceed 5 years, responsible parties may enter into an agreement with the appropriate payment approval authority to pay a substantial portion of the liability outstanding as a lump sum.

(b) For adoption investigations and non-residential services specified in s. 48.837, Stats., a responsible party shall pay the lesser of full liability or 24 times the monthly payment amount as calculated according to s. HSS 1.03 (12) or (13).

(c) For care and services in non-medical facilities, clients shall pay the lesser of full liability each month or the monthly payment rate calculated according to s. HSS 1.03 (2) to (6) for each month the client is a resident of the facility. Other responsible parties shall pay according to the provisions of par. (d).

(d) For all other care and services, the liability of responsible parties may be discharged by less than full payment if they pay the lesser of liability remaining after crediting third party payments each month or

the monthly payment rate as calculated under s. HSS 1.03 (12) or (13) and adjusted, as appropriate, under s. HSS 1.03 (14). When inpatient clients are minors who receive medical assistance, parents shall be billed before the medical assistance program is billed, and medical assistance claims shall be reduced by the amount of parental payments.

(e) The department may set annual minimum payment amounts for services billable under par. (d). An annual minimum payment may not exceed $1,000 unless there is a specific statutory mandate for a higher amount. An annual minimum payment shall be applied to the client's uninsured liability. Any uninsured liability beyond the annual minimum payment shall be subject to the provisions of par. (d). For medical services, the department may credit a family payment for an annual minimum payment up to the amount the family pays for medical insurance in a year if the insurance pays at least the amount of the credit. Where the statutes set other minimum amounts, bond amounts, deductibles or copayments, those provisions supersede this paragraph.

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

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (1), (2) (b), ren. (3) and (4) to be (8) and (9) and am. (8) (a) and (9), cr. (3) to (7), Register, November, 1979, No. 287, eff. 1-1-80; emerg. am. (6) (intro.) and (b) and (7), eff. 7-1-80; am. (6) (intro.) and (b) and (7), Register, October, 1980, No. 298, eff. 11-1-80; am. (2) (intro.), r. (2) (a) and (b), (6) and (7), renum. (8) and (9) to be (6) and (7) and am. (6), Register, December, 1980, No. 300, eff. 1-1-81; am. (1), r. and recr. (6), Register, September, 1984, No. 345, eff. 10-1-84.

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

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

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

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

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

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

(c) Repayment of previously incurred debts.

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

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

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

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

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

various service categories to assist payment approval authorities with this requirement.

(8) REFUSAL TO PROVIDE FULL FINANCIAL INFORMATION. A responsible party who is informed of his or her rights and knowingly refuses to provide full financial information and authorizations for billing all applicable insurance shall not be eligible under s. HSS 1.02 (6) to discharge liability other than by means of full payment.

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

(10) FINANCIAL INFORMATION FORM. (a) Except as otherwise provided in this chapter, the Financial Information Form (DMS 130) is mandatory when a responsible party chooses to be considered for ability to pay provisions.

Note: Form DMS 130 may be ordered from:

Department of Health & Social Services
Forms Center P.O. Box 7850
Madison, Wisconsin 53707

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

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

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

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

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

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

4. For services other than care to minors in state institutions, the department may permit a payment approval authority to add an amount based on the value of assets to monthly income. This amount may not exceed 1/6 of the assets that would be considered excess assets for the purpose of determining eligibility for the medical assistance program.

(12) MAXIMUM MONTHLY PAYMENT. A family providing full financial information shall be billed at a monthly rate that does not exceed the maximum amount computed by means of the following formulas:

(a) *Long-term support for adults.* For long-term support for adults in the department's community options program and similar programs, an amount not to exceed the monthly income computed according to sub. (11) less the following:

1. Estimated income taxes, social security or federal retirement obligations; and

2. An amount determined annually by the department which is no less than current income limits for medically needy persons in the Wisconsin medical assistance program.

(b) *Child day care.* For child day care, the monthly payment when income computed under sub. (11) is less than 50% of the state median income as defined by the department shall be zero. For income at 50% of the state median income, the maximum payment shall be $5.00 per month. For income at 60% of the state median income, the payment shall be $30.00 per month. The maximum payment for income at 100% of the state median income shall be $266 per month. The department shall annually publish a schedule which prorates the day care payments for income levels for each one percent increase in income from 50% to 100% of the state median income. Parental payment limits in sub. (18) (a) do not apply to this paragraph.

(c) *Other services for children.* For other services to children, the maximum monthly payment for a parent shall be computed as follows:

1.a. Subtract the appropriate minimum family budget in Table 1.03 (12) from the family's monthly income computed under sub. (11).

Table 1.03 (12)
MONTHLY MINIMUM FAMILY BUDGET

Persons Living in Family	CY 1984 Allowance	CY 1985 Allowance
1	$ 728	$ 758
2	952	991
3	1175	1222
4	1399	1455
5	1624	1689
6	1847	1921
7	2029	2110
8	2168	2255
9	2266	2357
10+	2364	2459

b. For years after calendar year 1985, the department shall update the allowances in Table 1.03 (12) by the same precentage used to update family budgets in the aid to families with dependent children program.

2. If remaining income is:

a. Less than $1.00, the maximum monthly payment is zero;

b. At least $1.00 but less than $543, the maximum monthly payment is 28% of the income in excess of $1.00;

c. At least $543, the maximum monthly payment is $152 plus 7% of the income in excess of $543.

3. The department shall publish a schedule annually for agencies to compute maximum monthly payment rates under this paragraph.

Note: $152 is assumed to represent a basic allowance to provide support for a child living in a family, and 7% of gross income above support is assumed to represent added support above basic needs that a family with higher income would provide for a child in the home.

(d) *All other services.* For all other services, the department shall publish maximum monthly payment schedules or formulas that require payments no higher than those computed under par. (a).

(13) MINIMUM PAYMENT. The appropriate payment approval authority may establish a minimum payment rate up to $25.00 per month or 3% of gross income across the board for all families receiving a fee chargeable service whose maximum monthly payment as calculated according to sub. (12) is less than the minimum rate. Where minimum rates are used, all families shall be expected to pay the applicable minimum rate except where liability is waived according to s. HSS 1.02 (7) or where a minimum payment exceeds the available income of the responsible party or parties. Minimum charges under this section may also be set on a per unit basis (e.g. per hour, per day, etc.) provided the charges do not accumulate to exceed $25.00 per month or 3% of monthly income.

(13m) SPECIAL PAYMENT SCHEDULES. The department may establish special payment schedules, to be used in place of schedules determined according to sub. (12) or (13), for designated providers and types of services on a pilot basis for periods not to exceed 3 years. Special payment schedules shall be directed toward goals which include, but are not limited to, increasing revenue to expand or maintain service levels, improving administration of the fee system and assessing the impact of different fee approaches on service. Beyond the pilot period, the payment schedule for the designated type of service shall be established according to sub. (12) or (13) or any other applicable provision of law. Special payment schedules shall incorporate standards for income and may incorporate standards for assets. These standards may not be more stringent than the income and assets provisions of the Wisconsin medical assistance program described in ss. HSS 103.02 and 103.03. However, where income is less than the limit for medical assistance eligibility, the department may approve schedules where assets are not considered and payments for a month of service do not exceed 3% of the family's gross monthly income.

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

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

(b) When payment at the maximum monthly payment rate, as calculated in sub. (12) or (13), would create a documentable hardship on the family, (such as the forced sale of the family residence or cessation of an education program), a lower maximum monthly payment rate may be

authorized by the appropriate payment approval authority under the following provisions:

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

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

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

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

(15) EXTENDED PAYMENT PLANS. Agencies may work out an extended payment plan with any responsible party who indicates that payment at the monthly payment rate would place a burden on the responsible party's family. This payment plan has the effect of the responsible party paying a lesser monthly amount over a longer period of time but with the total expected amount to equal the full application of the monthly payment rate under s. HSS 1.02 (6). Authority to approve extended payment plans may be placed at whatever staff level the payment approval authority determines is appropriate.

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

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

1. Recipients of SSI.

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

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

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

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

(18) EXCEPTIONS. (a) Parental payment limits set according to sub. (21) shall be applied to the billings to parents for each child who receives care or services. When parents of a client are divorced or separated, the

total billed to both parents for the care of a child may not exceed the one billing limit used for the care or service received by the child. When a minor child and an adult from one family receive services, the parental payment limit shall not apply to billings for services to the adult. Parental payment limits shall be applied to care and services as follows:

1. For outpatient psychotherapy normally covered by health insurance and purchased or provided by county agencies, parents who provide full insurance information and necessary authorizations for billing all applicable insurance shall not be billed a total amount per child per month greater than the monthly parental payment limit per month for each child who receives service.

2. For other services normally covered by health insurance, parents who provide full insurance information and necessary authorizations for billing all applicable insurance shall not be billed more than the daily parental payment limit per day for each child who receives service.

3. For residential care not normally covered by health insurance, the following applies:

a. When a child is in care for less than 20 days in a calendar month, the parents shall not be billed more than the daily parental payment limit per day for that child's care.

b. When a child is in care for more than 20 days in a calendar month, the payment approval authority shall adopt an agency policy for parental payment limits according to either the daily or monthly limit. The limit chosen shall apply uniformly to all parents.

c. When the daily limit is used, agencies may prorate daily billings for all families served by the agency according to their ability to pay. Under this prorating approach, the billing shall be the lesser of the daily limit or the family's monthly payment amount determined by sub. (12) or (13) multiplied by 12 and divided by 365.

Note: Example. If the maximum monthly payment for the family is $80, the daily rate would be $2.63.

($80/month x 12 months/year ÷ 365 days/year = $2.63/day)

d. As an alternative to c., when the daily limit is used, agencies may bill all parents the daily limit for each day of care up to their monthly payment rate determined according to sub. (12) or (13).

4. For all other care and services, the parents shall not be billed more than the daily parental payment limit.

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

(c) When residential care is provided under ch. 48, Stats., and there is a support order under ch. 52 or 767, Stats., in existence before the ch. 48 disposition, the billing amount to parents for residential care shall not be less than the previously ordered amount attributable to the child client. This provision supercedes maximum billing limitations of subs. (12), (13) and (13m).

Note: Before October 1, 1984 this subsection included the following limits on the amount that parents were expected to pay each month for care or services provided or purchased for their minor children.

For outpatient psychotherapy purchased or provided by county agencies, the maximum billing rate to qualified parents for outpatient psychotherapy was $4.00 per day per child client for such care from September 1, 1977 through December 31, 1979. For care from January 1, 1980 through June 30, 1980, the maximum rate for this service was $120 per month per child client. From July 1, 1980 through June 30, 1983, the maximum rate was $152 per month per child client. Since July 1, 1983 the maximum was $183 per month per child client.

For all other services, the maximum billing rate for care from September 1, 1977 through June 30, 1980 was $4.00 per day per child client; from July 1, 1980 through June 30, 1983, $5.00 per day per child client; since July 1, 1983, $6.00 per day per child client. Since Janaury 1, 1981 county departments of social services were permitted to convert the daily amounts for residential care to average monthly amounts.

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

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

(a) Liability has been met or

(b) A waiver of remaining liability is obtained or

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

(21) PARENTAL PAYMENT LIMIT. The parental payment limits shall be determined as follows:

(a) The daily parental payment limit shall be $5.00 subject to adjustment by the department according to par. (b).

(b) The daily parental payment limit shall be adjusted upward or downward in direct proportion to the Consumer Price Index. The adjustment shall be rounded downward to the nearest whole dollar. The base date for computing the adjustments shall be date of the last published Consumer Price Index for Milwaukee in 1979. The base dollar amount shall be $5.00 per day. This adjustment shall be computed at the end of each calendar year and shall be effective the following July.

(c) The monthly parental payment limit shall be the daily limit multiplied by 365 with the product divided by 12.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (2) to (6), renum. (7) to (14) to be (8), (11), (12), (14), (17) to (20) respectively and am. (8), (11), (14), (17), (18) (b) and (20), r. and recr. (18) (a), cr. (7), (9), (10), (13), (15) and (16), Register, November, 1979, No. 287, eff. 1-1-80; emerg. am. (18) (a), eff. 7-1-80; am. (18) (a), Register, October, 1980, No. 298, eff. 11-1-80; r. and recr. (18) (a), cr. (18) (c) and (21), Register, December, 1980, No. 300, eff. 1-1-81; cr. (13m), Register, June, 1981, No. 306, eff. 7-1-81; am. (8), (10), (13), (13m), (14) (a), (15) and (18) (c), r. and recr. (11) (b) 4. and (12), r. (11) (b) 5., Register, September, 1984, No. 345, eff. 10-1-84.

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

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

(b) *Fee calculation.* Fees shall be determined in advance for each calendar year, except that divisions may determine fees in advance for each fiscal year. For purchased services, the contract rate and billable units to the purchaser should be identical to the fee and billable units to the responsible party(s), wherever possible. Fees shall be determined by dividing either the number of patient days projected by the year in question, or, if the facility or service provides less than 24 hour care, the number of hours of billable client service projected for the year in question, into allowable anticipated facility or service-related expenditures for the year in question. For purchased services not easily converted to time units and where the contract or agreement specifies purchase units other than time, fees shall be set using the contract unit.

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

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

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

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

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

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

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

Note: For board-operated facilities only.

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

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

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

Note: Form CD-143 may be ordered from:
Department of Health & Social Services
Forms Center P.O. Box 7850
Madison, Wisconsin 53707.

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

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

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

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

Group fee = Therapist fee ÷ 7

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

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

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

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

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

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

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

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

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

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

(e) *County departments of social services.* In special circumstances with approval of the department, county departments of social services may use a fee of $12 per hour for services delivered by professional staff and $8 per hour for services provided by paraprofessionals instead of establishing fees under sub. (1). The department may adjust these rates to reflect changes in the Milwaukee consumer price index for all items, published by the U.S. department of labor. The base time for these adjustments shall be November 1978 at which time the index was 199.0.

(f) *Other procedures.* With the approval of the department, fee approval authorities may use other fee-setting procedures for designated services or groups of services. The procedures shall follow these guidelines:

1. Only costs associated with the service may be considered;

2. Those costs must be included in the department's allowable cost policy established under s. 46.036, Stats.;

3. The procedures may set more restrictive requirements for the costs to be considered; and

4. The procedures shall result in a fee per unit of service.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (1) (intro.) and (a), renum. (1) (d) and (e) to be (1) (g) and (h), r. and recr. (1) (g), cr. (1) (d) to (f), Register, November, 1979, No. 287, eff. 1-1-80; am. (1) (d) (intro.) and (2) (e), cr. (2) (f), Register, September, 1984, No. 345, eff. 10-1-84.

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

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

Note: Form CD-142 may be obtained from:

Department of Health & Social Services
Bureau of Collections
P.O. Box 7853
Madison, Wisconsin 53707

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

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

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

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

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

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

(4) STATE BUREAU OF COLLECTIONS. Except where responsibility for collections is delegated under sub. (1) or (2), the bureau of collections of the department shall be responsible for the billing and collection function, unless otherwise specified by the secretary. The bureau of collections shall also provide collection services for individual delinquent, or otherwise referred, client accounts.

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

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

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

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

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

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

(7) FIRST BILLINGS TO RESPONSIBLE PARTIES WHO HAVE AN ABILITY TO PAY OR WHO HAVE NOT PROVIDED FULL FINANCIAL INFORMATION. Where it is anticipated third-parties will pay less than the full liability, the first billing to responsible parties shall be sent during the calendar month following the month in which services were provided, except where an agreement to delay billing exists. If a responsible party has not provided full financial information and the payment approval authority determines that it is unlikely that the responsible party is able to pay full uninsured liability, the payment approval authority may set an estimated payment amount which shall be adjusted retroactively after the responsible party has provided full financial information. A cover letter explaining the liability and arrangements for making payment shall accompany the first billing statement to the responsible person(s) billed.

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

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

(b) Any payments received during the billing period.

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

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

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

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

(a) The client.

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

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

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

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

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

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

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

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

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

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

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

1. Payment from any unearned income of the client.

2. Payment from any earned income of the client.

3. Payment from any excess assets of the client.

4. Payment from any other responsible party.

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

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

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

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

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

4. Recommend referral of the account for collection.

(bm) The payment approval authority shall determine the course of action for unclear cases. Actions taken shall be documented in the client's collection file.

(c) *Referral of accounts for collection.* Agencies shall refer accounts for collection when the accounts are considered delinquent as defined in par. (a) and when the agency's own collection unit has completed required follow-up procedures.

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

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

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

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

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

a. Statement of charges.

b. A summary of all correspondence and actions taken.

c. Information relating to ability to pay.

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

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

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; renum. (1) to be (1) (a), cr. (1) (b) to (e), renum. (2) to be (2) (a) and cr. (2) (b), renum. (5), (6) and (7) to be (6), (12) and (13), and am., cr. (5) and (7) to (11), Register, November, 1979, No. 287, eff. 1-1-80; am. (12) (b) and (e), Register, December, 1980, No. 300, eff. 1-1-81; correction in (2) (d) under s. 13.93 (2m) (b) 7, Stats., and in (3) under s. 13.93 (2m) (b) 4, Stats., Register, September, 1984; am. (4), (7) and (13) (c) (intro.), Register, September, 1984, No. 345, eff. 10-1-84.

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

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

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

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

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

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

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

1. The client.

2. The spouse of the client.

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

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

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

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

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

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

Such information shall include:

1. Dates of service contacts.

2. Times and duration of such contacts.

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

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

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

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

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

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

3. Copies of all invoices sent to responsible parties.

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

5. Copies of all correspondence.

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

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

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

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

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

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