CR 91-137

CERTIFICATE

STATE OF WISCONSIN )
) SS
DEPARTMENT OF HEALTH AND SOCIAL SERVICES)

I, Gerald Whitburn, Secretary of the Department of Health and Social Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to administration of the Office of Health Care Information were duly approved and adopted by this Department on February 20, 1992.

I further certify that this copy has been compared by me with the original on file in the Department and that this copy is a true copy of the original, and of the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 20th day of February, 1992.

SEAL:

Gerald Whitburn, Secretary
Department of Health and Social Services



4-1-92

**ORDER OF THE**
**DEPARTMENT OF HEALTH AND SOCIAL SERVICES**
**REPEALING, RENUMBERING, AMENDING,**
**REPEALING AND RECREATING, AND CREATING RULES**

To repeal HSS 120.01 (1) and (2), 120.13 (1), 120.23 and 120.27; to renumber HSS 120.01 (intro.), 120.03 (9m) to (19), 120.13 (2) and (3) and 120.24; to amend HSS 120.01, as renumbered, 120.02, 120.03 (24), as renumbered, 120.06 (3) (b), 120.07 (3) (c) 2 d, 120.08 (4), 120.09, 120.12 (1) and (2) (a), 120.13 (1), as renumbered and 120.23 (1) (intro.), as renumbered; to repeal and recreate HSS 120.07 (1), (2) and (3) (intro.), 120.22 and 120.25; and to create HSS 120.03 (10), (12), (13), (15), (16) and (18), 120.23 (2) to (5), 120.24, subch. IV (title) and 120.40, relating to the administration of the Office of Health Care Information.

Analysis Prepared by the Department of Health and Social Services

Chapter 153, Stats., established an Office of Health Care Information in the Department to collect and disseminate information about health care services in Wisconsin. Section 153.75, Stats., directs and authorizes the Department to promulgate rules for administration of the Office. Given the scope of ch. 153, Stats., the rules are being promulgated in phases. These are the phase 5 rules. All rules for administration of the Office are set out in ch. HSS 120.

The first set of rules, requiring the reporting of hospital inpatient discharge data as well as providing for the confidentiality of reported data, went into effect on February 1, 1989. The second set of rules, which became effective July 1, 1989, required hospitals to report revenue and expense data, per unit charges for each of several charge elements and the number of times a charge was made for each charge element in a 12-month period; report the actual and anticipated charges for uncompensated health care; and provide notice to the public of any rate increase before that increase takes place. The third set of rules, which went into effect April 1, 1990, identified the methods and criteria used to assess hospitals fees to pay for the operation of the Board and Office; required hospitals to use and insurers to accept a uniform patient billing form; and required hospitals to report additional inpatient data elements, outpatient surgical data, and asset, liability and fund balance data. The fourth set of rules, which became effective February 1, 1991, required freestanding ambulatory surgery centers to report data on surgical procedures; required hospitals to separately report two balance sheet items that had been previously included in another item; required hospitals to report an additional patient data element to be used in conjunction with the encrypted case identifier; allowed the Office to determine if it will require hospitals to submit per unit charges for each of several charge elements; and renamed a hospital rate increase a price increase and changed the threshold for publishing a notice of a price increase.

This fifth set of rules modifies the language used for the release of physician-identifiable data; reorganizes and consolidates the specifications for hospital financial reporting requirements so that they are consistent with recent industry-wide changes; modifies the language used for the collection of uncompensated health care data so that hospitals report on an accrual basis; requires that each hospital submit to the Office data requested by the Department for the American Hospital Association's Annual Survey of Hospitals; and allows the Office to collect historical profile and charge information from health care providers other than hospitals and freestanding ambulatory surgery centers.

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The Department's authority to repeal, renumber, amend, repeal and recreate and create these rules is found in ss. 153.05 (8), 153.45 (1) (b) and (3) and 153.75 (1) (a), (c), (f) and (j) and (2) (a) and (c), Stats. The rules interpret ch. 153, Stats.

SECTION 1. HSS 120.01 (intro.) is renumbered 120.01 and HSS 120.01, as renumbered, is amended to read:

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 ~~about :~~ .

SECTION 2. HSS 120.01 (1) and (2) are repealed.

SECTION 3. HSS 120.02 is amended to read:

HSS 120.02 APPLICABILITY. This chapter applies to all ~~hospitals and freestanding ambulatory surgery centers~~ health care providers in Wisconsin.

SECTION 4. HSS 120.03 (9m) to (19) are renumbered 120.03 (11), (14), (17) and (19) to (26).

SECTION 5. HSS 120.03 (10), (12), (13), (15), (16) and (18) are created to read:

HSS 120.03 (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.

(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.

(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.

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

SECTION 6. HSS 120.03 (24), as renumbered, is amended to read:

HSS 120.03 (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 ~~practitioner~~ professional or employer and is available to the general public. "Public use data" includes data on a magnetic tape, other medium or form.

SECTION 7. HSS 120.06 (3) (b) is amended to read:

HSS 120.06 (3) (b) A ~~hospital, a freestanding ambulatory surgery center or a physician, the agent of a hospital, a freestanding ambulatory surgery center or a physician,~~ health care provider, the agent of a health care provider or the department to ensure the accuracy of the information in the data base;

SECTION 8. HSS 120.07 (1), (2) and (3) (intro.) are repealed and recreated to read:

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 subs. (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):

SECTION 9. HSS 120.07 (3) (c) 2 d is amended to read:

HSS 120.07 (3) (c) 2 d The request is made by a ~~hospital or a freestanding ambulatory surgery center~~ health care provider for ~~its~~ the health care provider's own data.

SECTION 10. HSS 120.08 (4) is amended to read:

HSS 120.08 (4) Prior to the release of a subfile or special report ~~which contains data that identifies a physician~~ 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.

SECTION 11. HSS 120.09 is amended to read:

HSS 120.09 ADMINISTRATIVE AND TECHNICAL INFORMATION. The office shall conduct throughout the state a series of training sessions for ~~hospitals and other~~ data submitters to explain its policies and procedures and to provide assistance in implementing the requirements of ch. 153, Stats. and this chapter.

SECTION 12. HSS 120.12 (1) and (2) (a) are amended to read:

HSS 120.12 (1) DETERMINATION, NOTICE OF VIOLATION AND FORFEITURE ASSESSMENT. If the office determines that a ~~hospital or a freestanding ambulatory surgery center~~ 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) (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 ~~10 working~~ 30 calendar days after notification of the determination to both the office and the department's office of administrative 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 administrative 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.

SECTION 13. HSS 120.13 (1) is repealed.

SECTION 14. HSS 120.13 (2) and (3) are renumbered 120.13 (1) and (2) and HSS 120.13 (1), as renumbered, is amended to read:

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

SECTION 15. HSS 120.22 is repealed and recreated to read:

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 RESPONSIBILITY. (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.

SECTION 16. HSS 120.23 is repealed.

SECTION 17. HSS 120.24 is renumbered 120.23 (1), and HSS 120.23 (1) (intro.), as renumbered, is amended to read:

HSS 120.23 (1) (intro.) The charge elements listed in Table ~~120.24~~ 120.23 (1) shall be reported to the office ~~in accordance with s. HSS 120.25~~ if required under sub. (2).

SECTION 18. HSS 120.23 (2) to (5) are created to read:

HSS 120.23 (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 separately 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 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.

SECTION 19. HSS 120.24 is created to read:

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 limited 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 specialty; 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 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) 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.

SECTION 20. HSS 120.25 is repealed and recreated to read:

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.

SECTION 21. HSS 120.27 is repealed.

SECTION 22. Subchapter IV (title) of ch. HSS 120 is created to read:

Subchapter IV - Other Health Care Provider Reporting Requirements

SECTION 23. HSS 120.40 is created to read:

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 anesthetists or the council on recertification of nurse anesthetists;

(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 privileges, 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 usual 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 regulation 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 regulation 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 regulation 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.

The repeals and rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s. 227.22 (2), Stats.

Approved by the Board on Health Care Information

Date: February 20, 1992

By: Ronald H. Dix
Ronald H. Dix
Chairperson

Wisconsin Department of Health and Social Services

Date: February 20, 1992

By:
Gerald Whitburn
Secretary

Seal:

**Tommy G. Thompson**
Governor

**Gerald Whitburn**
Secretary

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# State of Wisconsin
# Department of Health and Social Services

February 20, 1992



Mr. Bruce E. Munson
Revisor of Statutes
119 Martin Luther King, Jr., Blvd.
Madison, WI 53703

Dear Mr. Munson:

As provided in s. 227.20, Stats., there is hereby submitted a certified copy of HSS 120, administrative rules relating to administration of the Office of Health Care Information.

These rules are also being submitted to the Secretary of State as required by s. 227.20, Stats.

Sincerely,

Gerald Whitburn
Secretary

Enclosure