CR 92-145

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 billing by health care providers and claims processing under the Medical Assistance program were duly approved and adopted by this Department on January 12, 1993.

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 12th day of January, 1993.

SEAL:

Gerald Whitburn, Secretary
Department of Health and Social Services



3-1-93

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

To repeal HSS 106.04(6), (7) and (8); to renumber HSS 106.04(1m)(d) and (9) and 106.075 to 106.10; to amend HSS 105.01(3)(d)3 and (e), 106.04(1m)(c)1, 107.02(2)(c) and (d), 107.13(4)(a)2 and 108.02(4); to repeal and recreate HSS 101.03(35), 106.02(9), 106.03(1) to (3) and (7) and 106.04(5); and to create HSS 101.03(96m), 105.01(3)(f), 106.02(11), 106.03(8), 106.04(1m)(d), 106.08, 106.12(1m), 106.13, 107.02(2)(e) to (j) and (3)(i), 107.13(4)(a)8 and 108.02(8) and (9), relating to health care provider claims for reimbursement, recordkeeping and administrative sanctions under the Medical Assistance (MA) program.

Analysis Prepared by the Department of Health and Social Services

A recent session law, 1991 Wisconsin Act 269, directed the Department to promulgate rules relating to health care provider claims for reimbursement from the Medical Assistance (MA) program for services provided to MA recipients. This rulemaking order modifies the current rules in several respects. The deadline for billing for MA services is changed from 12 months to 365 days after the date of service, with exceptions spelled out. Exceptions include an allowed 455 days for the fiscal agent's receipt of resubmitted or adjusted claims, and instances where a Department-initiated adjustment, a Medicare or other insurance payment, retroactive recipient eligibility, or a court order or hearing decision is involved.

Existing requirements for recordkeeping and claims documentation necessary for the provision of medically necessary services and for submitting accurate and complete claims for those services have been clarified. A definition of "medically necessary" has been added. The rules are made to state explicitly that services are reimbursable only when billing, documentation, and recordkeeping requirements are met and that meeting these documentation and recordkeeping requirements are also a condition of continued certification in the MA program.

Requirements for submitting claims, whether by paper or electronic media, have been rewritten to clarify the respective responsibilities of providers and the Department. Language has been added to make clear that the Department's approval of a prior authorization request does not relieve the provider of responsibility for complying with all federal and state statutes and regulations as well as instructions contained in provider handbooks and bulletins issued by the Department. An approved prior authorization is not a guarantee of payment. The relationship between prior authorization and payment has been clarified.

Consistent with standard auditing practices, language has been added to allow use of nationally-accepted sampling and extrapolation methodologies to determine amounts owed by the provider to the Department as the result of an investigation or audit. Additionally the procedures and time schedule for return of overpayments have been defined.

Language has been added to enable the Department to impose an intermediate sanction, in lieu of suspension or termination of certification, when a provider does not comply with program requirements. Also, consistent with federal regulations, the rules permit the Department to temporarily withhold payments from a provider suspected of fraud.

The Department's authority to approve an application for waiver or variance of a rule in chs. HSS 102, 103, 104, 105, 107 or 108 has been amended to clarify that a waiver or a variance must comply with state law and federal requirements. A waiver or variance will not be available to permit coverage of a non-covered or medically unnecessary service. The appeals process has also been clarified to protect providers and recipients from arbitrary and capricious acts of the Department.

Appeal rights are found at various places in the existing rules. This order clarifies the application of those rights. The language also better defines non-reimbursable covered services, and clarifies that recipients are not responsible for payment of non-reimbursable covered services.

Requirements for billing for services when the recipient has Medicare or other third party insurance are revised to conform to current practice and federal requirements. Conditions for coverage of day treatment services for mentally ill recipients are clarified.

The Department's authority to repeal, renumber, amend, repeal and recreate and create these rules is found in s. 49.45(10), Stats. The rules interpret s. 49.45(3), Stats.

SECTION 1. HSS 101.03(35) is repealed and recreated to read:

HSS 101.03(35) "Covered service" means a service, procedure, item or supplies for which MA reimbursement is available, provided to a recipient of MA by an MA-certified provider qualified to provide the particular service, procedure, item or supplies or under the supervision of a certified and qualified provider.

SECTION 2. HSS 101.03(96m) is created to read:

HSS 101.03(96m) "Medically necessary" means a medical assistance service under ch. HSS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

3. Is appropriate with regard to generally accepted standards of medical practice;

4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

5. Is of proven medical value or usefulness and, consistent with s. HSS 107.035, is not experimental in nature;

6. Is not duplicative with respect to other services being provided to the recipient;

7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

SECTION 3. HSS 105.01(3)(d)3 and (e) are amended to read:

HSS 105.01(3)(d)3. Whether any of the persons named in compliance with subd. 1 or 2 is related to another as spouse, parent, child or sibling; ~~and~~

(e) Execute a provider agreement with the department~~.~~; and

SECTION 4. HSS 105.01(3)(f) is created to read:

HSS 105.01(3)(f) 1. Accept and consent to the use, based on a methodology determined by the investigating or auditing agency, of statistical sampling and extrapolation as the means to determine amounts owed by the provider to MA as the result of an investigation or audit conducted by the department, the department of justice medicaid fraud control unit, the federal department of health and human services, the federal bureau of investigation, or an authorized agent of any of these.

2. The sampling and extrapolation methodologies, if any, used in the investigation or audit shall be generally consistent, as applicable, with the guidelines on audit sampling issued by the statistical sampling subcommittee of the american institute of certified public accountants. Extrapolation, when performed, shall apply to the same period of time upon which the sampling is derived.

3. The department and the other investigative agencies shall retain the right to use alternative means to determine, consistent with applicable and generally accepted auditing practices, amounts owed as the result of an investigation or audit.

4. Nothing in this paragraph shall be construed to limit the right of a provider to appeal a department recovery action brought under s. HSS 108.02(9).

SECTION 5. HSS 106.02(9) is repealed and recreated to read:

HSS 106.02(9) MEDICAL AND FINANCIAL RECORDKEEPING AND DOCUMENTATION. (a) Preparation and maintenance. A provider shall prepare and maintain truthful, accurate, complete, legible and concise documentation and medical and financial records specified under this subsection, s. HSS 105.02(6), the relevant provisions of s. HSS 105.02(7), other relevant sections in chs. HSS 105 and 106 and the relevant sections of ch. HSS 107 that relate to documentation and medical and financial recordkeeping for specific services rendered to a recipient by a certified provider. In addition to the documentation and recordkeeping requirements specified in pars. (b) to (d), the provider's documentation, unless otherwise specifically contained in the recipient's medical record, shall include:

1. The full name of the recipient;

2. The identity of the person who provided the service to the recipient;

3. An accurate, complete and legible description of each service provided;

4. The purpose of and need for the service;

5. The quantity, level and supply of service provided;

6. The date of service;

7. The place where the service was provided; and

8. The pertinent financial records.

(b) Medical record content. A provider shall include in a recipient's medical record the following written documentation, as applicable:

1. Date, department or office of the provider, as applicable, and provider name and profession;

2. Chief medical complaint or purpose of the service or services;

3. Clinical findings;

4. Diagnosis or medical impression;

5. Studies ordered, such as laboratory or x-ray studies;

6. Therapies or other treatments administered;

7. Disposition, recommendations and instructions given to the recipient, including any prescriptions and plans of care or treatment provided; and

8. Prescriptions, plans of care and any other treatment plans for the recipient received from any other provider.

(c) Financial records. A provider shall maintain the following financial records in written or electronic form:

1. Payroll ledgers, cancelled checks, bank deposit slips and any other accounting records prepared by the provider;

2. Billings to MA, medicare, a third party insurer or the recipient for all services provided to the recipient;

3. Evidence of the provider's usual and customary charges to recipients and to persons or payers who are not recipients;

4. The provider's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable;

5. Billing claims forms for either manual or electronic billing for all health services provided to the recipient;

6. Records showing all persons, corporations, partnerships and entities with an ownership or controlling interest in the provider, as defined in 42 CFR 455.101; and

7. Employe records for those persons currently employed by the provider or who have been employed by the provider at any time within the previous 5 years. Employe records shall include employe name, salary, job qualifications, position description, job title, dates of employment and the employe's current home address or the last known address of any former employe.

(d) Other documentation. 1. The provider shall maintain documentation of all information received or known by the provider of the recipient's eligibility for services under MA, medicare or any other health care plan, including but not limited to an indemnity health insurance plan, a health maintenance organization, a preferred provider organization, a health insuring organization or other third party payer of heath care.

2. The provider shall retain all evidence of claims for reimbursement, claim denials and adjustments, remittance advice, and settlement or demand billings resulting from claims submitted to MA, medicare or other health care plans.

3. The provider shall retain all evidence of prior authorization requests, cost reports and supplemental cost or medical information submitted to MA, medicare and other third party payers of health care, including the data, information and other documentation necessary to support the truthfulness, accuracy and completeness of the requests, reports and supplemental information.

(e) Provider responsibility. 1. Each provider is solely responsible for the truthfulness, accuracy, timeliness and completeness of claims, cost reports, prior authorization requests and any supplementary information relating to the provider's MA certification or reimbursement for services

submitted to MA or to medicare or any other third party payer for claims or requests for MA recipients, whether or not these claims, reports and requests are submitted on paper or in electronic form. This includes but is not limited to the truthfulness, accuracy, timeliness and completeness of the documentation necessary to support each claim, cost report and prior authorization request. The use or consent to use of a service, system or process for the preparation and submission of claims, cost reports or prior authorization requests, whether in electronic form or on paper, does not in any way relieve a provider from sole responsibility for the truthfulness, accuracy, timeliness and completeness of claims, cost reports, prior authorization requests and any supplementary information relating to the provider's MA certification and claims for reimbursement for services submitted to MA or to medicare or any other third party payer in the case of claims, reports or requests for MA recipients. The provider is responsible whether or not the provider is charged for the services, systems or processes and whether or not the department or its fiscal agent consents to the electronic preparation and submission of claims, cost reports, prior authorization requests and any supplementary information relating to the provider's MA certification and claims for reimbursement for services.

2. All records under pars. (a) to (d) shall be retained by a provider for a period of not less than 5 years, except that a rural health clinic provider shall retain the records for not less than 6 years. This period shall begin on the date on which the provider received payment from the program for the service to which the records relate. Termination of a provider's participation does not terminate the provider's responsibility to retain the records unless an alternative arrangement for record retention and maintenance has been established by the provider.

3. Providers are solely responsible for all costs associated with meeting the responsibilities under the provider agreement required under s. HSS 105.01(3)(e) and the preparation and submission of claims, whether in electronic form or on paper, to MA or to medicare or other third party payers in the case of claims for MA recipients, regardless of the means or source of the preparation and

submission. This includes but is not limited to claims preparation, acquisition or submission services and services which prepare, acquire or submit claims to payers, including but not limited to MA, on behalf of the provider, whether or not the provider or the provider's membership organization is charged for the preparation or submission of claims, and any other activity required under the provider agreement in accordance with s. HSS 105.01(3)(e).

4. At the request of a person authorized by the department and on presentation of that person's credentials, a provider shall permit access to any requested records, whether in written, electronic, or micrographic form. Access for purposes of this subsection shall include the opportunity to inspect, review, audit and reproduce the records.

5. Except as otherwise provided under a contract between the department and providers or pre-paid health plans, and except for records requested by the peer review organization under contract with the department, all costs of reproduction by a provider of records under this subsection shall be paid by the department at the per-page rate for record reproduction established by the department under s. HSS 108.02(4). Reproduction costs for records requested by the peer review organization shall be paid at the prevailing per-page rate for MA records established by that organization.

(f) Condition for reimbursement. Services covered under ch. HSS 107 are non-reimbursable under the MA program unless the documentation and medical recordkeeping requirements under this section are met.

(g) Supporting documentation. The department may refuse to pay claims and may recover previous payments made on claims where the provider fails or refuses to prepare and maintain records or permit authorized department personnel to have access to records required under s. HSS 105.02(6) or (7) and the relevant sections of chs. HSS 106 and 107 for purposes of disclosing, substantiating or otherwise auditing the provision, nature, scope, quality, appropriateness and necessity of services which are the subject of claims or for purposes of determining provider compliance with MA requirements.

SECTION 6. HSS 106.02(11) is created to read:

HSS 106.02(11) PROVISION OF NON-REIMBURSABLE COVERED SERVICES. A provider may not bill a recipient for covered services which are non-reimbursable under s. HSS 107.02(2).

SECTION 7. HSS 106.03(1) to (3) and (7) are repealed and recreated to read:

HSS 106.03 MANNER OF PREPARING AND SUBMITTING CLAIMS FOR REIMBURSEMENT. (1) FORMAT. (a) In this subsection, "billing service" means a provider or an entity under contract to a provider which provides electronic media billing or electronic billing transmission for one or more providers.

(b) A provider shall use claim forms prescribed or furnished by the department, except that a provider may submit claims by electronic media or electronic transmission if the provider or billing service is approved by the department for electronic claims submission. A billing service shall be approved in writing by the department based on the billing service's ability to consistently meet format and content specifications required for the applicable provider type. The department shall, upon request, provide a written format and the content specifications required for electronic media or electronic transmission billings and shall advise the provider or billing service of procedures required to obtain department approval of electronic billing.

(c) Upon the department's approval of the provider or the provider's billing service to submit claims through electronic media or electronic transmission billing, the provider shall sign an agreement to comply with the format, content and procedural requirements of the department.

(d) The department may at its discretion revoke its approval and rescind the agreement for electronic media or electronically transmitted claims submission at any time if the provider or billing service fails to fully comply with all of the department's instructions for submission of electronic media or electronically transmitted claims, or repeatedly submits duplicate, inaccurate or incomplete

claims. The department may at its discretion revoke its approval and rescind the agreement under par. (c) when the provider's claims repeatedly fail to provide correct and complete information necessary for timely and accurate claims processing and payment in accordance with billing instructions provided by the department or its fiscal agent.

(2) CONTENT. (a) In the preparation of claims, the provider shall use, as applicable, diagnosis, place of service, type of service, procedure codes and other information specified by the department under s. HSS 108.02(4) for identifying services billed on the claim. The department shall inform affected providers of the name and source of the designated diagnosis and procedure codes.

(b) Claims shall be submitted in accordance with the claims submission requirements, claim forms instructions and coding information provided by the department.

(c) Whether submitted directly by the provider, by the provider's billing service or by another agent of the provider, the truthfulness, completeness, timeliness and accuracy of any claim is the sole responsibility of the provider.

(d) Every claim submitted shall be signed by the provider or by the provider's authorized agent, certifying to the accuracy and completeness of the claim and that services billed on the claim are consistent with the requirements of chs. HSS 101 to 108 and the department's instructions issued under s. HSS 108.02(4). For claims submitted by electronic media or electronic transmission, the provider agreement under sub. (1)(c) substitutes for the signature required by this paragraph for each claims submission.

(3) TIMELINESS OF SUBMISSION. (a) A claim may not be submitted to MA until the recipient has received the service which is the subject of the claim and the requirements of sub. (7) have been met. A claim may not be submitted by a nursing home for a recipient who is a nursing home resident until the day following the last date of service in the month for which reimbursement is claimed. A claim may not be submitted by a hospital for a recipient who is a hospital inpatient until the day following the last date of service for which reimbursement is claimed.

(b) 1. To be considered for payment, a correct and complete claim or adjustment shall be received by the department's fiscal agent within 365 days after the date of the service except as provided in subd. 4 and par. (c). The department fiscal agent's response to any claim or adjustment received more than 365 days after the date of service shall constitute final department action with respect to payment of the claim or adjustment in question.

2. The provider is responsible for providing complete and timely follow-up to each claim submission to verify that correct and accurate payment was made, and to seek resolution of any disputed claims.

3. To ensure that submissions are correct and there is appropriate follow-up of all claims, providers shall follow the claims preparation and submission instructions in provider handbooks and bulletins issued by the department.

4. If a claim was originally denied or incorrectly paid because of an error on the recipient eligibility file, an incorrect HMO designation, an incorrect nursing home level of care authorization or nursing home patient liability amount, the department may pay a correct and complete claim or adjustment only if the original claim was received by the department's fiscal agent within 365 days after the date of service and the resubmission or adjustment is received by the department's fiscal agent within 455 days after the date of service.

5. If a provider contests the propriety of the amount of payment received from the department for services claimed, the provider shall notify the fiscal agent of its concerns, requesting reconsideration and payment adjustment. All submissions of claims payment adjustments shall be made within 365 days from the date of service, except as provided in subd. 4 and par. (c). The fiscal agent shall, within 45 days of receipt of the request, respond in writing and advise what, if any, payment adjustment will be made. The fiscal agent's response shall identify the basis for approval or denial of the payment adjustment requested by the provider. This action shall constitute final departmental action with respect to payment of the claim in question.

(c) The sole exceptions to the 365 day billing deadline are as follows:

1. If a claim was initially processed or paid and the department subsequently initiates an adjustment to increase a rate or payment or to correct an initial processing error of the department's fiscal agent, the department may pay a correct and complete claim or adjustment only if the provider submits a request for an adjustment or claim and that request or claim is received by the department's fiscal agent within 90 days after the adjustment initiated by the department;

2. a. If a claim for payment under medicare has been filed with medicare within 365 days after the date of service, the department may pay a claim relating to the same service only if a correct and complete claim is received by the fiscal agent within 90 days after the disposition of the medicare claim;

b. If medicare or private health insurance reconsiders its initial payment and requests recoupment of a previous payment, the department may pay a correct and complete request for an adjustment which is received within 90 days after the notice of recoupment;

3. If a claim for payment cannot be filed in a timely manner due to a delay in the determination of a recipient's retroactive eligibility under s. 49.46(1)(b), Stats., the department may pay a correct and complete claim only if the claim is received by the fiscal agent within 180 days after mailing of the backdated MA identification card to the recipient; and

4. The department may make a payment at any time in accordance with a court order or to carry out a hearing decision or department-initiated corrective action taken to resolve a dispute. To request payment the provider shall submit a correct and complete claim to the department's fiscal agent within 90 days after mailing of a notice by the department or the court of the court order, hearing decision or corrective action to the provider or recipient.

(7) MEDICARE AND OTHER HEALTH CARE PLANS. (a) In this subsection:

1. "Health care plan" means a plan or policy which provides coverage of health services, regardless of the nature and extent of coverage or reimbursement, including an indemnity health insurance plan, a health maintenance organization, a health insuring organization, a preferred provider organization or any other third party payer of health care.

2. "Properly seek payment" means taking the following actions:

a. When required by the payer as a condition for payment for the particular service, the provider shall request prior authorization or pre-certification from medicare or the other health care plan, except in the case of emergency services. This includes following the preparation and submission requirements of the payer and ensuring that the information provided to the payer is truthful, timely, complete and accurate. Prior authorization or pre-certification means a process and procedures established by medicare or the other health care plan which involve requiring the review or approval by the payer or its agent prior to the provision of a service in order for the service to be considered for payment;

b. The provider shall file a truthful, timely, complete and accurate claim or demand bill for the services which complies with the applicable claim preparation and submission requirements of medicare or the other health care plan. This includes providing necessary documentation and pertinent medical information when requested by medicare or the other health care plan as part of pre-payment or post-payment review performed by medicare or the other health care plan; and

c. In the case of prior authorization or pre-certification requests, claims or demand bills which are returned or rejected, in whole or in part, by the payer for non-compliance with preparation or submission requirements of medicare or the other health care plan, the provider shall promptly correct and properly resubmit the prior authorization or pre-certification request, claim or demand bill, as applicable to the payer.

(b) Before submitting a claim to MA for the same services, a provider shall properly seek payment for the services provided to an MA recipient from medicare or, except as provided in par. (g), another health care plan if the recipient is eligible for services under medicare or the other health care plan.

(c) When benefits from medicare, another health care plan or other third party payer have been paid or are expected to be paid, in whole or in part, to either the provider or the recipient, the provider shall accurately identify the amount of the benefit payment from medicare, other health care plan or other third party payer on or with the bill to MA, consistent with the department's claims preparation, claims submission, cost avoidance and post-payment recovery instructions under s. HSS 108.02(4). The amount of the medicare, health care plan or other third party payer reimbursement shall reduce the MA payment amount.

(d) If medicare or another health care plan makes payment to the recipient or to another person on behalf of the recipient, the provider may bill the payee for the amount of the benefit payment and may take any necessary legal action to collect the amount of the benefit payment from the payee, notwithstanding the provisions set forth in ss. HSS 104.01(12) and 106.04(3).

(e) The provider shall bill medicare or another health care plan for services provided to a recipient in accordance with the claims preparation, claims submission and prior authorization instructions issued by the department under s. HSS 108.02(4). The provider shall also comply with the instructions issued by the department under s. HSS 108.02(4) with respect to cost avoidance and post-payment recovery from medicare and other health care plans.

(f) If, after the provider properly seeks payment, medicare or another health care plan denies coverage for all or a portion of the service, the provider may submit a claim to MA for the unpaid service, except as provided in par. (k). The provider shall retain all evidence of claims for reimbursement, settlements and denials resulting from claims submitted to medicare and other health care plans.

(g) If eligibility for a health care plan other than medicare is indicated on the recipient's MA identification card and billing against that plan is not required by par. (e), the provider may bill either MA or the indicated health care plan, but not both, for the services provided, as follows:

1. If the provider elects to bill the health care plan, the provider shall properly seek payment from the health care plan. A claim may not be submitted to MA until the health care plan pays part of or denies the original claim or 45 days have elapsed with no response from the health care plan; and

2. If the provider elects to submit a claim to MA, no claim may be submitted to the health care plan.

(h) In the event a provider receives a payment first from MA and then from medicare, another health care plan or another third party payer for the same service, the provider shall, within 30 days after receipt of the second and any subsequent payment, refund to MA the MA payment or the payment from medicare, the health care plan or other third party, whichever is less.

(i) Before billing MA for services provided to any recipient who is also a medicare beneficiary, a medicare-certified provider shall accept medicare assignment and shall properly seek payment from medicare for services covered under the medicare program. In filing claims or demand bills with medicare, a provider shall adhere to the requirements for properly seeking payment as defined under par. (a)2 and to the instructions issued by the department under s. HSS 108.02(4) relating to claims preparation, claims submission, prior authorization, cost-avoidance, and post-payment recovery.

(j) If another health care plan, other than medicare, provides coverage for services provided for an MA recipient and the provider has the required billing information, including any applicable assignment of benefits, the provider shall properly seek payment from the health care plan, except as provided in par. (g), and receive a response from that plan prior to billing MA unless 45 days have elapsed with no response from the health care plan, after which the provider may bill MA. This requirement does not apply to a managed health care plan as defined in par. (k).

(k) A provider authorized to provide services to a recipient under a managed health care plan other than MA, who receives a referral for services from the recipient's managed health care plan or provides emergency services for a recipient in a managed health care plan, shall properly seek payment from that managed health care plan before billing MA. A provider who does not participate in a managed health care plan, other than MA, that provides coverage to the recipient but who provides services covered by the plan may not bill MA for the services. In this paragraph, "managed health care plan" means a health maintenance organization, preferred provider organization or similarly organized health care plan.

SECTION 8. HSS 106.03(8) is created to read:

HSS 106.03(8) PERSONAL INJURY AND WORKERS COMPENSATION CLAIMS. If a provider treats a recipient for injuries or illness sustained in an event for which liability may be contested or during the course of employment, the provider may elect to bill MA for services provided without regard to the possible liability of another party or the employer. The provider may alternatively elect to seek payment by joining in the recipient's personal injury claim or workers compensation claim, but in no event may the provider seek payment from both MA and a personal injury or workers compensation claim. Once a provider accepts the MA payment for services provided to the recipient, the provider shall not seek or accept payment from the recipient's personal injury or workers compensation claim.

SECTION 9. HSS 106.04(1m)(c)1 is amended to read:

HSS 106.04(1m)(c)1. The provider requests a manual partial payment and ~~signs a contract allowing for~~ is informed that the ~~automatic recoupment of~~ payment will be automatically recouped when the provider's claims are later processed through the automated claims processing system;

SECTION 10. HSS 106.04(lm)(d) is renumbered 106.04(lm)(e).

SECTION 11. HSS 106.04(lm)(d) is created to read:

HSS 106.04(lm)(d) Recoupment of manual partial payments. Manual partial payments shall be automatically recouped when the provider's claims are processed through the automated claims system.

SECTION 12. HSS 106.04(5) is repealed and recreated to read:

HSS 106.04(5) RETURN OF OVERPAYMENT. (a) Except as provided in par. (b), if a provider receives a payment under the MA program to which the provider is not entitled or in an amount greater than that to which the provider is entitled, the provider shall return to the department the amount of the overpayment, including but not limited to erroneous, excess, duplicative, and improper payments, regardless of cause, within 30 days after the date of the overpayment in the case of a duplicative payment from MA, medicare, or other health care payer and within 30 days after the date of discovery in the case of all other overpayments.

(b) In lieu of returning the overpayment, a provider may notify the department in writing within 30 days after the date of the overpayment or its discovery, as applicable, of the nature, source and amount of the overpayment and request that the overpayment be deducted from future amounts owed the provider by the MA program.

(c) The department shall honor the request under par. (b) if the provider is actively participating in the program, is not currently under investigation for fraud or MA program abuse, is not subject to an intermediate sanction under s. HSS 106.08, and is claiming and receiving MA reimbursement in

amounts sufficient to reasonably ensure full recovery of the overpayment within a limited period of time. Any limited recovery period shall be consistent with the applicable federally required time period for the department's repayment of the federal financial participation associated with the overpayment as stated in 42 CFR 433.300-322.

(d) If the department denies the provider's request under par. (b) to have the overpayment deducted from future amounts paid, the provider shall return to the department the full amount of the overpayment within 30 days after receipt of the department's written denial.

SECTION 13. HSS 106.04(6), (7) and (8) are repealed.

SECTION 14. HSS 106.04(9) is renumbered 106.04(6).

SECTION 15. HSS 106.075 to 106.10 are renumbered 106.09 to 106.12.

SECTION 16. HSS 106.08 is created to read:

HSS 106.08 INTERMEDIATE SANCTIONS (1) To enforce compliance with MA program requirements, the department may impose on a provider for a violation listed under sub. (2) one or more of the sanctions under sub. (3) unless the requirements of s. HSS 106.065 apply. Any sanction imposed by the department pursuant to this section may be appealed by the provider under s. HSS 106.12. Prior to imposing any alternative sanction under this section the department shall issue a written notice to the provider in accordance with s. HSS 106.12(3). Nothing in this chapter shall be construed to compel the department, through a fair hearing or otherwise, to impose an intermediate sanction in lieu of suspension or termination of certification, a different intermediate sanction, monetary recoveries, auditing, withholding of claims or pre-payment review, nor may

imposition of an intermediate sanction on a provider be construed to limit the department's authority under s. HSS 106.06, 106.065, 106.07, 106.10 or 106.11, under this section, or under the applicable provider agreement, concluded pursuant to s. 49.45(2)(a)9, Stats.

(2) The department may impose an intermediate sanction under sub. (3) for any of the following violations of this chapter:

(a) For conduct specified in s. HSS 106.06;

(b) For refusal to grant the department access to records under s. HSS 106.02(9)(e);

(c) For conduct resulting in repeated recoveries under s. HSS 108.02(9);

(d) For non-compliance with one or more certification requirement applicable to the type of provider under ch. HSS 105;

(e) For interference with recipient rights specified under ch. HSS 104; or

(f) For refusal or repeated failure to comply with one or more requirement specified under this chapter.

(3) The department may impose one or more of the following intermediate sanctions for a violation listed under sub. (2):

(a) Referral to the appropriate peer review organization, licensing authority or accreditation organization;

(b) Transfer to a provider agreement of limited duration which also may stipulate specific conditions of participation;

(c) Requiring prior authorization of some or all of the provider's services;

(d) Review of the provider's claims before payment;

(e) Restricting the provider's participation in the MA program;

(f) Requiring an independent audit of the provider's practices and records, with the findings and recommendations to be provided to the department;

(g) Requiring the provider to perform a self-audit following instructions provided by the department; and

(h) Requiring the provider, in a manner and time specified by the department, to correct deficiencies identified in a department audit, independent audit or department survey or inspection.

(4) In determining the appropriate sanction or sanctions to be applied to a non-compliant provider and the duration of the sanction or sanctions, the department shall consider:

(a) The seriousness and extent of the offense or offenses;

(b) History of prior offenses;

(c) Prior sanctions;

(d) Provider willingness and ability to comply with MA program requirements;

(e) Whether a lesser sanction will be sufficient to remedy the problem in a timely manner;

(f) Actions taken or recommended by peer review organizations, licensing authorities and accreditation organizations;

(g) Potential jeopardy to recipient health and safety and the relationship of the offense to patient care;

(h) Potential jeopardy to the rights of recipients under federal or state statutes or regulations.

SECTION 17. HSS 106.12(1m) is created to read:

HSS 106.12(1m) APPLICATION. The provisions of this section do not apply to either of the following:

(a) Hearings to contest recoveries by the department of overpayments to providers. Requests for hearings and hearings under these circumstances are governed exclusively by s. HSS 108.02 (9)(e); or

(b) Contests by providers of the propriety of the amount of payment received from the department, including contests of claim payment denials. The exclusive procedure for these contests is as provided in s. HSS 106.03(3)(b)5, except as may be provided under the terms of the applicable provider agreement, pursuant to s. 49.45(2)(a)9, Stats.

SECTION 18. HSS 106.13 is created to read:

HSS 106.13 DISCRETIONARY WAIVERS AND VARIANCES. A provider or recipient may apply for and the department shall consider applications for a discretionary waiver or variance of any rule in chs. HSS 102 to 105, 107 and 108, excluding ss. HSS 107.02 (1)(b), (2)(e) to (j) and (3)(a) and (b) and (d) to (h), 107.03 (1) to (8) and (10) to (18), and 107.035. Waivers and variances shall not be available to permit coverage of services that are either expressly identified as non-covered in ch. HSS 107 or are not expressly mentioned in ch. HSS 107. The following requirements and procedures apply to applications under this section:

(1) REQUIREMENTS FOR A DISCRETIONARY WAIVER OR VARIANCE. A discretionary waiver or variance may be granted only if the department finds all of the following are met:

(a) The waiver or variance will not adversely affect the health, safety or welfare of any recipient;

(b) Either:

1. Strict enforcement of a requirement would result in unreasonable hardship on the provider or on a recipient; or

2. An alternative to a rule, including a new concept, method, procedure or technique, new equipment, new personnel qualifications or the implementation of a pilot project is in the interests of better care or management;

(c) The waiver or variance is consistent with all applicable state and federal statutes and federal regulations;

(d) Consistent with the MA state plan with the federal health care financing administration and other applicable federal program requirements, federal financial participation is available for all services under the waiver or variance; and

(e) Services relating to the waiver or variance are medically necessary.

(2) APPLICATION FOR A DISCRETIONARY WAIVER OR VARIANCE. (a) A request for a waiver or variance may be made at any time. All applications for a discretionary waiver or variance shall be made in writing to the department, specifying the following:

1. The rule from which the waiver or variance is requested;

2. The time period for which the waiver or variance is requested;

3. If the request is for a variance, the specific alternative action which the provider proposes;

4. The reasons for the request; and

5. Justification that sub. (1) would be satisfied.

Note: Discretionary waiver or variance requests should be sent to the Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701.

(b) The department may require additional information from the provider or the recipient prior to acting on the request.

(c) The terms of a discretionary waiver or variance may be modified by the department at any time to ensure that the requirements of sub. (1) and the conditions or limitations established under this paragraph are met during the duration of the waiver or variance. The department may impose any conditions or limitations on the granting of a discretionary waiver or variance necessary to ensure that the requirements of sub. (1) are met during the duration of the waiver or variance or to ensure compliance with rules not waived or varied. The department may limit the duration of any discretionary waiver or variance.

(d) The department may revoke a discretionary waiver or variance at any time if it determines that the terms, conditions or limitations established under par. (c) or any of the requirements under sub. (1) are not met, if it determines that there is evidence of fraud or MA program abuse by the provider or recipient, or if any of the facts upon which the waiver or variance was originally based is no longer true. The department may also revoke a waiver or variance at any time upon request of the applicant. The department shall mail a written notice at least 10 days prior to the effective date of the revocation or modification to the provider or recipient who originally requested the waiver or variance.

(e) The denial, modification, limitation or revocation of a discretionary waiver or variance may be contested under s. HSS 106.12 or 104.01(5) by the provider or recipient who requested the discretionary waiver or variance, provided that the sole issue in any fair hearing under this paragraph is whether the department acted in an arbitrary and capricious manner or otherwise abused its discretion in denying, modifying, limiting or revoking a discretionary waiver or variance.

SECTION 19. HSS 107.02(2)(c) and (d) are amended to read:

HSS 107.02(2)(c) Non-emergency services provided by a person who is not a certified provider; ~~and~~

(d) Services provided to recipients who were not eligible on the date of the service, except as provided under a prepaid health plan or HMO~~.~~ ;

SECTION 20. HSS 107.02(2)(e) to (j) and (3)(i) are created to read:

HSS 107.02(2)(e) Services for which records or other documentation were not prepared or maintained, as required under s. HSS 106.02(9);

(f) Services provided by a provider who fails or refuses to prepare or maintain records or other documentation as required under s. HSS 106.02(9);

(g) Services provided by a provider who fails or refuses to provide access to records as required under s. HSS 106.02(9)(e)4;

(h) Services for which the provider failed to meet any or all of the requirements of s. HSS 106.03, including but not limited to the requirements regarding timely submission of claims;

(i) Services provided inconsistent with an intermediate sanction or sanctions imposed by the department under s. HSS 106.08; and

(j) Services provided by a provider who fails or refuses to meet and maintain any of the certification requirements under ch. HSS 105 applicable to that provider.

(3)(i) Significance of prior authorization approval. 1. Approval or modification by the department or its fiscal agent of a prior authorization request, including any subsequent amendments, extensions, renewals, or reconsideration requests:

a. Shall not relieve the provider of responsibility to meet all requirements of federal and state statutes and regulations, provider handbooks and provider bulletins;

b. Shall not constitute a guarantee or promise of payment, in whole or in part, with respect to any claim submitted under the prior authorization; and

c. Shall not be construed to constitute, in whole or in part, a discretionary waiver or variance under s. HSS 106.13.

2. Subject to the applicable terms of reimbursement issued by the department, covered services provided consistent with a prior authorization, as approved or modified by the department or its fiscal agent, are reimbursable provided:

a. The provider's approved or modified prior authorization request and supporting information, including all subsequent amendments, renewals, and reconsideration requests, is truthful and accurate;

b. The provider's approved or modified prior authorization request and supporting information, including all subsequent amendments, extensions, renewals, and reconsideration requests, completely and accurately reveals all facts pertinent to the recipient's case and to the review process and criteria provided under s. HSS 107.02(3);

c. The provider complies with all requirements of applicable state and federal statutes, the terms and conditions of the applicable provider agreement pursuant to s. 49.45(2)(a)9, Stats, all applicable requirements of chs. HSS 101 to 108, including but not limited to the requirements of ss. HSS 106.02, 106.03, 107.02, and 107.03, and all applicable prior authorization procedural instructions issued by the department under s. HSS 108.02(4);

d. The recipient is MA eligible on the date of service; and

e. The provider is MA certified and qualified to provide the service on the date of the service.

SECTION 21. HSS 107.13(4)(a)2 is amended to read:

HSS 107.13(4)(a)2. The supervising psychiatrist approves, signs, and dates a written treatment plan for each recipient and reviews and signs the plan no less frequently than once every 60 days. The treatment plan shall be based on the initial evaluation and shall include the individual goals, the treatment modalities including identification of the specific group or groups to be used to achieve these goals, and the expected outcome of treatment;

SECTION 22. HSS 107.13(4)(a)8 is created to read:

HSS 107.13(4)(a)8. The groups shall be led by a qualified professional staff member, as defined under s. HSS 105.24(1)(b)4a, and the staff member shall be physically present throughout the group sessions and shall perform or direct the service.

SECTION 23. HSS 108.02(4) is amended to read:

HSS 108.02(4) PROVIDER HANDBOOKS AND BULLETINS. The department shall publish provider handbooks, bulletins and other periodic updates to inform providers of changes in state or federal law, ~~interim~~ policy, reimbursement rates and formulas, departmental interpretation, and procedural directives such as billing and prior authorization procedures, specific reimbursement changes and items of general information. The department shall inform providers in a handbook, bulletin or other publication of specific services requiring collection of benefits from medicare or other health care plans under s. HSS 106.03(7) before benefits are claimed from the MA program. Information regarding eligibility for medicare or for another health care plan as identified on the recipient's MA identification card shall also be included in these publications.

SECTION 24. HSS 108.02(8) and (9) are created to read:

HSS 108.02(8) THIRD PARTY LIABILITY FOR COST OF SERVICES. (a) The department shall make reasonable efforts to identify any third party insurer, including medicare, legally liable to contribute in whole or in part to the cost of services provided to a recipient under the MA program.

(b) When the department has determined that medicare or any other health care plan provides health care coverage to the recipient which is primary to MA, as stated in s. 632.755(2), Stats., the medicare or other insurance coverage shall be identified on the recipient's MA identification card by specific codes.

(c) In the event payment for services otherwise covered by medicare or by another health care plan is unavailable, the provider may bill the department's MA fiscal agent, identifying the efforts to seek reimbursement from medicare or the other health care plan, on condition that the provider complies with the instructions issued by the department under sub. (4).

(9) DEPARTMENTAL RECOUPMENT OF OVERPAYMENTS. (a) Recoupment methods. If the department finds that a provider has received an overpayment, including but not limited to erroneous, excess, duplicative and improper payments regardless of cause, under the program, the department may recover the amount of the overpayment by any of the following methods, at its discretion:

1. Offsetting or making an appropriate adjustment against other amounts owed the provider for covered services;

2. Offsetting or crediting against amounts determined to be owed the provider for subsequent services provided under the program if:

a. The amount owed the provider at the time of the department's finding is insufficient to recover in whole the amount of the overpayment, and

b. The provider is claiming and receiving MA reimbursement in amounts sufficient to reasonably ensure full recovery of the overpayment within a reasonable period of time; or

3. Requiring the provider to pay directly to the department the amount of the overpayment.

(b) Written notice. No recovery by offset, adjustment or demand for payment may be made by the department under par. (a), except as provided under par. (c), unless the department gives the provider prior written notice of the department's intention to recover the amount determined to have been overpaid. The notice shall set forth the amount of the intended recovery, identify the claim or claims in question or other basis for recovery, summarize the basis for the department's finding that the provider has received amounts to which the provider is not entitled or in excess of that to which the provider is entitled, and inform the provider of a right to appeal the intended action under par. (e). Payment due the department shall be made by the provider within 30 days after the date of service of the notice of intent to recover. Final notices of intent to recover shall be sent by certified mail.

(c) Exception. The department need not provide prior written notice under par. (b) when the overpayment was made as a result of a computer processing or clerical error, for a recoupment of a manual partial payment, or when the provider requested or authorized the recovery to be made. In any of these cases the department or its fiscal agent shall provide written notice of any payment adjustments made on the next remittance issued the provider. This notice shall specify the amount of the adjustment made and the claim or claims which were the subject of the adjustments.

(d) Withholding of payment involving fraud or willful misrepresentation. 1. The department may withhold MA payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for withholding of payments involve fraud or willful misrepresentation under the MA program. Reliable evidence of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges for those activities against the provider or one of its agents or employees by a prosecuting attorney. The department may withhold payments without first notifying the provider of its intention to withhold the payments. A provider is entitled to a hearing under s. HSS 106.12.

2. The department shall send written notice to the provider of the department's withholding of MA program payments within 5 days after taking that action. The notice shall generally set forth the allegations leading to the withholding, but need not disclose any specific information concerning the ongoing investigation of allegations of fraud and willful misrepresentation. The notice shall:

a. State that payments are being withheld in accordance with this paragraph;

b. State that the withholding action is for a temporary period, as defined under subd. 3, and cite the circumstances under which withholding will be terminated;

c. Specify, when appropriate, to which type or types of MA claims withholding is effective; and

d. Inform the provider that the provider has a right to submit to the department written evidence regarding the allegations of fraud and willful misrepresentation for consideration by the department.

3. Withholding of the provider's payments shall be temporary. Withholding of payment may not continue after:

a. The department determines after a preliminary investigation that there is not sufficient evidence of fraud or willful misrepresentation by the provider to require referral of the matter to an appropriate law enforcement agency pursuant to 42 CFR 455.15 and, to the extent of the department's knowledge, the matter is not already the subject of an investigation or a prosecution by a law enforcement agency or a prosecuting authority;

b. Any law enforcement agency or prosecuting authority which has investigated or commenced prosecution of the matter determines that there is insufficient evidence of fraud or misrepresentation by the provider to pursue criminal charges or civil forfeitures; or

c. Legal proceedings relating to the provider's alleged fraud or willful misrepresentation are completed and charges against the provider have been dismissed. In the case of a conviction of a provider for criminal or civil forfeiture offenses, those proceedings shall not be regarded as being completed until all appeals are exhausted. In the case of an acquittal in or dismissal of criminal or civil forfeiture proceedings against a provider, the proceedings shall be regarded as complete at the time of dismissal or acquittal regardless of any opportunities for appeal which the prosecuting authority may have.

(e) Request for hearing on recovery action. If a provider chooses to contest the propriety of a proposed recovery under par. (a), the provider shall, within 20 days after receipt of the department's notice of intent to recover, request a hearing on the matter. The request shall be in writing and shall briefly identify the basis for contesting the proposed recovery. Receipt of a timely request for hearing shall prevent the department from making the proposed recovery while the hearing proceeding is pending. If a timely request for hearing is not received, the department may recover from current or future obligations of the program to the provider the amount specified in the notice of intent to recover and may take such other legal action as it deems appropriate to collect the amount specified.

All hearings on recovery actions by the department shall be held in accordance with the provisions of ch. 227, Stats. The date of service of a provider's request for a hearing shall be the date on which the department's office of administrative hearings receives the request.

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.

Wisconsin Department of Health and Social Services

Dated: January 12, 1993

By: _____
Gerald Whitburn
Secretary

SEAL:

**Tommy G. Thompson**
Governor

**Gerald Whitburn**
Secretary

Mailing Address
1 West Wilson Street
Post Office Box 7850
Madison, WI 53707-7850
Telephone (608) 266-9622

# State of Wisconsin
# Department of Health and Social Services

January 12, 1993



Mr. Bruce E. Munson
Revisor of Statutes
131 W. Wilson St.
Suite 800
Madison, WI 53703

Dear Mr. Munson:

As provided in s. 227.20, Stats., there is hereby submitted a certified copy of HSS 101 and 105 to 108, administrative rules relating to billing by health care providers and claims processing under the Medical Assistance program.

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

Sincerely,

Gerald Whitburn
Secretary

Enclosure