Chapter HSS 106

PROVIDER RIGHTS AND RESPONSIBILITIES

HSS 106.01 Introduction. In addition to provisions of chs. HSS 105 and 107 relating to individual provider types and the manner by which specified services are to be provided and paid for under medical assistance (MA), the participation of all providers certified under ch. HSS 105 to provide or claim reimbursement for services under the program shall be subject to the conditions set forth in this chapter.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 106.02 General requirements for provision of services. Providers shall comply with the following general conditions for participation as providers in the MA program:

(1) CERTIFICATION. A provider shall be certified under ch. HSS 105.

(2) COVERED SERVICES. A provider shall be reimbursed only for covered services specified in ch. HSS 107.

(3) RECIPIENT ELIGIBLE ON DATE OF SERVICE. A provider shall be reimbursed for a service only if the recipient of the service was eligible to receive MA benefits on the date the service was provided.

(4) COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS. A provider shall be reimbursed only if the provider complies with applicable state and federal procedural requirements relating to the delivery of the service.

(5) APPROPRIATE AND MEDICALLY NECESSARY SERVICES. A provider shall be reimbursed only for services that are appropriate and medically necessary for the condition of the recipient.

(6) PROVISION OF NON-COVERED SERVICES. If a provider determines that, to assure quality health care to a recipient, it is necessary to provide a non-covered service, nothing in this chapter shall preclude the provider from furnishing the service, if before rendering the service the provider advises the recipient that the service is not covered under the program and that, if provided, the recipient is responsible for payment.

(7) SERVICES TO RECIPIENTS WITH A PRIMARY PROVIDER. A provider other than the designated primary provider may not claim reimburse-

ment for a service to an individual whose freedom to choose a provider has been restricted under s. HSS 104.03 or 104.05 as indicated on the recipient's MA identification card unless the service was rendered pursuant to a written referral from the recipient's designated primary provider or the service was rendered in an emergency. If rendered in an emergency, the provider seeking reimbursement shall submit to the fiscal agent a written description of the nature of the emergency along with the service claim.

(8) REFUSAL TO PROVIDE MA SERVICES. A provider is not required to provide services to a recipient if the recipient refuses or fails to present a currently valid MA identification card. If a recipient fails, refuses or is unable to produce a currently valid identification card, the provider may contact the fiscal agent to confirm the current eligibility of the recipient. The department shall require its fiscal agent to install and maintain adequate toll-free telephone service to enable providers to verify the eligibility of recipients to receive benefits under the program.

(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 services;

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 health 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.

(10) NONDISCRIMINATION. Providers shall comply with the civil rights act of 1964, 42 USC 2000d et. seq., and s. 504 of the rehabilitation act of 1973, as amended. Accordingly, providers may not exclude, deny or refuse to provide health care services to recipients on the grounds of race, color, gender, age, national origin or handicap, nor may they discriminate in their employment practices.

(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).

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; am. Register, February, 1986, No. 362, eff. 3-1-86; emerg. r. and recr. (9), eff. 7-1-92; r. and recr. (9), cr. (11), Register, February, 1993, No. 446, eff. 3-1-93; correction made in (10) under s. 13.93 (2m) (b) 7, Stats., Register, June, 1994, No. 462.

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 are 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