Chapter HSS 106

MEDICAL ASSISTANCE: 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 reimbursement 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 indentification card, the provider may contact the fiscal agent to confirm the current eligiblility 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) RECORDS. (a) A provider shall prepare and maintain all records specified under s. HSS 105.02 (6) and the relevant paragraphs of s. HSS 105.02 (7) to fully disclose the nature and scope of services provided under the program.

(b) All records under par. (a) shall be retained by the provider for a period of not less than 5 years, or 6 years in the case of rural health clinics. This period shall commence 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 shall not terminate the provider's responsibility to retain the records unless an alternative arrangement for retention and maintenance has been established by the provider and approved by the department.

(c) The secretary of the department shall designate persons authorized to have access to, inspect, audit, review or reproduce the records required to be maintained under this subsection. These persons shall be issued credentials, including photographic identification, verifying the authorization.

(d) On request of an authorized person and on presentation of the authorized person's credentials, a provider shall permit access to the records requested. Access for purposes of this section shall include the opportunity to inspect, review, audit and reproduce the subject records. All costs of reproduction of records shall be borne by the department. The department may not use or disclose data or information relating to recipients and contained in a provider's records except for purposes directly related to the administration of the program.

(10) NONDISCRIMINATION. Providers shall comply with the civil rights act of 1964, 42 USC 1000d 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.

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

HSS 106.03 Manner of preparing and submitting claims for reimbursement. (1) FORMAT. A provider shall use claim forms prescribed and furnished by the department, except that a provider may use magnetic tape billing if the tape is prepared by a tape billing service approved by the department. In this section, "tape billing service" means a provider or an entity under contract to a provider which provides magnetic tape billing for one or more providers. A tape billing service shall be approved in writing by the department based on the tape billing service's ability to meet format and content specifications required for the applicable provider types. The department shall, upon request, provide a written format and content specifications required for magnetic tape billings and shall advise the provider or tape billing service of procedures required to obtain departmental approval of magnetic tape billing. The accuracy and completeness of tape billings shall be the sole responsibility of the provider.

(2) CONTENT. A provider shall make all reasonable attempts to ensure that the information contained on the provider's claim forms is complete and accurate. In the preparation of claims, providers shall use, where applicable, diagnosis and procedure codes specified by the department for identifying the services that are the subject of the claim. The department shall inform affected providers of the name and source of the designated diagnosis and procedure codes. Every claim submitted shall be signed by the provider or by the provider's authorized agent.

(3) TIMELINESS. A claim may not be submitted until the recipient has received the service which is the subject of the claim. A claim shall be submitted to the fiscal agent within 12 months of the date the service was provided. Payment may not be made for any claim submitted after that 12-month period, except where the provider demonstrates to the satisfaction of the department that circumstances beyond the provider's control prevented timely submission of the claim.

(4) HEALTH CARE SERVICES REQUIRING PRIOR AUTHORIZATION. No payment may be made on a claim for service requiring prior authorization if written prior authorization was not requested and received by the provider prior to the date of service delivery, except that claims that would ordinarily be rejected due to lack of the provider's timely receipt of prior authorization may be paid under the following circumstances:

(a) Where the provider's initial request for prior authorization was denied and the denial was either rescinded in writing by the department or overruled by an administrative or judicial order;

(b) Where the service requiring prior authorization was provided before the recipient became eligible, and the provider applies to and receives from the department retroactive authorization for the service; or

(c) Where time is of the essence in providing a service which requires prior authorization, and verbal authorization is obtained by the provider from the department's medical consultant or designee. To ensure payment on claims for verbally-authorized services, the provider shall retain records which show the time and date of the authorization and the identity of the individual who gave the authorization, and shall follow-up with a written authorization request form attaching documentation pertinent to the verbal authorization.

(5) PROVIDERS ELIGIBLE TO RECEIVE PAYMENT ON CLAIMS. (a) *Eligible providers.* Payment for a service shall be made directly to the provider furnishing the service or to the provider organization which provides or arranges for the availability of the service on a prepayment basis, except that payment may be made:

1. To the employer of an individual provider if the provider is required as a condition of employment to turn over fees derived from the service to the employer or to a facility; or

2. To a facility if a service was provided in a hospital, clinic or other facility, and there exists a contractual agreement between the individual provider and the facility, under which the facility prepares and submits the claim for reimbursement for the service provided by the individual provider.

(b) *Facility contracting with providers.* An employer or facility submitting claims for services provided by a provider in its employ or under contract as provided in par. (a) shall apply for and receive certification from the department to submit claims and receive payment on behalf of the provider performing the services. Any claim submitted by an employer or facility so authorized shall identify the provider number of the individual provider who actually provided the service or item that is the subject of the claim.

(c) *Prohibited payments.* No payment which under par. (a) (intro.) is made directly to an individual provider or provider organization may be made to anyone else under a reassignment or power of attorney except to an employer or facility under par. (a)1 or 2, but nothing in this paragraph shall be construed:

1. To prevent making the payment in accordance with an assignment from the person or institution providing the service if the service is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction; or

2. To preclude an agent of the provider from receiving any payment if the agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for services in connection with the billing or collection of payments due the person or institution under the program is unrelated, directly or indirectly, to the amount of payments or the claims for them, and is not dependent upon the actual collection of the payment.

(6) ASSIGNMENT OF MEDICARE PART B BENEFITS. A provider providing a covered service to a dual entitlee shall accept assignment of the recipient's part B medicare benefits if the service provided is, in whole or in part, reimbursable under medicare part B coverage. All services provided to dual entitlees which are reimbursable under medicare part B shall be billed to medicare. In this subsection, "dual entitlee" means an MA recipient who is also eligible to receive part B benefits under medicare.

(7) THIRD PARTY LIABILITY FOR COST OF SERVICES. (a) *Identification.* The department shall make reasonable efforts to identify third party resources legally liable to contribute in whole or in part to the cost of services provided a recipient under the program.

(b) *Availability of information.* If the department identifies a third-party insurer that provides health or accident coverage for a recipient, the insurance coverage shall be identified in a code on the recipient's MA card. The department shall prepare and distribute to providers code conversion information which indicates whether other insurance coverage is available, and instructions regarding procedures for third-party recovery including any exceptions to the billing standards set forth in pars. (c) to (e).

(c) *Collection from third-party insurer.* If the existence of a third party source of insurance is identified, a provider of any of the following services shall, before submitting an MA claim, seek to obtain payment from that third party for the service:

1. Services of physicians if surgery, surgical assistance, anesthesiology, or hospital visits to inpatients are included in the items billed;

2. All hospital services, whether inpatient or outpatient;

3. Services by all types of mental health providers, including but not limited to, counseling and chemical abuse treatment;

4. All therapy when rendered to hospital inpatients; and

5. If the recipient is covered by the civilian health and medical program of the uniformed services (CHAMPUS), all services except the following:

a. Periodic routine examinations and general physical examinations such as for school entry and EPSDT screening;

b. Vision care, except that surgical procedures and pin hole glasses shall be billed to CHAMPUS; and

c. Dental care, except that any service which is treatment of oral infection or removal of broken teeth shall be billed to CHAMPUS.

(d) *Denial from third-party insurer.* If the third party denies coverage for all or a portion of the cost of the service, the provider may then submit a claim to MA for the unpaid amount. The provider shall retain all evidence of claims for reimbursement, settlement or denials resulting from claims submitted to third-party payers of health care.

(e) *Provider's choice for billing.* If third-party coverage is indicated on the recipient's MA identification card and the third party billing is not required by par. (c) or as a medicare-covered service, the provider has the option of billing either MA or the indicated third party, but not both, for the services provided, as follows:

1. If the provider elects to bill the third party, a claim may not be submitted to MA until the third party pays part of or denies the original claim; and

2. If the provider elects to submit a claim to MA, no claim may be submitted to the third party.

(f) *Duplicate payment.* In the event a provider receives a payment from MA and from a third party for the same service, the provider shall,

within 30 days of receipt of the second payment, refund to MA the lesser of the MA payment or the third-party payment.

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

HSS 106.04 Payment of claims for reimbursement. (1) TIMELINESS. (a) *Timeliness of payment.* The department shall reimburse a provider for a properly provided covered service according to the provider payment schedule entitled "terms of provider reimbursement," found in the appropriate MA provider handbook distributed by the department. The department shall issue payment on claims for covered services, properly completed and submitted by the provider, in a timely manner. Payment shall be issued on at least 95% of these claims within 30 days of claim receipt, on at least 99% of these claims within 90 days of claim receipt, and on 100% of these claims within 180 days of receipt. The department may not consider the amount of the claim in processing claims under this subsection.

(b) *Exceptions.* The department may exceed claims payment limits under par. (a) for any of the following reasons:

1. If a claim for payment under medicare has been filed in a timely manner, the department may pay a MA claim relating to the same services within 6 months after the department or the provider receives notice of the disposition of the medicare claims;

2. The department may make payments at any time in accordance with a court order, or to carry out hearing decisions or department corrective actions taken to resolve a dispute; or

3. The department may issue payments in accordance with waiver provisions if it has obtained a waiver from the federal health care financing administration under 42 CFR 447.45 (e).

(2) COST SHARING. (a) *General policy.* Pursuant to s. 49.45 (18), Stats., the department shall establish copayment rates and deductible amounts for medical services covered under MA. Recipients shall provide the copayment amount or coinsurance to the provider or pay for medical services up to the deductible amount as appropriate. Providers are not entitled to reimbursement from MA for the copayment, coinsurance or deductible amounts for which a recipient is liable.

(b) *Exempted recipients and services.* Providers may not collect copayments, co-insurance or deductible amounts for the following recipients and services:

1. Recipients who are nursing home residents;

2. Recipients who are members of a health maintenance organization or other prepaid health plan for services provided by the HMO or PHP;

3. A service to any recipient who is under age 18;

4. Services furnished to pregnant women if the services relate to the pregnancy or to any medical condition which may complicate the pregnancy, when it can be determined from the claim submitted that the recipient was pregnant;

5. Emergency hospital and ambulance services and emergency services related to the relief of dental pain;

6. Family planning services and related supplies;

7. Transportation services by a specialized medical vehicle;

8. Transportation services provided through or paid for by a county social services department;

9. Home health services or nursing services if a home health agency is not available;

10. Laboratory and x-ray services prescribed by a physician; and

11. Physician office visits over 6 visits per recipient, per physician, per calendar year.

(c) *Limitation on copayments for prescription drugs.* Providers may not collect copayments in excess of $5 a month from a recipient for prescription drugs if the recipient uses one pharmacy or pharmacist as his or her sole provider of prescription drugs.

(d) *Limitation on copayments for outpatient psychotherapy.* Providers may not collect copayments from a recipient for outpatient psychotherapy services received over 15 hours or $500, whichever comes first, during one calendar year.

(e) *Limitation on copayments for occupational, physical and speech therapy.* Providers may not collect copayments from a recipient for occupational, physical or speech therapy services over 30 hours or $1,500 for any one therapy, whichever comes first, during one calendar year.

(f) *Liability for refunding erroneous copayment.* In the event that medical services are covered by a third party and the recipient makes a copayment to the provider, the department is not responsible for refunding the copayment amount to the recipient.

(3) NON-LIABILITY OF RECIPIENTS. A provider shall accept payments made by the department in accordance with sub. (1) as payment in full for services provided a recipient. A provider may not attempt to impose an unauthorized charge or receive payment from a recipient, relative or other person for services provided, or impose direct charges upon a recipient in lieu of obtaining payment under the program, except under any of the following conditions:

(a) A service desired, needed or requested by a recipient is not covered under the program or a prior authorization request is denied and the recipient is advised of this fact before receiving the service;

(b) An applicant is determined to be eligible retroactively under s. 49.46 (1) (b), Stats., and a provider has billed the applicant directly for services rendered during the retroactive period, in which case the provider shall, upon notification of the recipient's retroactive eligiblility, submit claims under this section for covered services provided during the retroactive period. Upon receipt of payment from the program for the services, the provider shall reimburse in full the recipient or other person who has made prior payment to the provider. A provider shall not be required to reimburse the recipient or other person in excess of the amount reimbursed by the program; or

(c) A recipient in a nursing home chooses a private room in the nursing home and the provisions of s. HSS 107.09 (3) (k) are met.

(4) RELEASE OF BILLING INFORMATION BY PROVIDERS. (a) *Restrictions.* A provider may not release information to a recipient or to a recipient's attorney relating to charges which have been billed or which will be billed to MA for the cost of care of a recipient without notifying the department, unless any real or potential third-party payer liability has been assigned to the provider.

(b) *Provider liability.* If a provider releases information relating to the cost of care of a recipient or beneficiary contrary to par. (a), and the recipient or beneficiary receives payment from a liable third-party payer, the provider shall repay to the department any MA benefit payment it has received for the charges in question. The provider may then assert a claim against the recipient or beneficiary for the amount of the MA benefit repaid to the department.

Note: See the Wisconsin Medical Assistance Provider Handbook for specific information on procedures to be followed in the release of billing information.

(5) RETURN OF OVERPAYMENT. If a provider receives a payment under the program to which the provider is not entitled or in an amount greater than that to which the provider is entitled, the provider shall promptly return to the department the amount of the erroneous or excess payment. In lieu of returning the overpayment, a provider may notify the department in writing of the nature, source and amount of the overpayment and request that the excess payment be deducted from future amounts owed the provider under the program. The department shall honor the request if the provider is actively participating in the program and is claiming and receiving reimbursement in amounts sufficient to allow recovery of the overpayment within a reasonable period of time, as agreed to by the department and the provider.

(6) REQUEST FOR CLAIM PAYMENT ADJUSTMENT. 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 requests for claims payment adjustment shall be made within 90 days from the date of payment on the original claim. 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.

(7) DEPARTMENTAL RECOUPMENT OF EXCESS PAYMENTS. (a) *Recoupment methods.* If the department finds that a provider has received payment under the program to which the provider is not entitled or in an amount greater than that to which the provider is entitled, the department may recover the amount of the improper or excess payment by any of the following methods:

1. By offset or appropriate adjustment against other amounts owed the provider for covered services;

2. If the amount owed the provider at the time of the department's finding is insufficient to recover in whole the amount of the improper or excessive payment, by offset or credit against amounts determined to be

owed the provider for subsequent services provided under the program; or

3. By requiring the provider to pay directly to the department the amount of the excess or erroneous payment.

(b) *Written notice.* No recovery by offset, adjustment, or demand for payments 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 its intent to recover the amount determined to have been erroneously or improperly paid. The notice shall set forth the amount of the intended recovery, shall identify the claim or claims in question or the basis for recovery, and shall 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 shall call to the provider's attention the right to appeal the intended action under par. (d).

(c) *Exception.* The department need not provide prior written notice under par. (b) when the payment was made as a result of a computer processing or clerical error or when the provider has requested or authorized the recovery to be made. In either 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) *Request for hearing on recovery action.* If the provider chooses to contest the propriety of a proposed recovery, the provider shall, within 20 days after receipt of the department's notice of intent to recover, request a hearing on the matter. Such a request shall be in writing and shall briefly identify the basis for contesting the proposed recovery. Receipt of a timely request for hearing shall preclude 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. All hearings on recovery actions by the department pursuant to s. 49.45 (2) (a)10, Stats., shall be in accordance with the provisions of ch. 227, Stats.

(e) *Request for hearing on payment adjustments.* If the provider contests the propriety of adjustments made under par. (c), the provider shall, within 30 days of receipt of the remittance, request in writing a hearing on the matter. This written request shall be accompanied by a copy of the remittance reflecting the adjustment and by a brief summary statement of the basis for contesting the adjustment. All hearings on contested adjustments shall be held in accordance with the provisions of ch. 227, Stats.

(8) SUPPORTING DOCUMENTATION. The department may refuse to make payment and may recover previous payments made on claims where the provider has failed or refused to prepare and maintain records or provide authorized department personnel access to records required under s. HSS 105.02 (6) or (7) for purposes of disclosing and substantiating the nature, scope and necessity of services which are the subject of the claims.

(9) GOOD FAITH PAYMENT. A claim denied for recipient eligibility reasons may qualify for a good faith payment if the service provided was provided in good faith to a recipient with an MA identification card which the provider saw on the date of service and which was apparently valid for the date of service.

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

HSS 106.05 Voluntary termination of program participation. (1) PROVIDERS OTHER THAN NURSING HOMES. (a) *Termination notice.* Any provider other than a skilled nursing facility or intermediate care facility may at any time terminate participation in the program. A provider electing to terminate program participation shall at least 30 days before the termination date notify the department in writing of that decision and of the effective date of termination from the program.

(b) *Reimbursement.* A provider may not claim reimbursement for services provided recipients on or after the effective date specified in the termination notice. If the provider's notice of termination fails to specify an effective date, the provider's certification to provide and claim reimbursement for services under the program shall be terminated on the date on which notice of termination is received by the department.

(2) SKILLED NURSING AND INTERMEDIATE CARE FACILITIES. (a) *Termination notice.* A provider certified under ch. HSS 105 as a skilled nursing facility or intermediate care facility may terminate participation in the program upon advance written notice to the department and to the facility's resident recipients or their legal guardians in accordance with s. 50.03 (14) (e), Stats. The notice shall specify the effective date of the facility's termination of program participation.

(b) *Reimbursement.* A skilled nursing facility or intermediate care facility electing to terminate program participation may claim and receive reimbursement for services for a period of not more than 30 days beginning on the effective termination date. Services furnished during the 30-day period shall be reimbursable provided that:

1. The recipient was not admitted to the facility after the date on which written notice of program termination was given the department; and

2. The facility demonstrates to the satisfaction of the department that it has made reasonable efforts to facilitate the orderly transfer of affected resident recipients to another appropriate facility.

(3) RECORD RETENTION. Voluntary termination of a provider's program participation under this section does not end the provider's responsibility to retain and provide access to records as required under s. HSS 106.02 (9) unless an alternative arrangement for retention, maintenance and access has been established by the provider and approved in writing by the department.

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

HSS 106.06 Involuntary termination or suspension from program participation. The department may suspend or terminate the certification of any person, partnership, corporation, association, agency, institution or other entity participating as a health care provider under the program, if

the suspension or termination will not deny recipients access to MA services and if after reasonable notice and opportunity for a hearing the department finds that:

(1) NON-COMPLIANCE WITH MA REQUIREMENTS. The provider has repeatedly and knowingly failed or refused to comply with federal or state statutes, rules or regulations applicable to the delivery of, or billing for, services under the program;

(2) REFUSAL TO COMPLY WITH PROVIDER AGREEMENT. The provider has repeatedly and knowingly failed or refused to comply with the terms and conditions of its provider agreement;

(3) IMPROPER ACTIVITIES. (a) The provider has prescribed, provided, or claimed reimbursement for services under the program which were:

1. Inappropriate;

2. Unnecessary or in excess of the recipient's needs;

3. Detrimental to the health and safety of the recipient; or

4. Of grossly inferior quality.

(b) Findings precipitating action by the department under this subsection shall be based on the written findings of a peer review committee established by the department or a PRO under contract to the department to review and evaluate health care services provided under the program. The findings shall be presumptive evidence that the provider has engaged in improper activities under this subsection.

(4) SUSPENSION OR REVOCATION. The licensure, certification, authorization or other official entitlement required as a prerequisite to the provider's certification to participate in the program has been suspended, restricted, terminated, expired or revoked;

(5) PUBLIC HEALTH IN JEOPARDY. A provider's licensure, certification, authorization or other official entitlement has been suspended, terminated, expired or revoked under state or federal law following a determination that the health, safety or welfare of the public is in jeopardy;

(6) MEDICARE SANCTIONS. (a) The provider is excluded or terminated from the medicare program or otherwise sanctioned by the medicare program because of fraud or abuse of the medicare program under 42 CFR 420.101 or 474.10.

(b) The provider is suspended from the medicare program for conviction of a medicare program-related crime under 42 CFR 420.122.

(c) The provider is a party convicted of a crime, ineligible to participate in the medicare program and the health care financing administration directs the department to suspend the provider;

(7) SERVICE DURING PERIOD OF NONCERTIFICATION. The provider has provided a service to a recipient during a period in which provider's licensure, certification, authorization, or other entitlement to provide the service was terminated, suspended, expired or revoked;

(8) CRIMINAL CONVICTION. The provider has been convicted of a criminal offense related to providing or claiming reimbursement for services under medicare or under this or any other state's MA program. In this

subsection, "convicted" means that a judgment of conviction has been entered by a federal, state or local court, irrespective of whether an appeal from that judgment is pending;

(9) FALSE STATEMENTS. The provider knowingly made or caused to be made a false statement or misrepresentation of material fact in connection with provider's application for certification or recertification;

(10) FAILURE TO REPORT STATUS CHANGE. The provider has concealed, failed or refused to disclose any material change in licensure, certification, authorization, or ownership which, if known to the department, would have precluded the provider from being certified;

(11) CONCEALMENT OF OUTSIDE CONTROLLING INTERESTS. The provider at the time of application for certification under ch. HSS 105 or after receiving that certification knowingly misrepresented, concealed or failed to disclose to the department full and complete information as to the identity of each person holding an ownership or controlling interest in the provider;

(12) CONCEALMENT OF PROVIDER'S CONTROLLING INTERESTS. The provider at the time of application for certification under ch. HSS 105 or after receiving that certification knowingly misrepresented, concealed or failed to disclose to the department an ownership or controlling interest the provider held in a corporation, partnership, sole proprietorship or other entity certified under the program;

(13) FALSE STATEMENTS CONCERNING THE NATURE AND SCOPE OF SERVICES. The provider made or caused to be made false statements or misrepresentation of material facts in records required under s. HSS 105.02 (4), (6), or (7) and maintained by the provider for purposes of identifying the nature and scope of services provided under the program;

(14) FALSE STATEMENTS CONCERNING THE COSTS OF SERVICES. The provider has knowingly made or caused to be made false statements or has misrepresented material facts in connection with the provider's usual and customary charges submitted to the department as a claim for reimbursement;

(15) FALSE STATEMENTS CONCERNING COST REPORTS. The provider has knowingly made or caused to be made false statements or misrepresentation of material facts in cost reports relating to the provider's costs, expenditures or usual and customary charges submitted to the department for the purpose of establishing reimbursement rates under the program;

(16) FAILURE TO KEEP RECORDS. The provider has failed or refused to prepare, maintain or make available for inspection, audit or copy by persons authorized by the department, records necessary to fully disclose the nature, scope and need of services provided recipients;

(17) FALSE STATEMENT ON CLAIM. The provider has knowingly made or caused to be made a false statement or misrepresentation of a material fact in a claim;

(18) OBSTRUCTION OF INVESTIGATION. The provider has intentionally by act of omission or commission obstructed an investigation or audit being conducted by authorized departmental personnel pursuant to s. 49.45 (3) (g), Stats.;

(19) PAYMENT FOR REFERRAL. The provider has offered or paid to another person, or solicited or received from another person, any remuneration in cash or in kind in consideration for a referral of a recipient for the purpose of procuring the opportunity to provide covered services to the recipient, payment for which may be made in whole or in part under the program;

(20) FAILURE TO REQUEST COPAYMENTS. The provider has failed to request from recipients the required copayment, deductible or coinsurance amount applicable to the service provided to recipients after having received a written statement from the department noting the provider's repeated failure to request required copayments, deductible or coinsurance amounts and indicating the intent to impose a sanction if the provider continues to fail to make these requests;

Note: See s. 49.45 (18), Stats., and s. HSS 106.04 (2) for requirements on copayments, deductibles and coinsurance amounts.

(21) CHARGING RECIPIENT. The provider has, in addition to claiming reimbursement for services provided a recipient, imposed a charge on the recipient for the services or has attempted to obtain payment from the recipient in lieu of claiming reimbursement through the program contrary to provisions of s. HSS 106.04 (3);

(22) RACIAL OR ETHNIC DISCRIMINATION. The provider has refused to provide or has denied services to recipients on the basis of the recipient's race, color or national origin in violation of the civil rights act of 1964, as amended, 42 USC 200d, et. seq., and the implementing regulations, 45 CFR Part 80;

(23) HANDICAPPED DISCRIMINATION. The provider has refused to provide or has denied services to a handicapped recipient solely on the basis of handicap, thereby violating s. 504 of the rehabilitation act of 1973, as amended, 29 USC 794;

(24) FUNDS MISMANAGEMENT. A provider providing skilled nursing or intermediate care services has failed to or has refused to establish and maintain an accounting system which ensures full and complete accounting of the personal funds of residents who are recipients, or has engaged in, caused, or condoned serious mismangement or misappropriation of the funds;

Note: See s. HSS 107.09 (3) (i) for requirements concerning accounting for the personal funds of nursing home residents.

(25) REFUSAL TO REPAY ERRONEOUS PAYMENTS. The provider has failed to repay or has refused to repay amounts that have been determined to be owed the department either under s. HSS 106.04 (7) or pursuant to a judgment of a court of competent jurisdiction, as a result of erroneous or improper payments made to the provider under the program;

(26) FAULTY SUBMISSION OF CLAIMS, FAILURE TO HEED MA BILLING STANDARDS, OR SUBMISSION OF INACCURATE BILLING INFORMATION. The provider has created substantial extraordinary processing costs by submitting MA claims for services that the provider knows, or should have known, are not reimbursable by MA, MA claims which fail to provide correct or complete information necessary for timely and accurate claims processing and payment in accordance with proper billing instructions published by the department or the fiscal agent, or MA claims which

include procedure codes or procedure descriptions that are inconsistent with the nature, level or amount of health care provided to the recipient, and, in addition, the provider has failed to reimburse the department for extraordinary processing costs attributable to these practices;

(27) REFUSAL TO PURGE CONTEMPT ORDER. The provider failed or refused to purge a contempt order issued under s. 885.12, Stats., as a result of the provider's refusal to obey a subpoena under s. 49.45 (3) (h)1, Stats.;

(28) OTHER TERMINATION REASONS. The provider, a person with management responsibility for the provider, an officer or person owning directly or indirectly 5% or more of the shares or other evidences of ownership of a corporate provider, a partner in a partnership which is a provider, or the owner of a sole proprietorship which is a provider, was:

(a) Terminated from participation in the program within the preceding 5 years;

(b) A person with management responsibility for a provider previously terminated under this section, or a person who was employed by a previously terminated provider at the time during which the act or acts occurred which served as the basis for the termination of the provider's program anticipation and knowingly caused, concealed, performed or condoned those acts;

(c) An officer of or person owning, either directly or indirectly, 5% of the stock or other evidences of ownership in a corporate provider previously terminated at the time during which the act or acts occurred which served as the basis for the termination;

(d) An owner of a sole proprietorship or a partner in a partnership that was terminated as a provider under this section, and the person was the owner or a partner at the time during which the act or acts occurred which served as the basis for the termination;

(e) Convicted of a criminal offense related to the provision of services or claiming of reimbursement for services under medicare or under this or any other state's medical assistance program. In this subsection "convicted" means that a judgment of conviction has been entered by a federal, state or local court, irrespective of whether an appeal from the judgment is pending; or

(f) Excluded, terminated, suspended or otherwise sanctioned by medicare or by this or any other state's medical assistance program;

(29) BILLING FOR SERVICES OF A NON-CERTIFIED PROVIDER. The provider submitted claims for services provided by an individual whose MA certification had been terminated or suspended, and the submitting provider had knowledge of the individual's termination or suspension; or

(30) BUSINESS TRANSFER LIABILITY. The provider has failed to comply with the requirements of s. 49.45 (21), Stats., regarding liability for repayment of overpayments in cases of business transfer.

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

HSS 106.07 Effects of suspension or involuntary termination. (1) LENGTH OF SUSPENSION OR INVOLUNTARY TERMINATION. In determining the per-

iod for which a party identified in this chapter is to be disqualified from participation in the program, the department shall consider the following factors:

(a) The number and nature of the program violations and other related offenses;

(b) The nature and extent of any adverse impact on recipients caused by the violations;

(c) The amount of any damages;

(d) Any mitigating circumstances; and

(e) Any other pertinent facts which have direct bearing on the nature and seriousness of the program violations or related offenses.

(2) MEDICARE OR OTHER STATE MEDICAL ASSISTANCE SANCTIONS. Notwithstanding any other provision in this chapter, a party identified in this chapter who is suspended, excluded or terminated under the medicare program or under the medical assistance program of another state shall be barred from participation as a provider during the term of the suspension, exclusion or termination.

(3) REFERRAL TO LICENSING AGENCIES. The secretary shall notify the appropriate state licensing agency of the suspension or termination by MA of any provider licensed by the agency and of the act or acts which served as the basis for the provider's suspension or termination.

(4) OTHER POSSIBLE SANCTIONS. In addition or as an alternative to the suspension or termination of a provider's certification, the secretary may impose any or all of the following sanctions against a provider who has been found to have engaged in the conduct described in s. HSS 106.06:

(a) Referral to the appropriate state regulatory agency;

(b) Referral to the appropriate peer review mechanism;

(c) Transfer to a provider agreement of limited duration not to exceed 12 months; or

(d) Transfer to a provider agreement which stipulates specific conditions of participation.

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

HSS 106.075 Departmental discretion to pursue monetary recovery. Nothing in this chapter shall preclude the department from pursuing monetary recovery from a provider at the same time action is initiated to impose sanctions provided for under this chapter.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86.

HSS 106.08 Withholding payment of claims. (1) WHEN TERMINATION ACTION IS INITIATED. When termination action is initiated against a provider by the department under s. HSS 106.06 (6), (8), (9), (13), (14), (15), (16), (17) or (25), the department may withhold issuance of payments on the provider's claims while proceedings are pending on the action, except that if a final administrative decision by the hearing officer has not been issued within 150 days of the initiation of the action and the delay has not been caused by the subject provider, payment may no

longer be withheld and shall be issued to the provider. If the final decision of the hearing officer approves the department action, payments that have been withheld under this subsection shall be permanently denied the provider.

(2) WITHHOLDING CLAIMS DURING SANCTION PERIOD. (a) Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association for any health care provided under MA, except for health care provided prior to the suspension or termination.

(b) No clinic, group, corporation or other association which is a provider of services may submit any claim for payment for any health care provided by an individual provider within that organization who has been suspended or terminated from participation in MA, except for health care provided prior to the suspension or termination.

(c) The department may recover any payments made in violation of this subsection. Knowing submission of these claims shall be a grounds for administrative sanctions against the submitting provider.

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

HSS 106.09 Pre-payment review of claims. (1) HEALTH CARE REVIEW COMMITTEES. The department shall establish committees of qualified health care professionals to evaluate and review the appropriateness, quality and quantity of services furnished recipients.

(2) REFERRAL OF ABERRANT PRACTICES. If the department has cause to suspect that a provider is prescribing or providing services which are not necessary for recipients, are in excess of the medical needs of recipients, or do not conform to applicable professional practice standards, the department shall, before issuing payment for the claims, refer the claims to the appropriate health care review committee established under sub. (1). The committee shall review and evaluate the medical necessity, appropriateness and propriety of the services for which payment is claimed. The decision to deny or issue the payment for the claims shall take into consideration the findings and recommendation of the committee.

(3) WITHDRAWAL OF REVIEW COMMITTEE MEMBERS FOR CONFLICT OF INTEREST. No individual member of a health care review committee established under sub. (1) may participate in a review and evaluation contemplated in sub. (2) if the individual has been directly involved in the treatment of recipients who are the subject of the claims under review or if the individual is financially or contractually related to the provider under review or if the individual is employed by the provider under review.

(4) PROVIDER NOTIFICATION OF PREPAYMENT REVIEW. A provider shall be notified by the department of the institution of the pre-payment review process under sub. (2). Payment shall be issued or denied, following review by a health care review committee, within 60 days of the date on which the claims were submitted to the fiscal agent by the provider.

(5) APPLICATION OF SANCTION. If a health care review committee established under sub. (1) finds that a provider has delivered services that are inappropriate or not medically necessary, the department may re-

quire the provider to request and receive from the department authorization prior to the delivery of any service under the program.

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

HSS 106.10 Procedure, pleadings and practice. (1) SCOPE. The provisions of this section shall govern the following administrative actions by the department:

(a) Decertification or suspension of a provider from the medical assistance program pursuant to s. 49.45 (2) (a) 12, Stats.;

(b) Imposition of additional sanctions for non-compliance with the terms of provider agreements under s. 49.45 (2) (a) 9, Stats., or certification criteria established under s. 49.45 (2) (a) 11, Stats., pursuant to s. 49.45 (2) (a) 13, Stats.; and

(c) Any action or inaction for which due process is otherwise required by law.

(2) DUE PROCESS. The department shall assure due process in implementing any action described in sub. (1) by providing written notice, a fair hearing and written decision pursuant to s. 49.45 (2) (a) 14, Stats., or as otherwise required by law. In addition to any provisions of this section, the procedures implementing a fair hearing and a written decision shall comply with the provisions of ch. 227, Stats.

(3) WRITTEN NOTICE. The department shall begin actions described under sub. (1) by serving upon the provider written notice of the intended action or written notice of the action. Notice of intended action described under sub. (1) (a) and (b) shall include the following:

(a) A brief and plain statement specifying the nature of and identifying the statute, regulation or rule giving the department the authority to initiate the action;

(b) A short and plain statement identifying the nature of the transactions, occurrences or events which served as the basis for initiating the action; and

(c) A statement advising the provider of the right to a hearing and the procedure for requesting a hearing.

(4) REQUEST FOR HEARING. A provider desiring to contest a departmental action or inaction under sub. (1) may request a hearing on any matter contested. The request shall be in writing and shall:

(a) Be served upon the department's office of administrative hearings unless otherwise directed by the secretary;

(b) For requests for hearings on actions or intended actions by the department, be served within 20 days of the date of service of the department's notice of intended action or notice of action;

(c) For requests for hearings on inactions by the department, be served within 60 days from the date the provider first became aware of, or should have become aware of with the exercise of reasonable diligence, the cause of the appeal;

(d) Contain a brief and plain statement identifying every matter or issue contested; and

(e) Contain a brief and plain statement of any new matter which the provider believes constitutes a defense or mitigating factor with respect to non-compliance alleged in the notice of action.

Note: Hearing requests should be sent to the Office of Administrative Hearings, P.O. Box 7875, Madison, WI 53707.

(5) PRIOR HEARING REQUIREMENT; EXCEPTION. (a) Except as provided in s. HSS 106.08 (1), if no request for hearing has been timely filed, no action described in sub. (1) (a) and (b) shall be taken by the department until 20 days after the notice of intended action has been served unless conditions under par. (b) are met. Except as provided in s. HSS 106.08 (1), if a request for a hearing has been timely filed, no action described in sub. (1) (a) and (b) shall be taken by the department until all provider appeal rights have become exhausted, unless conditions under par. (b) are met.

(b) Actions described under sub. (1) (a) and (b) may be taken against a provider without a prior hearing when the action is initiated on the basis of the department's finding that:

1. The health or safety of a recipient is in imminent danger as a result of the provider's failure to comply with applicable state or federal law relating to the provision of health care services;

2. The licensure, certification, authorization or other official entitlement required under state or federal law as a prerequisite to the provider's certification has been suspended, terminated or revoked; or

3. Federal financial participation is unavailable for payments issued to the provider because the provider has been excluded, terminated, suspended or otherwise sanctioned by medicare or by this or any other state's medical assistance program.

(c) Any action initiated under par. (b) which is based on findings described in par. (b) 2 or 3 may be retroactively enforced to coincide with the period for which federal financial participation is unavailable.

(6) FINAL DECISION. (a) If payment of claims to the provider is being withheld by the department under s. HSS 106.08 (1), a final decision shall be made by the department within 150 days of receipt of the hearing request.

(b) The hearing examiner's decision shall be the final decision of the department for contested actions under sub. (1) (a) and (b).

(7) EFFECT OF FAILURE TO APPEAR AT HEARING. (a) If the department fails to appear on the date set for a hearing on a contested action under sub. (1) (a) or (b), the hearing examiner may enter an order dismissing the department's action, pursuant to the motion of the provider or on its own motion.

(b) If the department fails to appear on the date set for a hearing on a contested action under sub. (1) (c), the hearing examiner may enter an order granting the relief sought by the provider upon due proof of facts which show the provider's entitlement to the relief.

(c) If the provider fails to appear on the date set for a hearing on a contested action under sub. (1) (a) or (b), the hearing examiner may enter an order dismissing the provider's appeal upon due proof of facts which show the department's entitlement to the remedy or relief sought in the action.

(d) If the provider fails to appear on the date set for a hearing on a contested action under sub. (1) (c) the hearing examiner may enter an order dismissing the provider's appeal, pursuant to the motion of the department or on its own motion.

(e) The department's office of administrative hearing may by order reopen a default arising from a failure of either party to appear on the date set for hearing. The order may be issued upon motion or petition duly made and good cause shown. The motion shall be made within 20 days after the date of the hearing examiner's default order.

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

HSS 106.11 Waivers and variances. The department shall consider applications for a waiver or variance of any rule in chs. HSS 101 to 108 provided that the following requirements and procedures are followed:

(a) *Requirements for a waiver or variance.* A waiver or variance may be granted if the department finds that the waiver or variance will not adversely affect the health, safety or welfare of any recipient and that:

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, procedures or technique, new equipment, new personnel qualifications or the implementation of a pilot project is in the interests of better care or management.

(b) *Application for a waiver or variance.* 1. A request for a waiver or variance may be made at any time. All applications for waiver or variance shall be made in writing to the department, specifying the following:

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

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

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

d. The reasons for the request; and

e. Justification that par. (a) would be satisfied.

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

2. The department may require additional information from the provider prior to acting on the request. If the department requires more information, the 90-day period under subd. 3 for department review and approval or denial of the request shall be extended by 60 days from receipt by the department of the additional information.

3. The department shall grant or deny each request for waiver or variance in writing. A notice of denial shall contain the reasons for denial. If a notice of denial is not issued within 90 days after the receipt of a complete request, the waiver or variance shall be automatically approved.

4. The terms of a requested variance may be modified upon written agreement between the department and a provider. The department may impose any conditions on the granting of a waiver or variance which it considers necessary. The department may limit the duration of any waiver or variance.

5. The department may revoke a waiver or variance if:

a. It is determined that the waiver or variance is adversely affecting the health, safety, or welfare of recipients;

b. The provider has failed to comply with the variance as granted;

c. The applicant notifies the department in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or

d. Revocation of the waiver or variance is required by a change in law.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86.