Chapter HSS 120

OFFICE OF HEALTH CARE INFORMATION

Subchapter I — General Provisions

HSS 120.01 Authority and purpose. This chapter is promulgated under the authority of s. 153.75, Stats., to implement ch. 153, Stats. Its purpose is to provide definitions and procedures to be used by the department to administer the office of health care information. The office is responsible for collecting, analyzing and disseminating information in language that is understandable to lay persons about hospital service utilization, charges, revenues, expenditures, mortality and morbidity rates, health care coverage and uncompensated health care services.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; am. Register, June, 1989, No. 402, eff. 7-1-89.

HSS 120.02 Applicability. This chapter applies to all hospitals in Wisconsin.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89.

HSS 120.03 Definitions. In this chapter:

(1) "Bad debts" means claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

(2) "Board" means the board on health care information established under s. 15.195 (6), Stats.

(3) "Calculated variable" means a data element that is computed or derived from an original data item or derived using another data source.

(4) "Charge element" means any service, supply or combination of services or supplies that is specified in the categories for payment under the charge revenue code for the uniform patient billing form.

(5) "Charity care" means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. "Charity care" does not include any of the following:

(a) Care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care;

(b) Contractual adjustments in the provision of health care services below normal billed charges;

(c) Differences between a hospital's charges and payments received for health care services provided to the hospital's employes, to public employes or to prisoners;

(d) Hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy; or

(e) Bad debts.

(6) "Contractor" means a person under contract to the office to collect, process, analyze or store data for the purposes of this chapter.

(7) "Contractual adjustment" means the difference between a hospital's normal charges for patient services and the discounted charge or payment received by the hospital from the payer.

(8) "Data element" means an item of information from a uniform patient billing form record.

(9) "Department" means the Wisconsin department of health and social services.

(10) "Hospital" has the meaning specified in s. HSS 124.02 (6).

(11) "Office" means the office of health care information.

(12) "Patient" has the meaning specified in s. 153.01 (7), Stats., namely, a person who receives health care services from a health care provider.

(13) "Payer" means a party responsible for payment of a hospital charge, including but not limited to, an insurer or a federal, state or local government.

(14) "Person" means any individual, partnership, association or corporation, the state or a political subdivision or agency of the state or of a local unit of government.

(15) "Physician" means a person licensed under ch. 448, Stats., to practice medicine or osteopathy.

(16) "Public program" means any program funded with government funds.

Note: Examples of public programs are general relief under s. 49.01 (5m), Stats., primary care under s. 146.93, Stats., medicare under 42 USC 1395 and 42 CFR subchapter B, medical assistance (medicaid) under ss. 49.43 to 49.497, Stats., and chs. HSS 101 to 108 and CHAMPUS under 10 USC 1071 to 1103.

(17) "Public use data" means data extracted from the office's comprehensive discharge data base that does not identify a specific patient, physician, individual health care practitioner or employer and is available to the general public. "Public use data" includes data on a magnetic tape, other medium or form.

(18) "Uncompensated health care services" means charity care and bad debts.

(19) "Uniform patient billing form" means, for hospital inpatient discharges, the uniform billing form UB-82/HCFA-1450 or, for hospital outpatient discharges, the health insurance claim form HCFA-1500 or the uniform billing form UB-82/HCFA 1450.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. (1) to be (1m), cr. (1), (2m), (2r), (3m), (10m) and (11m), Register, June, 1989, No. 402, eff. 7-1-89; renum. (1m) to (12) to be (2) to (13) and (15) to (19) and am. (19), cr. (14), Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.04 Assessments to fund the operations of the office and the board. (1) DEFINITION. In this section, "state fiscal year" means the 12-month period beginning July 1 and ending the following June 30.

(2) ESTIMATION OF EXPENDITURES. The office shall by October 1 of each year estimate the total expenditures for the office and the board for the current state fiscal year from which the office shall deduct the following:

(a) The estimated total amount of monies to be received by the office from user fees, gifts, grants, bequests, devises and federal funds for that state fiscal year; and

(b) The unencumbered balances of the total amount of monies received through assessments, user fees, gifts, grants, bequests, devises and federal funds from the prior state fiscal year.

(3) CALCULATION OF ASSESSMENTS. (a) The office shall annually assess hospitals, as a group, the net amount determined under sub. (2) in order to fund the operations of the office and the board at the expenditure level authorized in s. 20.435 (1) (hg), Stats., and to fulfill the requirements of ch. 153, Stats., and this chapter.

(b) The assessment for an individual hospital shall be based on the proportion of that hospital's gross private-pay patient revenue reported to the office for its most recently concluded entire fiscal year, which is that fiscal year ending 120 days prior to July 1 each year, compared to the total assessment for hospitals as a group.

(4) PAYMENT OF ASSESSMENTS. (a) *Payment deadline.* Each hospital shall pay the amount it has been assessed on or before December 31 each year. Payment of the assessment is on time if it is mailed in a properly addressed envelope, postmarked before midnight of December 31 of the year in which due, with postage prepaid, and is received by the office not more than 5 days after the prescribed date for making the payment. A payment which fails to satisfy these requirements solely because of a de-

lay or administrative error of the U.S. postal service shall be considered to be on time.

Note: Send all assessment fees to the Department of Health and Social Services, Division of Health, License Renewal, Drawer 296, Milwaukee, Wisconsin, 53293-0296. Make the check or money order payable to the Department of Health and Social Services.

(b) *Forfeitures.* If the assessment is not paid by December 31, the department shall directly assess a forfeiture of $25 for each day after December 31 that the assessment is not paid, subject to a maximum forfeiture equal to the amount of the assessment due or $500, whichever is greater. The department shall send a notice of the forfeiture assessed to the alleged violator and shall include a notice of the appeal process under s. HSS 120.12 (2). If the department determines pursuant to an appeal that the sole reason the payment was not timely was a delay or administrative error by the U.S. postal service, the department shall reimburse to the appellant any forfeiture paid.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.05 Uniform patient billing form. (1) USE. All hospitals in Wisconsin shall use the uniform patient billing form for all inpatient and outpatient care provided by them.

(2) ACCEPTANCE. All private-pay patients and payers who are insurers shall accept the uniform patient billing form as the only billing form for payment purposes. On an individual case basis, any private-pay patient or payer who is an insurer may request additional medical record or billing information from a hospital to justify payment of a bill.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.06 Patient confidentiality. (1) NONRELEASE OF PATIENT IDENTIFIABLE DATA. No data that identifies a patient may be released by the office, except as provided in sub. (3). The identification of a patient shall be protected by all necessary means, including the use of calculated or aggregated variables.

(2) RELEASE OF PATIENT IDENTIFIABLE DATA. A patient identifiable record obtained under ch. 153, Stats., and this chapter is not a public record under s. 19.35, Stats. The office may not release any data that would permit the identification of a patient, except as specified in sub. (3). Procedures to ensure the protection of patient confidentiality shall include the following:

(a) Requests for patient identifiable data shall be made in writing to the office. A request shall include the requester's name, address, reason for the request and supporting written evidence necessary to comply with sub. (3);

(b) Upon receiving a request for patient identifiable data, the office shall, as soon as practicable and without delay, either fill the request, as provided in sub. (3), or notify the requester in writing of the office's denial of the request in whole or in part and the reasons for the denial; and

(c) A record requester whose written request has been denied by the office may appeal the decision in accordance with procedures pursuant to ss. 19.31 to 19.39, Stats.

(3) ACCESS TO PATIENT IDENTIFIABLE DATA. Only the following may have access to patient identifiable data maintained by the office, in accordance with s. 153.50, Stats.:

(a) The patient or a person granted permission in writing by the patient for release of the patient's records;

(b) A hospital, a physician, the agent of a hospital or physician, or the department to ensure the accuracy of the information in the data base;

(c) The department for:

1. Epidemiological investigation purposes; or

2. Eliminating the need to maintain duplicative data bases; or

(d) Other entities that enter into a written agreement with the office, in accordance with the following conditions:

1. The entity shall have a statutory mandate for obtaining patient identifiable data for:

a. Epidemiological investigation purposes; or

b. Eliminating the need to maintain duplicative data bases, as stated under s. 153.45 (2), Stats.;

2. The office may review and approve specific requests by the entity for patient identifiable data to fulfill its statutory mandate. This review shall include the requester providing the office with written statutory evidence that the requester is entitled to have access to patient identifiable data from the office; and

3. The entity shall identify for the office any statutes that require it to uphold the patient confidentiality provisions specified in this section or stricter patient confidentiality provisions than those specified in this section. If these statutory requirements do not exist, the entity shall agree in writing to uphold the patient confidentiality provisions in this section.

Note: Examples of other entities include the centers for disease control of the U.S. public health service and cancer registries in other states.

(4) DATA ELEMENTS CONSIDERED CONFIDENTIAL. Data elements from the uniform patient billing form that identify a patient shall be considered confidential, except as stated in sub. (3). These elements are the following:

(a) Patient medical record or chart number;

(b) Patient control number;

(c) Patient date of birth;

(d) Date of admission;

(e) Date of discharge;

(f) Date of principal procedures; and

(g) Encrypted case identifier.

(5) AGGREGATION OF SMALL NUMBERS. (a) In this subsection, "small number" means any number that is not large enough to be statistically significant, as determined by the office.

(b) To ensure that the identity of patients is protected when information generated by the office is released, any data element category containing small numbers shall be aggregated using procedures developed by the office and approved by the board. The procedures shall follow commonly accepted statistical methodology.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.05, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.04 and am. (4) (e) and (f), cr. (4) (g), Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.07 Release of physician identifiable data. (1) PHYSICIAN CONFIDENTIALITY. Any information that identifies a physician may not be released as public use data. The identification of the physician shall be protected by all necessary means, including the use of calculated or aggregated variables.

(2) PATIENT CONFIDENTIALITY. Any information identifying a physician and which would permit the identification of specific patients shall be considered confidential and may not be released, except under s. HSS 120.06.

(3) RELEASE OF PHYSICIAN IDENTIFIABLE DATA. Except as stated in subs. (1) and (2), the office shall release data that identifies a physician to any person who requests the data, other than the reports specified in s. 153.25, Stats., under the following conditions:

(a) Requests for data that identifies a physician shall be made in writing to the office, indicating the physician's name or Wisconsin physician license number;

(b) The following procedures apply to persons requesting data who wish to re-release data that identifies a physician:

1. Except as stated in par. (c), prior to the release of data that identifies a physician, the office shall notify the physician of the request by 1st class mail using the last known address maintained by the Wisconsin department of regulation and licensing. The notification shall include a statement that the physician may submit written comments on the data to the office. If the physician's comments are received by the office not more than 30 calendar days from the date of the postmark on the notification from the office, the office shall release the requested data and the comments received to the requester. If the office receives the physician's comments after the data is released, the office shall make the comments available to anyone requesting them;

2. The review and comment period by the physician does not apply if a request is identical to a previous request and the office has at the time of release the physician's prior written comments on file. The office shall notify the physician about the request and shall release the physician's written comments to the requester with the requested data; and

3. Prior to the release of physician identifiable data to the requester, the requester shall sign an agreement stating that if the data is re-released by the requester, the physician's written comments shall be appended to it; or

(c) The following procedures apply to persons requesting data who do not wish to re-release data that identifies a physician:

1. The review and comment period by the physician, as stated in par. (b), does not apply provided that the requester executes a written agreement with the office assuring the office that the data will not be re-released; and

2. One of the following applies:

a. The request is made by the department to fulfill epidemiological investigation purposes or to eliminate the need to maintain duplicative data bases, as stated under s. 153.50, Stats.;

b. The request is accompanied by a signed and notarized statement from the physician or a person designated by the physician waiving the 30-calendar day comment period provided in par. (b);

c. The request is made by a payer for aggregated or nonidentifiable patient care data and the payer is responsible for paying the charges for that care; or

d. The request is made by a hospital for its own data.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.06, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.05 and am. (2), (3) (c) 2. b. and c., cr. (3) (c) 2. d., Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.08 Data dissemination. (1) The office shall prepare quarterly and annual reports as specified in ss. 153.10 to 153.35, Stats. The office shall make these reports available to the public at a charge which meets the cost of printing, copying and mailing a report to the requester.

(2) In addition to the reports under sub. (1), the office shall respond to requests by individuals, agencies of government and organizations in the private sector for public use data, data to fulfill statutory mandates for epidemiological purposes or to minimize the duplicate collection of similar data elements, and information that identifies a physician pursuant to s. HSS 120.07. The board shall designate the form in which the data for these requests shall be made available. The office shall charge the requester the total actual and necessary cost of producing the requested data.

(3) The office shall prepare special studies or analyses upon request. Prior to the release of any special studies or analyses conducted by the office pertaining to morbidity or mortality data in which a physician or hospital is identified, the office shall notify the identified physician or hospital of the request by 1st class mail using the last known address. The physician or hospital may submit written comments on the data to the office. If the physician's or hospital's comments are received by the office not more than 30 calendar days from the date of the postmark on the notification from the office, the office shall release the requested data and the comments received to the requester. If the office receives the physician's or hospital's comments after the data is released, the office shall make the comments available to anyone requesting them.

(4) Prior to the release of a subfile or special report which contains data that identifies a physician, the office shall include with the subfile or in-

sert in the special report a statement cautioning the user or reader about the meaning and significance of the data.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.07, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.06 and am. (2), Register, March, 1990, No. 411, eff. 4-1-90.

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

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.08, Register, June, 1989, No. 402, eff. 7-1-89.

HSS 120.10 Selection of a contractor. (1) DEFINITION. In this section, "major purchaser, payer or provider of health care services" means any of the following:

(a) A person, a trust, a multiple employer trust, a multiple employer welfare association, a third party administrator or a labor organization that purchases health benefits, which provides health care benefits or services for more than 500 of its full-time equivalent employes, or members in the case of a labor organization, either through an insurer or by means of a self-funded program of benefits;

(b) An insurer that writes accident and health insurance and is among the 20 leading insurers for either group or individual accident and health insurance, as specified in the market shares table of the most recent annual Wisconsin insurance report of the state commissioner of insurance. "Major purchaser, payer or provider of health care services" does not include an insurer that writes only disability income insurance;

(c) A trust, a multiple employer trust, a multiple employer welfare association or a third party administrator, including an insurer, that administers health benefits for more than 29,000 individuals; or

(d) A person that provides health care services and has 100 or more full-time equivalent employes.

(2) ELIGIBLE CONTRACTORS. (a) If the board decides under s. 153.05 (6), Stats., to designate a contractor for the provision of data processing services for the office, including the collection, analysis and dissemination of health care information, the contractor shall be a public or private organization that does not have a potential conflict with the purposes of the office as specified under s. 153.05 (1), Stats.

(b) A contractor may not be:

1. A major purchaser, payer or provider of health care services in Wisconsin, except as provided in par. (c);

2. A subcontractor of an organization in subd. 1;

3. A subsidiary or affiliate of an organization in subd. 1 in which a controlling interest is held and may be exercised by that organization either independently or in concert with any other organization in subd. 1; or

4. An association of major purchasers, payers or providers of health care services.

(c) The department is exempt from the requirement under par. (b) regarding eligibility to contract and may offer a bid if the board decides to bid the contract for services under s. 153.07 (2), Stats., and this section.

(3) CONFIDENTIALITY. The office may grant the contractor authority to examine confidential materials and perform other functions authorized by the office. The contractor shall comply with all confidentiality requirements established under this chapter. The release of confidential information by the contractor without the written consent of the office shall constitute grounds for the office to terminate any agreement between the contractor and the office.

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. HSS 120.08 and am. (1) (a) and (d), Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.09 Naming contractors. History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; Register, June, 1989, No. 402, eff. 7-1-89.

HSS 120.11 Penalties and forfeitures. (1) PENALTIES. (a) *Civil.* In accordance with s. 153.85, Stats., whoever violates the patient confidentiality provisions defined in s. HSS 120.06 shall be liable to the patient for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation.

(b) *Criminal.* In accordance with s. 153.90 (1), Stats., whoever intentionally violates s. HSS 120.06 may be fined not more than $10,000 or imprisoned for not more than 9 months or both.

(2) FORFEITURES. In accordance with s. 153.90 (2), Stats., whoever violates ch. 153, Stats. or this chapter, except for s. HSS 120.04 or 120.06, shall forfeit not more than $100 for each violation. Except as stated in s. 153.90 (2), Stats., each day of a violation constitutes a separate offense.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.11, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.09 and am. Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.12 Notice of violation and opportunity for appeal. (1) DETERMINATION, NOTICE OF VIOLATION AND FORFEITURE ASSESSMENT. If the office determines that a hospital has failed to submit the required information, failed to submit the information by the due date, failed to submit the information in the proper form or failed to submit corrected information, the department may directly assess forfeitures under s. 153.90 (2), Stats., and shall send a notice of the forfeiture assessment to the alleged violator. The notice shall specify the alleged violation of the statute or rule and the amount of the forfeiture assessed, shall explain how the forfeiture amount was calculated and shall include a notice of the appeal process under sub. (2).

(2) APPEAL PROCESS. (a) *Request for a hearing.* Whoever wishes to challenge a determination of the office that ch. 153, Stats. or this chapter has been violated may request a hearing as specified under s. 227.44, Stats. A written request for a hearing shall be submitted no later than 10 working days after notification of the determination to both the office and the department's office of adminstrative hearings. Hearing requests based on multiple violations shall be adjudicated within one hearing. A request for a hearing is considered submitted on the date that the office and the office of adminstrative hearings receive it. If it is not received by both offices on

the same date, the later of the 2 dates shall be used to determine if the request was filed on time.

Note: The request for a hearing should be submitted to the Director, Office of Health Care Information, P.O. Box 309, Madison, Wisconsin 53701-0309 and the Office of Administrative Hearings, P.O. Box 7875, Madison, Wisconsin 53707-7875.

(b) *Start of hearing process.* The department shall start the hearing process within 45 days after receiving a request unless all parties to a hearing consent to an extension of this period. The hearing process is considered started when a prehearing conference is held.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.12, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.095 and am. (1), Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.13 Communications addressed to the office. (1) ADDRESS. All written communications with the office required or permitted under this chapter shall be addressed to the director of the office.

(2) FORMAT. All written information or communications submitted on behalf of a hospital to the office shall be signed by the chief executive officer of the hospital or the designee of the chief executive officer.

(3) TIMING. Except as stated in ss. HSS 120.07 (3) (b) and 120.08 (3), all written communications, including documents, reports and information required to be submitted to the office shall be submitted by 1st class or registered mail or by delivery in person. The date of submission is the day the written communication is postmarked or delivered in person.

Note: Send all communications, except the actual payment of assessments under s. HSS 120.04 (3), to the Director, Office of Health Care Information, P.O. Box 309, Madison, Wisconsin 53701-0309, or deliver them to 1 West Wilson, Room 272, Madison, Wisconsin.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.10 and am. (2) and (3), Register, March, 1990, No. 411, eff. 4-1-90.

HSS120.14 Timing, format and review of fiscal data reports. History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; r. Register, March, 1990, No. 411, eff. 4-1-90.

Subchapter II — Hospital Reporting Requirements

HSS 120.20 Hospital responsibility to report inpatient data. (1) DATA ELEMENTS COLLECTED. (a) Each hospital shall report to the office information on all inpatient discharges from the hospital, using the data elements available on uniform patient billing forms. The data shall include the elements listed in Table 120.20.

TABLE 120.20
REQUIRED DATA ELEMENTS

DATA ELEMENT	UNIFORM PATIENT BILLING FORM ITEM
Patient control number, if applicable	3
Type of bill	4
Federal tax number of the hospital	6
Encrypted case identifier	10
Patient zip code	11
Patient date of birth	12
Patient sex	13
Date of admission	15
Type of admission	17
Source of admission	18
Patient status	21
Date of discharge	22
Race and ethnicity	27
Condition codes, if applicable	35 - 39
Patient medical record or chart number	45
Adjusted total charges and components of those charges	51 - 53
Primary and secondary sources of payments	57
Principal and other diagnoses	77 - 81
Principal and other procedures, if applicable	84 - 86
Date of principal procedure, if applicable	84 - 86
Attending physician license number	92
Other physician license number, if applicable	93

(b) Each hospital shall prepare for submission to the office an extract of the uniform patient billing form containing data elements specified in this subsection. The information reported on each extract shall include the following:

1. Individual data elements; and

2. Aggregations of revenue related data elements, except that hospitals are not required to report the total charges for a patient that had accumulated a hospital stay of more than 100 calendar days. The aggregations will be specified in a technical manual issued by the office.

(c) After collection of each full calendar year of data, the office shall analyze the completeness and accuracy of the reporting and usefulness of each data element. Based on this analysis, the office may recommend to the board for its approval changes in the rules to provide that:

1. Certain data elements not be collected in subsequent years due to significant problems in collecting these data elements;

2. Additional uniform patient billing form data elements be collected; or

3. New data elements defined by the office be added to the uniform patient billing form.

(2) SUBMISSION DATES. (a) Each hospital shall submit the data specified in sub. (1) for all inpatient discharges occurring on or after January 1, 1989.

(b) Data shall be submitted to the office on a quarterly basis. Calendar quarters shall begin on January 1 and end on March 31, begin on April 1 and end on June 30, begin on July 1 and end on September 30, and begin on October 1 and end on December 31. For discharges occurring in calendar year 1989, data for each calendar quarter shall be submitted to the office within 60 calendar days following the end of a calendar quarter. For discharges occurring in calendar year 1990 and in subsequent calendar years, the data shall be submitted within 45 calendar days following the end of a calendar quarter.

(c) An extension of the time limits specified under par. (b) may be granted by the office only when need for additional time is adequately justified by the hospital. Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension may be granted for up to 30 calendar days.

(3) ACCEPTABLE MEDIA FOR DATA SUBMISSION. (a) Except as provided in pars. (b) and (c), each hospital shall submit an extract of the uniform patient billing form information on a magnetic diskette or magnetic tape to the office. The office shall specify in a technical manual:

1. Physical specifications for the data submittal media; and

2. A recommended format for data submission.

(b) A hospital with fewer than 600 annual patient discharges, as determined by the department's most recently published hospital directory, may submit extracts on a paper form acceptable to the office for calendar years 1989 and 1990. If a hospital elects to submit data on an electronic medium, the hospital shall submit the data in accordance with par. (a).

(c) A hospital that does not meet either of the requirements specified in par. (b) may submit data on a paper form acceptable to the office if the hospital reimburses the office for all the actual and necessary costs of converting the data to an electronic medium with physical specifications and format acceptable to the office.

(d) Beginning with 1991 calendar year data, all hospitals shall submit information on electronic media with physical specifications, format and record layout prescribed in a technical manual issued by the office.

(e) Any group of 6 or more hospitals or any group of hospitals which in the aggregate have more than 30,000 patient discharges per year may request in writing a waiver from the office format, record layout or electronic data submission requirements under par. (a) or (d) if the hospitals have a common alternative electronic media, format and record layout for the required data.

(f) The office shall provide consultation to a hospital upon written request of the hospital to enable it to submit data according to office specifications.

(4) REVIEW OF DATA BY HOSPITALS PRIOR TO DATA SUBMISSION. As stated in s. 153.40, Stats., prior to submitting data to the office, a hospital shall review the data. The review shall consist of checks for accuracy and completeness which are designed by the office or designed by the hospital and approved by the office.

(5) VERIFICATION OF PATIENT MEDICAL RECORD DATA BY PHYSICIAN PRIOR TO DATA SUBMISSION. (a) The physician who maintains primary responsibility for determining a patient's continued need for acute care and readiness for discharge, even when this physician has referred the patient to one or more consulting physicians for specialized treatment, shall confirm the validity of a patient's principal and secondary diagnoses and the primary and secondary procedures specified in a patient's medical record within 30 calendar days after the patient is discharged from the hospital. The diagnoses and procedures shall be as defined in the uniform patient billing form manual. The physician shall use the procedures under par. (b) to fulfill this requirement.

(b) Hospitals, with their medical staffs, shall establish appropriate procedures and mechanisms to ensure verification by the physician. As stated in s. 153.40, Stats., if verification is not made on a timely basis for each calendar quarter, the hospital shall submit the data noting the lack of verification.

(6) REVIEW OF DATA BY OFFICE AND HOSPITALS AFTER DATA SUBMISSION. (a) The office shall check the accuracy and completeness of submitted data. All errors or probable errors shall be recorded on paper for each patient discharge. Acceptable data submissions shall be integrated into the case level data base. Unacceptable data or tapes shall be returned to the hospital with a paper copy of the information for revision and resubmission.

(b) All data revisions required as a result of the checks performed shall be corrected and resubmitted to the office within 10 working days after a hospital's receipt of the unacceptable data.

(c) Patient records data resubmitted by hospitals shall be grouped with the appropriate amendments or additions. Additional patient records data from the same calendar quarter as the revised data may be submitted with the revised data.

(d) After receipt of data revisions and additional records, the office shall aggregate each hospital's data and shall send a written copy to the hospital. Each hospital shall review the aggregated data for accuracy and completeness and shall supply to the office within 10 working days after receipt of the data any corrections or additions to the data at the patient discharge level.

(e) Within the same 10-working day period under par. (d), the chief executive officer or designee of each hospital shall submit to the office a statement, subscribed under oath or affirmation before a notary public, affirming that the data submitted to the office have been verified pursuant to subs. (4) and (5); that any corrections to the data have been verified pursuant to pars. (a) to (d); and that the data are accurate and complete to the best of his or her knowledge.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; renum. from HSS 120.04, Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.11 and am. (1) (a), Table, (3) (b) and (6) (d) and (e), Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.21 Hospital responsibility to report outpatient surgical data. (1) REPORTING RESPONSIBILITY. Each hospital shall report to the office information on specific outpatient discharges from a hospital outpatient department or a hospital-affiliated ambulatory surgical center as described in 42 CFR 416.120. The office, upon recommendation by the board, shall determine which outpatient discharges are to be reported by annually specifying in a technical manual a list of surgical procedures for which information is to be collected.

(2) DATA ELEMENTS COLLECTED. (a) For each outpatient discharged from a hospital where the outpatient received a surgical procedure listed in the technical manual, the hospital shall report information using the data elements available on the uniform patient billing form. The following data elements shall be reported:

1. Patient control number, if applicable;

2. Type of bill;

3. Federal tax number of the hospital;

4. Encrypted case identifier;

5. Patient zip code;

6. Patient date of birth;

7. Patient sex;

8. Date of admission;

9. Type of admission;

10. Source of admission;

11. Patient status;

12. Date of discharge;

13. Condition codes, if applicable;

14. Race and ethnicity;

15. Patient medical record or chart number;

16. Adjusted total charges;

17. Primary and secondary sources of payment;

18. Principal and other diagnoses;

19. Principal and other procedures;

20. Date of principal procedure;

21. Attending physician license number; and

22. Other physician license number, if applicable.

(b) Each hospital shall prepare for submission to the office an extract of the uniform patient billing form containing data elements specified in this subsection. The information to be reported on each data element shall be specified in a technical manual issued by the office.

(c) After collection of each full calendar year of data, the office shall analyze the completeness and accuracy of the reporting and usefulness of each data element. Based on this analysis, the office may recommend to the board for its approval changes in the rules to provide that:

1. Certain data elements not be collected in subsequent years due to significant problems in collecting these data elements;

2. Additional uniform patient billing form data elements be collected; or

3. New data elements defined by the office be added to the uniform patient billing form.

(3) SUBMISSION DATES. (a) Each hospital shall submit the data specified in sub. (2) for all specified outpatient discharges occurring on or after July 1, 1990.

(b) Outpatient surgical data shall be submitted to the office on a quarterly basis. Calendar quarters shall begin on January 1 and end on March 31, begin on April 1 and end on June 30, begin on July 1 and end on September 30, and begin on October 1 and end on December 31. For discharges occurring in calendar year 1990, data for each calendar quarter shall be submitted to the office within 60 calendar days following the end of a calendar quarter. For discharges occurring in calendar year 1991 and in subsequent calendar years, the data shall be submitted within 45 calendar days following the end of a calendar quarter.

(c) An extension of the time limits specified under par. (b) may be granted by the office only when need for additional time is adequately justified by the hospital. Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension may be granted for up to 30 calendar days.

(4) ACCEPTABLE MEDIA FOR DATA SUBMISSION. (a) Except as provided in pars. (b) and (c), each hospital shall submit an extract of the uniform patient billing form data on a magnetic diskette or magnetic tape to the office. The office shall specify in a technical manual:

1. Physical specifications for the data submittal media; and

2. A recommended format for data submission.

(b) A hospital that qualifies for submitting its inpatient discharge data on paper under s. HSS 120.20 (3) (b) shall qualify for paper submittal of its outpatient surgical data for calendar years 1990 and 1991.

(c) A hospital that does not meet the requirement in par. (b) may submit outpatient surgical data on a paper form acceptable to the office if the hospital reimburses the office for all the actual and necessary costs of converting the data to an electronic medium with physical specifications and format acceptable to the office.

(d) Beginning with 1992 calendar year data, all hospitals shall submit outpatient surgical data on electronic media with physical specifications, format and record layout prescribed in a technical manual issued by the office.

(e) Any group of hospitals that qualify for a waiver by the office for submitting its inpatient discharge data under s. HSS 120.20 (3) (e) shall qualify for a waiver by the office for submission of its outpatient surgical data.

(f) The office shall provide consultation to a hospital upon written request of the hospital to enable it to submit outpatient surgical data according to office specifications.

(5) REVIEW OF OUTPATIENT SURGICAL DATA BY HOSPITALS PRIOR TO DATA SUBMISSION. As provided under s. 153.40, Stats., prior to submitting outpatient surgical data to the office, a hospital shall review the data. The review shall consist of checks for accuracy and completeness which are designed by the office or designed by the hospital and approved by the office.

(6) VERIFICATION OF OUTPATIENT SURGICAL RECORD DATA BY PHYSICIAN PRIOR TO DATA SUBMISSION. (a) The surgeon performing the principal procedure shall confirm the validity of the outpatient's principal and secondary diagnoses and the primary and secondary surgical procedures specified in the patient's medical record within a calendar month after the patient is discharged from the hospital. The diagnoses and procedures shall be as defined in the uniform patient billing form manual. The physician shall use the procedures under par. (b) to fulfill this requirement.

(b) A hospital, with its medical staff, shall establish appropriate procedures and mechanisms to ensure verification by a physician. As provided under s. 153.40, Stats., if verification is not made on a timely basis for each calendar quarter, the hospital shall submit the outpatient surgical data noting the lack of verification by the physician.

(7) REVIEW OF OUTPATIENT SURGICAL DATA BY THE OFFICE AND HOSPITALS AFTER DATA SUBMISSION. (a) The office shall check the accuracy and completeness of submitted outpatient surgical data. All errors or probable errors shall be recorded on paper for each outpatient discharge. Acceptable data submissions shall be integrated into the case level data base. Unacceptable data or tapes shall be returned to the hospital with a paper copy of the information for revision and resubmission.

(b) All data revisions required as a result of the checks performed shall be corrected and resubmitted to the office within 10 working days after a hospital's receipt of the unacceptable data.

(c) Outpatient records data resubmitted by hospitals shall be grouped with the appropriate amendments or additions. Additional outpatient records data from the same calendar quarter as the revised data may be submitted with the revised data.

(d) After receipt of data revisions and additional records, the office shall aggregate each hospital's data and shall send a written copy to the hospital. Each hospital shall review the aggregated data for accuracy and completeness and shall supply to the office within 10 working days after receipt of the data any corrections or additions to the data at the patient discharge level.

(e) Within the same 10-working day period under par. (d), the chief executive officer or designee of each hospital shall submit to the office a statement, subscribed under oath or affirmation before a notary public,

affirming that the data submitted to the office have been verified pursuant to subs. (5) and (6); that any corrections to the data have been verified pursuant to pars. (a) to (d); and that the data are accurate and complete to the best of his or her knowledge.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.22 Revenue and expense data. (1) SUBMITTAL. Each hospital shall annually submit to the office an extract of the information requested by the office from its final audited financial statements. A hospital does not have to alter the way it otherwise records its financial data in order to comply with this section. If a hospital is jointly operated in connection with a nursing home, home health agency or other organization, the hospital shall submit the required information for the hospital unit only.

(2) DEFINITIONS. In this section:

(a) "Health maintenance organization" or "HMO" means a health care plan that makes available to its participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

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

(3) REVENUE CATEGORIES. The information reported on each extract shall include the dollar amounts for each of the following revenue categories:

(a) *Gross revenue from service to patients.* Gross revenue from service to patients, including the following subcategories:

1. Gross revenue from room, board, and medical and nursing services to inpatients, based on full established rates;

2. Gross inpatient ancillary revenue for services other than room, board, and medical and nursing services that are provided to hospital patients in the course of inpatient care;

Note: Examples of these other services provided to inpatients are laboratory, radiology, pharmacy and therapy services.

3. Gross revenue from service to outpatients, based on full established rates; and

4. Total gross revenue from service to patients, obtained by adding the amounts in subds. 1 to 3;

5. Gross revenue from service to patients, by source, which shall be the actual dollar values or a reasonable estimate based on a hospital's internal records. Inpatient and outpatient dollar values shall be listed separately for subpar. a; subpar. b; subpar. h; subpar. i; an aggregation of subpars. c, d, and e; an aggregation of subpars. f, g, and j; and an aggregation of subpars. k and l as follows:

a. Medicare, excluding medicare reimbursement through HMOs under 42 CFR pt. 417;

b. Medical assistance under ss. 49.43 to 49.497, Stats., excluding medical assistance reimbursement through HMOs under s. 49.45 (3) (b), Stats.;

c. General relief, as defined in s. 49.01 (5m), Stats.;

d. Programs under ss. 51.42 and 51.437, Stats.;

e. All other public programs;

f. Group and individual accident and health insurance and self-funded plans;

g. HMOs, except HMOs under subpars. h and i, and all other alternative health care payment systems;

h. HMOs reimbursed by medical assistance under s. 49.45 (3) (b), Stats.;

i. HMOs reimbursed by medicare under 42 CFR pt. 417;

j. Workers' compensation;

k. Self pay;

l. All other nonpublic sources; and

m. Total gross revenue from service to patients, by source, obtained by adding the total amounts in subpars. a to l. This dollar value shall equal the dollar value in subd. 4;

(b) *Deductions from revenue obtained from service to patients.* Deductions from revenue obtained from service to patients, which shall be the actual dollar values or a reasonable estimate based on a hospital's internal records, as follows:

1. For contractual adjustments, this includes the difference between billed and paid amounts. Inpatient and outpatient dollar values shall be listed separately for subpar. a; subpar. b; subpar. h; subpar, i; an aggregation of subpars. c, d, and e; an aggregation of subpars. f, g, and j; and subpar. k:

a. Medicare, excluding medicare reimbursement through HMOs under 42 CFR pt. 417;

b. Medical assistance under ss. 49.43 to 49.497, Stats., excluding medical assistance reimbursement through HMOs under s. 49.45 (3) (b), Stats.;

c. General relief, as defined in s. 49.01 (5m), Stats.;

d. Programs under ss. 51.42 and 51.437, Stats.;

e. All other public programs;

f. Group and individual accident and health insurance, and self-funded plans;

g. HMOs, except HMOs under subpar. h and i, and all other alternative health care payment systems;

h. HMOs reimbursed by medical assistance under s. 49.45 (3) (b), Stats.;

i. HMOs reimbursed by medicare under 42 CFR pt. 417;

j. Workers' compensation;

k. All other nonpublic sources; and

l. Total contractual adjustments, obtained by adding the amounts in subpars. a to k;

2. For other deductions from revenue, this includes the following uncollectible revenue;

a. Bad debts;

b. Charity care;

c. All other deductions; and

d. Total other deductions from revenue from service to patients, obtained by adding the amounts in subpars. a to c; and

3. Total deductions from revenue, obtained by adding the amounts in subds. 1 l and 2 d;

(c) *Total net revenue from service to patients.* Total net revenue from service to patients, which is obtained by subtracting total deductions from revenue from service to patients under par. (b) 3 from total gross revenue from service to patients under par. (a) 4;

(d) *Other operating revenue.* Other operating revenue, which consists of tax appropriations and revenue from service to patients that are not patient care services, plus sales and activities made available to persons other than patients, which are normally part of the day-to-day operation of a hospital. This shall be reported in the following subcategories:

1. Tax appropriations;

2. All other operating revenue; and

Note: Examples of revenue from hospital operations that are not patient care services are revenue from educational programs, cafeteria sales and gift shop sales.

3. Total other operating revenue. This is obtained by adding the dollar values for subds. 1 and 2;

(e) *Nonoperating revenue.* Nonoperating revenue, including but not limited to unrestricted gifts, contributions from donors, unrestricted income from endowment funds and income from investments other than income related to borrowed funds; and

(f) *Grand total net revenue.* Grand total net revenue, which is the total of the sums under pars. (c), (d) and (e).

(4) EXPENSE CATEGORIES. The information reported on each extract shall include the dollar amounts for each of the following expense categories:

(a) *Payroll expenses.* Payroll expenses, with the following expense subcategories:

1. Physicians and dentists engaged in clinical practice, excluding those physicians and dentists whose clinical work is totally financed by outside research grants or fellowships;

2. Medical and dental residents and interns;

3. Trainees, including medical technology, x-ray therapy, administrative residency and other specialties who have not completed the necessary requirements for certification or qualifications required for full salary under the related title;

4. Registered nurses and licensed practical nurses;

5. All other personnel, including the payroll for physicians and dentists who hold administrative positions; and

6. Total payroll expenses. This is obtained by adding the dollar values for subds. 1 to 5;

(b) *Nonpayroll expenses.* Nonpayroll expenses, with the following expense subcategories:

1. Employe benefits, including social security, group insurance and retirement benefits;

2. Professional fees, including medical, dental, legal, auditing and consulting fees;

3. Contracted nursing services, including staff from nursing registries and temporary help agencies;

4. Depreciation expense;

5. Interest expense;

6. Amortization of financing expenses;

7. Rents and leases;

8. Capital component of insurance premiums;

9. Nonoperating expenses;

10. All other expenses, including supplies, purchased services, utilities and property taxes; and

11. Total nonpayroll expenses obtained by adding the amounts in subds. 1 to 10;

(c) *Total expenses.* Total expenses obtained by adding the amounts in pars. (a) 6 and (b) 11; and

(d) *Medical education expenses.* The total allowable expenses for medical education activities approved by Medicare under 42 CFR 412 as amended and excerpted from the total expenses in par. (c). These expenses shall be separated into the following expense subcategories:

1. Direct medical education expenses; and

2. Indirect medical education expenses.

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.12 and am. (3) (a) 5. and (b), Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.23 Asset, liability and fund balance data. (1) SUBMITTAL. (a) Except for the department-operated state mental health institutes and county-owned psychiatric or alcohol and other drug abuse hospitals, each hospital shall annually submit to the office an extract of the asset, liability and fund balance data from its final audited financial state-

ments. In order to comply with this section, a hospital does not have to alter the way it otherwise records its financial data.

(b) If a hospital is jointly operated in connection with a nursing home, home health agency or other organization, and the asset, liability and fund balance data are not available from the hospital's final audited financial statements for the hospital unit alone, the hospital shall use data from its most recent medicare cost report to derive the required data for the hospital unit for subs. (2) (b), (c), (d) and (f), and (3) (b). If the assets and funds under subs. (2) (h) and (4) (a) relate directly to the hospital unit, a hospital shall report these data for the hospital unit only; otherwise a hospital shall report these data based on the total facility. For subs. (2) (a), (e) and (g), (3) (a), (c) and (d), and (4) (b) and (c), a hospital shall report these data based on the total facility if the hospital unit data cannot be separated from the total facility data.

(2) UNRESTRICTED ASSET CATEGORIES. The information reported on each extract shall include the dollar amounts for each of the following unrestricted asset categories:

(a) Current cash and short-term investments;

(b) Current receivables;

(c) Uncollectibles;

(d) Net receivables, obtained by subtracting the uncollectibles under par. (c) from the current receivables under par. (b);

(e) Other current assets;

(f) Buildings and equipment, including the following subcategories:

1. Gross plant assets, including:

a. Buildings;

b. Fixed equipment; and

c. Land;

2. Movable equipment;

3. Accumulated depreciation, including:

a. Buildings;

b. Fixed equipment; and

c. Movable equipment; and

4. Net plant and equipment assets, obtained by subtracting accumulated depreciation under subd. 3 from the sum of gross plant assets under subd. 1 and movable equipment under subd. 2.

(g) Long-term investments, reported at the lower of cost or market;

(h) Other unrestricted assets; and

(i) Total unrestricted assets. This is obtained by adding the current cash and short-term investments under par. (a), the net receivables under par. (d), the other current assets under par. (e), the net plant and

equipment assets under par. (f) 4, the long-term investments under par. (g) and the other unrestricted assets under par. (h).

(3) UNRESTRICTED LIABILITIES AND FUND BALANCES. The information reported on each extract shall include the dollar amounts for each of the following unrestricted liabilities and fund balance categories:

(a) Current liabilities;

(b) Long-term debt;

(c) Other liabilities;

(d) Unrestricted fund balances; and

(e) Total unrestricted liabilities and fund balances, obtained by adding pars. (a) through (d).

(4) RESTRICTED HOSPITAL FUNDS. The information reported on each extract shall include the dollar amounts for each of the following restricted hospital fund balances:

(a) Specific purpose funds;

(b) Plant replacement and expansion funds; and

(c) Endowment funds.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.24 Hospital charges by charge element. The charge elements listed in Table 120.24 shall be reported to the office in accordance with s. HSS 120.25.

TABLE 120.24
HOSPITAL CHARGE ELEMENTS

CHARGE ELEMENT	UB-82 REVENUE CODE
ROOM AND BOARD — PRIVATE	
General classification	110
Medical/surgical/gynecology	111
Obstetrics	112
Pediatric	113
Psychiatric	114
Hospice	115
Detoxification	116
Oncology	117
Other	119
ROOM AND BOARD — SEMI PRIVATE TWO BED	
General classification	120
Medical/surgical/gynecology	121
Obstetrics	122
Pediatric	123
Psychiatric	124
Hospice	125
Detoxification	126
Oncology	127
Other	129
NURSERY	
General classification	170
Newborn	171
Premature	172
Neonatal intensive care unit	175
Other	179
INTENSIVE CARE	
General classification	200
Surgical	201
Medical	202
Pediatric	203
Psychiatric	204
Post intensive care unit	206
Burn care	207
Trauma	208
Other	209
CORONARY CARE	
General classification	210
Myocardial infarction	211
INCREMENTAL NURSING CHARGE RATE	
General classification	230
Nursery	231
Intensive care	233
Coronary care	234

OTHER IMAGING SERVICES	
Mammography, excluding physician fees	401
EMERGENCY ROOM	
General classification — based on highest volume, excluding physician fees	450
LABOR ROOM/DELIVERY	
General classification	720
Labor	721
Delivery	722
Circumcision	723
Birthing center	724
Other	729
PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS	
General classification	900
Electroshock treatment	901
Milieu therapy	902
Play therapy	903
Other	909
PSYCHIATRIC/PSYCHOLOGICAL SERVICES	
General classification	910
Rehabilitation	911
Day care	912
Night care	913
Individual therapy	914
Group therapy	915
Family therapy	916
Biofeedback	917
Testing	918
Other	919

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120. 13 and am. (intro.), Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.25 Timing, extensions, format and review of hospital charge element and fiscal data reports. (1) CHARGES BY CHARGE ELEMENT. (a) By July 1, 1989, each hospital shall submit to the office:

1. The amount of the per unit charge for each of the hospital charge elements under s. HSS 120.24 as of that date and the amount one year previous to that date. The outpatient per unit charge shall be listed separately if it differs from the inpatient per unit charge; and

2. The number of times a charge occurred for each of the hospital charge elements under s. HSS 120.24 in the 12-month period of the hospital's most recently completed fiscal year and in the 12-month period previous to the most recently completed fiscal year. A hospital may estimate the volume of charges for each charge element, rounded to the nearest 100, except that if a charge occurred less than 50 times in a 12-month

period, the hospital shall count the exact number of times that the charge occurred.

(b) By July 1, 1990 and annually thereafter, each hospital shall submit to the office:

1. The amount of the per unit charge for each of the hospital charge elements under s. HSS 120.24 as of that date. The outpatient per unit charge shall be listed separately if it differs from the inpatient per unit charge; and

2. The number of times a charge occurred for each of the hospital charge elements under s. HSS 120.24 for the 12-month period of the hospital's most recently completed fiscal year. A hospital may estimate the volume of charges for each charge element, rounded to the nearest 100, except that if a charge occurred less than 50 times in a 12-month period, the hospital shall count the exact number of times that the charge occurred.

(2) REVENUE AND EXPENSE DATA. (a) Except as provided in par. (b), by July 1, 1989, each hospital shall submit to the office the dollar amounts of the revenue and expense data included in its audited financial statements, as specified under s. HSS 120.22, for the hospital's fiscal years 1987, 1988 and 1989.

(b) If a hospital's 1989 fiscal year ends after March 1, 1989, the hospital shall submit the 1989 fiscal data to the office no later than 120 calendar days following the close of its 1989 fiscal year.

(c) For each subsequent fiscal year, the hospital shall annually submit to the office the dollar amounts of the revenue and expense data included in its audited financial statements, as specified under s. HSS 120.22, no later than 120 calendar days following the close of that fiscal year.

(d) If the exact audited financial data required for pars. (a), (b) and (c) are available from the department's Wisconsin annual survey of hospitals, a hospital may use the data from that source to submit the required audited revenue and expense data to the office.

(e) Except as provided in par. (b), by July 1, 1989, each hospital shall report to the office the total gross and net revenue figures required under s. HSS 120.22 (3) (a) 4 and (c) for its fiscal years 1987, 1988 and 1989; the dollar difference between the revenue figures for each of these fiscal years; and an explanation of the amount of the dollar difference that was due to a utilization change.

(f) For each subsequent fiscal year, each hospital shall annually submit to the office, no later than 120 calendar days following the close of the hospital's fiscal year, the following information for the fiscal year and the previous fiscal year:

1. The total gross and net revenue figures required under s. HSS 120.22 (3) (a) 4 and (c);

2. The dollar difference between the revenue figures for each of these fiscal years; and

3. The amount in subd. 2 attributable to a price change and the amount attributable to a utilization change.

(3) ASSET,LIABILITY AND FUND BALANCE DATA. (a) By May 1, 1990, each hospital shall submit to the office the dollar amounts of the asset, liability and fund balance data included in its audited financial statements, as specified under s. HSS 120.23, for the hospital's fiscal years 1988 and 1989.

(b) For each subsequent fiscal year, the hospital shall annually submit to the office, no later than 120 calendar days following the close of the hospital's fiscal year, the dollar amounts of the asset, liability and fund balance data included in its audited financial statements, as specified under s. HSS 120.23.

(c) If the exact audited financial data required for par. (a) are available from the department's Wisconsin annual survey of hospitals, a hospital may use the data from that source to submit the required audited asset, liability and fund balance data to the office.

(4) EXTENSION OF SUBMITTAL DEADLINES. (a) Except as provided in par. (b) the office may grant an extension of a deadline specified in this section for submission of a report only when need for additional time is adequately justified by the hospital. Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension for adequate justification may be granted for up to 30 calendar days.

(b) An extension of a deadline specified in this section for submission of a report by a department-operated state mental health institute may be granted for up to 90 calendar days upon written request.

(5) FORMAT FOR DATA SUBMISSION. Each hospital shall submit the charge element data under sub. (1) and fiscal data under subs. (2) and (3) to the office in a paper medium format provided by the office.

(6) REVIEW OF DATA BY OFFICE AND HOSPITALS AFTER DATA SUBMISSION. (a) The office shall check the accuracy and completeness of submitted charge element and fiscal data. Unacceptable data shall be returned to the hospital that submitted it with a paper copy of the information for revision and resubmission if the office has contacted the hospital and has determined that the data cannot be corrected by telephone. Data returned to the hospital shall be resubmitted to the office within 10 working days after the hospital's receipt of the unacceptable data.

(b) After the office has made any data revisions under par. (a) relating to the charge element and fiscal data for a particular hospital, the office shall send to the hospital a written copy of all data variables submitted by that hospital to the office or subsequently corrected by the office. The hospital shall review the data for accuracy and completeness and shall supply to the office within 10 working days after receipt of the data any corrections to the data.

(c) Within the same 10-working day period under par. (b), the chief executive officer of each hospital shall submit to the office a statement, subscribed under oath or affirmation before a notary public, affirming that any corrections to the data have been verified pursuant to par. (b),

and that the data are accurate and complete to the best of his or her knowledge.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.26 Publication of a rate increase notice. (1) USE. The procedures set out in this section shall be used by a hospital to provide notice to the public of a rate increase.

(2) DEFINITIONS. In this section:

(a) "Affidavit of publication" means a sworn statement in writing affirming the publication of the notice issued by the editor, publisher, printer or proprietor of any newspaper, or by the printer or proprietor's lead worker or principal clerk.

(b) "Class 1 notice" has the meaning specified in s. 985.07 (1), Stats., namely, a notice requiring at least one insertion.

(c) "Reportable rate increase" means an increase that raises a hospital's total gross revenue from continuing services to patients, as determined under s. HSS 120.22 (3) (a) 4, not less than one-half percent within a 12-month period.

(3) TYPE OF NOTICE. A hospital shall publish a class 1 notice at least 10 days prior to instituting a reportable rate increase to inform interested persons of the increase. The notice shall be published in one or more newspapers of general circulation likely to give notice to the hospital's patients and payers.

(4) PUBLICATION OF NOTICE. If at any time a hospital's cumulative rate increases meet the definition of a reportable rate increase in sub. (2) (c), the hospital shall publish a notice of the most recent rate increase in accordance with sub. (5).

(5) CONTENTS OF NOTICE. A hospital shall include in a notice of rate increase at least the following elements:

(a) A bold heading entitled, "NOTICE OF HOSPITAL RATE INCREASE FOR (name of hospital)" printed in capital letters of not less than 18 point type size. The text of the notice shall be printed in not less than 10 point type size. Any numbers printed in the notice shall be expressed as numerals;

(b) The address of the hospital;

(c) Beginning and ending dates of a hospital's fiscal year;

(d) An increase in the rate for any charge element under s. HSS 120.24. If a rate for a charge element will not increase, the hospital is not required to list that charge element in the notice. The information about the increase shall be formatted as follows:

1. Name of the charge element;

2. Previous per unit dollar value of the charge element;

3. New per unit dollar value of the charge element;

4. Dollar increase between subds. 2 and 3; and

5. Percentage increase between subds. 2 and 3;

(e) The anticipated overall increase in a hospital's total gross revenue under s. HSS 120.22 (3) (a) 4 that will result from rate changes in all reportable and unreportable charge elements for the following 12-month period, expressed as an annualized percentage;

(f) The date the rate increase will go into effect;

(g) The date and annualized percentage of each rate increase within the 12 months prior to this rate increase;

(h) The date of the last rate increase if there was no increase specified under par. (g); and

(i) A hospital shall include footnotes in the notice to explain any rate increase or decrease reported. The explanatory footnotes shall be clearly separated from the required information and printed in type no larger than that required by par. (a) for the text of the notice.

(6) AFFIDAVIT OF PUBLICATION. Within 2 weeks after the date on which a rate increase notice is published, the hospital shall submit to the office an affidavit of the publication annexed to a copy of the notice, clipped from the paper in which it was published, that specifies the date of insertion and the name of the newspaper.

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.15 and am. (2) (c), (3), (4), (5) (d) (intro.) and (e), cr. (5) (i), Register, March, 1990, No. 411, eff. 4-1-90.

HSS 120.27 Uncompensated health care services. (1) PLAN. Every hospital shall submit to the office a written plan for providing uncompensated health care services as required under sub. (2). The plan shall include at least the following elements:

(a) A set of definitions describing terms used throughout the plan;

(b) The procedures used to determine a patient's ability to pay for health care services received and to verify financial information from the patient;

(c) The number of patients who received uncompensated health care services provided by the hospital in its preceding fiscal year, and the total charges for those services, as determined by:

1. The number of patients who received charity care from the hospital in that fiscal year;

2. The total charges for charity care, obtained from the hospital's final audited financial statements, that was provided to patients by the hospital in that fiscal year;

3. The number of patients whose charges were determined to be bad debts in that fiscal year; and

4. The total charges determined to be bad debts, as obtained from the hospital's final audited financial statements in that fiscal year;

(d) The projected number of patients who will receive uncompensated health care services from the hospital in its ensuing fiscal year, and the projected total charges for those services, as determined by:

1. The hospital's projected number of patients to whom charity care will be provided by the hospital for that fiscal year;

2. The hospital's projected total charges for charity care to be provided by the hospital for that fiscal year;

3. The hospital's projected number of patients whose charges will be bad debts for that fiscal year;

4. The hospital's projected total charges for bad debts for that fiscal year; and

5. A rationale for the hospital's projections under subds. 1 to 4, considering the hospital's total patients and audited total charges for the preceding fiscal year; and

(e) The hospital's procedure to inform the public about charity care available at that hospital.

(2) SUBMISSION DATES. (a) By July 1, 1989 each hospital shall submit its uncompensated health care services plan to the office for its most recently completed fiscal year.

(b) If a hospital's 1989 fiscal year ends after March 1, 1989, the hospital does not have to submit the 1989 plan to the office until 120 calendar days following the close of its 1989 fiscal year.

(c) A hospital shall submit every subsequent uncompensated health care services plan to the office annually in accordance with sub. (1) in a format prescribed by the office in a technical manual no later than 120 calendar days following the close of the hospital's most recently completed fiscal year.

(3) HILL-BURTON UNCOMPENSATED SERVICES PROGRAM REQUIREMENTS. Any hospital that has a current obligation or obligations under 42 CFR pt. 124 shall annually report to the office on the same date as provided in sub. (2) the date or dates the obligation or obligations went into effect, the amount of the total federal assistance under obligation at the hospital and the date or dates the obligation or obligations will be satisfied.

History: Cr. Register, June, 1989, No. 402, eff. 7-1-89; renum. from HSS 120.16 and am. (2) (a) and (c) and (3), Register, March, 1990, No. 411, eff. 4-1-90.