(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) *IProvider'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; renum. (3) to be (3) (a), cr. (3) (b), Register, February, 1988, No. 386, eff. 3-1-88.

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 preg-

nancy, when it can be determined from the claim submitted that the recipient was pregnant;

5. Services to any recipient enrolled in a hospice under s. HSS 107.31;

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

7. Family planning services and related supplies;

8. Transportation services by a specialized medical vehicle;

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

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

11. Personal care services provided by a certified personal care provider; and

12. Case management services.

(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.

(f) *Date of service of notice.* 1. The date of service of the written notice required under par. (b) or the date of a remittance issued by the department under par. (c) shall be the date on which the provider receives the

notice. The notice shall be conclusively presumed to have been received within 5 days after evidence of mailing.

2. The date of service of a provider's request for a hearing under par. (d) or (e) shall be the date on which the department's office of administrative hearings receives the request.

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

(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; r. (2) (b) 10. and 11., cr. (7) (f), Register, February, 1988, No. 386, eff. 3-1-88; renum. (2) (b) 5. to 9. to be 6. to 10. and am. 9. and 10., cr. (2) (b) 5., 11. and 12., Register, December, 1988, No. 396, eff. 1-1-89.

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

eral, state or local court, irrespective of whether an appeal from the judgment is pending;

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

(g) Barred from participation in medicare by the federal department of health and human services, and the secretary of the federal department of health and human services has directed the department to exclude the individual or entity from participating in the MA program under the authority of s. 1128 or 1128A of the social security act of 1935, as amended.

(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; emerg. am. (28) (e) and (f), cr. (28) (g), eff. 2-19-88; am. (28) (e) and (f), cr. (28) (g), Register, August, 1988, No. 392, eff. 9-1-88.

HSS 106.07 Effects of suspension or involuntary termination. (1) LENGTH OF SUSPENSION OR INVOLUNTARY TERMINATION. In determining the period 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) FEDERAL EXCLUSIONS. Notwithstanding any other provision in this chapter, a party who is excluded from participation in the MA program under s. HSS 106.26 (28) (e), (f) or (g) as the result of a directive from the secretary of the federal department of health and human services under the authority of s. 1128 or 1128A of the social security act of 1935, as amended, shall be excluded from participation in the MA program for the period of time specified by the secretary of that federal agency.

(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; emerg. r. and recr. (2), eff. 2-19-88; am. (2), Register, February, 1988, No. 386, eff. 3-1-88; r. and recr. (2), Register, August, 1988, No. 392, eff. 9-1-88.

HSS 106.075 Departmental discretion to pursue monetary recovery. (1) 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.

(2) The department may pursue monetary recovery from a provider of case management services when an audit adjustment or disallowance has been attributed to the provider by the federal health care financing administration or the department. The provider shall be liable for the entire amount. However, no fiscal sanction under this subsection shall be taken against a provider unless it is based on a specific policy which was:

(a) In effect during the time period being audited; and

(b) Communicated to the provider in writing by the department or the federal health care financing administration prior to the time period audited.

History: Cr. Register, February, 1986, No. 362, eff. 3-1-86; r. and recr. Register, February, 1988, No. 386, eff. 3-1-88.

HSS 106.08 Withholding payment of claims (1) 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.

(2) 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.

(3) 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; r. (1), renum. (2) (a) to (c) to be (1) to (3), Register, February, 1988, No. 386, eff. 3-1-88.

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.