Chapter Ins 120

OFFICE OF HEALTH CARE INFORMATION

Note: Chapter HSS 120 was renumbered ch. Ins 120, Register, February, 1995, No. 470, eff. 3-1-95.

Subchapter I — General Provisions

Ins 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 OHCI in administering its responsibility for collecting, analyzing and disseminating information about health care providers in language that is understandable to lay persons.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; am. Register, June, 1989, No. 402, eff. 7-1-89; r. and recr. Register, January, 1991, No. 421, eff. 2-1-91; renum. (intro.) and am., r. (1) and (2), Register, March, 1992, No. 435, eff. 4-1-92; am., Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.02 Applicability. This chapter applies to all health care providers in this state.

History: Cr. Register, January, 1989, No. 397, eff. 2-1-89; am. Register, January, 1991, No. 421, eff. 2-1-91; am. Register, March, 1992, No. 435, eff. 4-1-92; am., Register, February, 1995, No. 470, eff. 3-1-95.

Ins 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 OHCI 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) "Facility level data base" means data pertaining to a health care facility, including aggregated utilization, staffing or fiscal data for the facility but not including data on an individual patient or data on an individual health care professional.

(10) "Freestanding ambulatory surgery center" means any distinct entity that is operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with the federal health care financing administration under 42 CFR 416.25 and 416.30 to participate as an ambulatory surgery center, and meets the conditions set forth in 42 CFR 416.25 to 416.49. "Freestanding ambulatory surgery center" does not include a hospital-affiliated ambulatory surgical center as described in 42 CFR 416.120 (b).

(11) "Health care provider" means an individual or institutional provider of health care services and equipment in the state of Wisconsin who is certified or eligible for certification under ch. HSS 105.

(12) "Health maintenance organization" has the meaning specified under s. 609.01 (2), Stats.

(13) "Medical assistance" means the assistance program operated by the department of health and social services under ss. 49.43 to 49.497, Stats., and chs. HSS 101 to 108.

(14) "Medicare" means the health insurance program operated by the U.S. department of health and human services under 42 USC 1395 to 1395 ccc and 42 CFR ch. IV, subch. B.

(15) "OHCI" means the office of health care information in the office of the commissioner of insurance.

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

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

(18) "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.

(19) "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.

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

(21) "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.

(22) "Public use data" means data from OHCI's comprehensive discharge data base or facility level data base that does not identify a specific patient, physician, other individual health care professional or employer. "Public use data" includes data on a magnetic tape, magnetic disk, other medium or form.

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

(24) "Uniform patient billing form" means, for hospital inpatient discharges, the uniform billing form HCFA-1450 or, for hospital outpatient discharges or freestanding ambulatory surgery center discharges, the health insurance claim form HCFA-1500 or the uniform billing form 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; cr. (9m) and am. (19), Register, January, 1991, No. 421, eff. 2-1-91; renum. (9m) to (19) to be (11), (14), (17) and (19) to (26) and am. (24), cr. (10), (12), (13), (15), (16) and (18), Register, March, 1992, No. 435, eff. 4-1-92; renum. (1) to (8), (10) to (13), (15) to (26) to be (1) to (24) and am. (6), (12), (13), (15), (22), (24), r. (9), (14), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.04 Assessments to fund the operations of OHCI 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. By October 1 of each year, OHCI shall estimate the total expenditures for itself and the board for the current state fiscal year from which it shall deduct the following:

(a) The estimated total amount of monies OHCI will receive 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) OHCI shall annually assess hospitals and freestanding ambulatory surgery centers in order to fund the operations of OHCI and the board as authorized in s. 153.60, Stats. OHCI shall calculate net expenditures and resulting assessments separately for hospitals, as a group, and freestanding ambulatory surgery centers, as a group, based on the collection, analysis and dissemination of information related to each group.

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

(c) The assessment for an individual freestanding ambulatory surgery center shall be based on the freestanding ambulatory surgery center's proportion of the number of reported surgical procedures for all freestanding ambulatory surgery centers for the most recently concluded calendar year.

(4) PAYMENT OF ASSESSMENTS. Each hospital and each freestanding ambulatory surgery center shall pay the amount it has been assessed on or before December 1 of each year by check or money order payable as specified in the assessment notice. Payment of the assessment is on time if it is mailed to the address specified in the assessment notice, postmarked before midnight of December 1 of the year in which due, with postage prepaid, and is received 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 delay or administrative error of the U.S. postal service shall be considered to be on time.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90, r. and recr. (3), am. (4) (a), Register, January, 1991, No. 421, eff. 2-1-91; am. (2) (intro.), (a) and (3), renum. (4) (a) to be (4) and am., r. (4) (b), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.05 Uniform patient billing form. All hospitals and freestanding ambulatory surgery centers in this state shall use the uniform patient billing form for all inpatient and outpatient care provided by them, as provided in s. Ins 3.65.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90; am. (1), Register, January, 1991, No. 421, eff. 2-1-91; r. (2), renum. (1) and am., Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.06 Patient confidentiality. (1) NONRELEASE OF PATIENT IDENTIFIABLE DATA. OHCI may not release any data that identifies a patient, except as provided in sub. (3). The identity 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. OHCI 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 OHCI. 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, OHCI shall, as soon as practicable and without delay, either fill the request, as provided in sub. (3), or notify the requester in writing that OHCI is denying the request in whole or in part, the reasons for the denial and the procedures for appealing the denial under s. 19.37 (1), Stats.

(3) ACCESS TO PATIENT IDENTIFIABLE DATA. Only the following may have access to patient identifiable data maintained by OHCI, 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, freestanding ambulatory surgery center or physician, an agent of any of them or the commissioner of insurance to ensure the accuracy of the information in the data base;

(c) The department of health and social services 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 OHCI, 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. OHCI 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 OHCI with written statutory evidence that the requester is entitled to have access to patient identifiable data from OHCI; and

3. The entity shall identify for OHCI 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;

(g) Encrypted case identifier; and

(h) Insured's policy number.

(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 OHCI.

(b) To ensure that the identity of patients is protected when information generated by OHCI is released, any data element category containing small numbers shall be aggregated using procedures developed by OHCI 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; am. (3) (b), (4) (f) and (g), cr. (4) (h), Register, January, 1991, No. 421, eff. 2-1-91; am. (3) (b), Register, March, 1992, No. 435, eff. 4-1-92; am. (1), (2) (intro.), (a), (b), (3) (intro.), (b), (c) (intro.), (d) (intro.), 2. and 3., (5), r. (2) (c), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.07 Release of physician data. (1) DATA BASE INFORMATION. OHCI shall release to any requester data from its comprehensive discharge data base or facility level data base, but may not release any information that identifies a specific patient, physician, other health professional or employer. OHCI shall protect the confidentiality of a physician's identity by all necessary means, including the use of calculated or aggregated variables.

(2) PHYSICIAN PROFILE DATA. OHCI shall release physician profile data collected under s. Ins 120.40 (2) (a) to any requester.

(3) BILLING AND PAID CLAIM DATA; OPPORTUNITY FOR PHYSICIAN REVIEW. (a) *Release of data required.* OHCI shall release data collected from uniform patient billing forms or other billing forms and paid claims information subject to the conditions specified in pars. (b) to (d). A request shall be in writing and shall include the physician's name or Wisconsin physician license number.

(b) *Opportunity for physician review required.* The following procedures apply, except as provided in pars. (c) and (d):

1. Upon receipt of a request, OHCI shall notify each identified physician of the request by 1st class mail, using the last known address on file with the department of regulation and licensing.

2. The notice shall include all of the following:

a. A statement that the enclosed request is urgent and that the physician has 15 calendar days from the date the notice was postmarked to notify OHCI that he or she intends to review the requested data before release.

b. Instructions on how the physician may obtain the data.

c. A cover letter informing the physician that OHCI will not provide further notice of the right to review if it receives subsequent requests for the same data.

3. If a physician files a timely request to review data before release, OHCI shall promptly mail the data to the physician. If, within 30 calendar days after the date the mailing is postmarked, the physician submits written comments on the data to OHCI, OHCI shall include the comments with the data released to the requester.

4. If no requests to review the data have been received by the deadline specified in subd. 2. a, OHCI shall release the data to the requester.

5. If OHCI receives comments from a physician after the deadline specified in subd. 3, it shall retain the comments and provide them to any person that submits a subsequent request for the same data.

(c) *Release to physician.* The procedure specified in par. (b) does not apply if the requester is a physician requesting his or her own data.

(d) *Release without physician review.* If any of the following conditions apply, OHCI shall release the requested data without offering the physician the opportunity for comment after the requester executes a written agreement with OHCI that the data will not be re-released to any other person:

1. The requester is the department of health and social services for the purposes specified in s. 153.50, Stats.

2. The request is for aggregated or nonidentifiable patient care data and the requester is a payer responsible for payment of the charges for that care.

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; am. (3) (c) 2. d., Register, January, 1991, No. 421, eff. 2-1-91; r. and recr. (1) to (3) (intro.), am. (3) (c) 2. d., Register, March, 1992, No. 435, eff. 4-1-92; r. and recr. Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.08 Data dissemination. (1) OHCI shall prepare quarterly and annual reports as specified in ss. 153.10 to 153.35, Stats., and 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), OHCI 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. Ins 120.07. The board shall designate the form in which the data for

these requests shall be made available. OHCI shall charge the requester the total actual and necessary cost of producing the requested 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; am. (4), Register, March, 1992, No. 435, eff. 4-1-92; am. (1) and (2), r. (3) and (4), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.09 Administrative and technical information. OHCI shall conduct throughout the state a series of training sessions for 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; am. Register, March, 1992, No. 435, eff. 4-1-92; am. Register, February, 1995, No. 470, eff. 3-1-95.

Ins 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, an employe benefit plan 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 an employe benefit plan 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 OHCI, 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 OHCI as specified under s. 153.05 (1), Stats.

(b) 1. A major purchaser, payer or provider of health care services in this state, 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 of health and social services 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. OHCI may grant the contractor authority to examine confidential materials and perform other specified functions. The contractor shall comply with all confidentiality requirements established under this chapter. The release of confidential information by the contractor without OHCI's written consent shall constitute grounds for OHCI to terminate the contract.

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; am. (1) (a) to (c), (2) (a), (b) 1., (c) and (3), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.11 Civil liability; penalties. (1) CIVIL LIABILITY. In accordance with s. 153.85, Stats., whoever violates the patient confidentiality provisions defined in s. Ins 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.

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

(b) *Forfeitures.* 1. In accordance with s. 153.90 (2), Stats., whoever violates ch. 153, Stats., or this chapter, except as provided in subd. 2, 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. This subdivision does not apply to a violation of the patient confidentiality requirements of s. Ins 120.06.

2. A hospital or freestanding ambulatory surgery center that does not comply with s. Ins 120.04 (4) is subject to 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.

(3) RIGHT TO HEARING. A person that receives an order of forfeiture under sub. (2) has the right to a hearing under ch. Ins 5 before the commissioner of insurance, as provided in s. 601.62 (3) (a), Stats.

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; renum. (1) (a), (b) and (2) to be (1), (2) (a) and (b) and am., cr. (3), Register, February, 1995, No. 470, eff. 3-1-95.

HSS 120.12 Notice of violation and opportunity for appeal. 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; am. (1), Register, January, 1991, No. 421, eff. 2-1-91; am. (1) and (2) (a), Register, March, 1992, No. 435, eff. 4-1-92; r. Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.13 Communications addressed to OHCI. (1) FORMAT. All written information or communications submitted by or on behalf of a health care provider to OHCI shall be signed by the individual health care professional or the chief executive officer of the facility or the designee of the individual health care professional or the chief executive officer of the facility.

(2) TIMING. All written communications, including documents, reports and information required to be submitted to OHCI 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. Ins 120.04 (3), to the Office of Health Care Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver them to 121 East Wilson Street, 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; am. (2), Register, January, 1991, No. 421, eff. 2-1-91; r. (1), renum. (2) and (3) to be (1) and (2) and am. (1), Register, March, 1992, No. 435, eff. 4-1-92; am. Register, February, 1995, No. 470, eff. 3-1-95.

Subchapter II — Reporting Requirement: Hospitals and Freestanding Ambulatory Surgery Centers

Ins 120.20 Hospital responsibility to report inpatient data. (1) DATA ELEMENTS COLLECTED. (a) Each hospital shall report to OHCI information on all inpatient discharges from the hospital, using the data elements available on uniform patient billing forms. The data shall include all of the following elements:

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. Race and ethnicity.
14. Condition codes, if applicable.
15. Patient medical record or chart number.
16. Adjusted total charges and components of those charges.
17. Primary and secondary sources of payments.
18. Insured's policy number.
19. Principal and other diagnoses.
20. Principal and other procedures, if applicable.
21. Date of principal procedure, if applicable.

22. Attending physician license number.

23. Other physician license number, if applicable.

(b) Each hospital shall submit to OHCI 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 OHCI.

(c) After collection of each full calendar year of data, OHCI shall analyze the completeness and accuracy of the reporting and usefulness of each data element. Based on this analysis, OHCI 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 OHCI be added to the uniform patient billing form.

(2) TIME OF SUBMISSION. (a) The data required under sub. (1) shall be submitted to OHCI within 45 calendar days after the end of each calendar quarter. 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.

(b) An extension of the time limits specified under par. (a) may be granted by OHCI 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 OHCI 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) FORMAT. (a) Each hospital shall submit the data required under sub. (1) electronically in accordance with physical specifications, format and record layout prescribed in a technical manual issued by OHCI.

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

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

(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 verify, within a calendar month after the patient is discharged from the hospital, that the patient's principal and secondary diagnoses and the primary and secondary procedures were as specified in the patient's medical record. 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 OHCI AND HOSPITALS AFTER DATA SUBMISSION. (a) OHCI shall check the accuracy and completeness of all submitted data.

(b) If OHCI determines the data to be unacceptable, OHCI may return the unacceptable data to the hospital, and the hospital shall resubmit the required data.

(c) OHCI shall edit submitted data and record all errors or probable errors for each inpatient discharge and submit the errors to the hospital.

(d) All data resubmissions and revisions required as a result of the checks performed under pars. (a) to (c) shall be corrected and resubmitted to OHCI within 10 working days after a hospital's receipt of the unacceptable data.

(e) Acceptable data submissions shall be integrated into the case level data base.

(f) The process specified in pars. (a) to (d) may be performed as many times as necessary for OHCI to determine that the data are accurate and complete.

(g) 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.

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

(i) Within the same 10-working day period under par. (h), the chief executive officer or designee of each hospital shall submit to OHCI a signed statement, affirming that the data have been verified pursuant to subs. (4) and (5); that any corrections to the data have been made; 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; am. Table, (5) (a) and (6) (e), Register, January, 1991, No. 421, eff. 2-1-91; renum. (1) (a), (2) (b) and (c), (3) (d) and (f), (6) (b) to (c) to be (1) (a) (intro.), (2) (a) and (b), (3) (a) and (b), (6) (d), (g), (h) and (i) and am., r. Table, (2) (a), (3) (a) to (c) and (e), cr. (1) (a) 1. to 23., (6) (b), (c), (e) and (f), am. (1)

(b) (intro.) and 2., (c) (intro.) and 3., (4) and (6) (a), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.21 Responsibility to report ambulatory patient surgical data. (1) TYPES OF PROCEDURES REPORTED. Each hospital and each freestanding ambulatory surgery center shall report to OHCI information relating to any ambulatory patient surgical procedure falling within the following general types, as required by OHCI:

(a) Operations on the integumentary system;

(b) Operations on the musculoskeletal system;

(c) Operations on the respiratory system;

(d) Operations on the cardiovascular system;

(e) Operations on the hemic and lymphatic systems;

(f) Operations on the mediastinum and diaphragm;

(g) Operations on the digestive system;

(h) Operations on the urinary system;

(i) Operations on the male genital system;

(j) Operations on the female genital system;

(k) Obstetrical procedures;

(l) Operations on the endocrine system;

(m) Operations on the nervous system;

(n) Operations on the eye and ocular adnexa; and

(o) Operations on the auditory system.

(2) DATA ELEMENTS COLLECTED. (a) Each hospital and each freestanding ambulatory surgery center shall report information on specific ambulatory patient discharges required under sub. (1) from a hospital outpatient department, a hospital-affiliated ambulatory surgery center, as described in 42 CFR 416.120, or a freestanding ambulatory surgery center, using the data elements available on the uniform patient billing form:

1. For hospitals, patient control number, if applicable;

2. For hospitals, type of bill;

3. Federal tax number of the hospital or freestanding ambulatory surgery center;

4. Encrypted case identifier;

5. Patient zip code;

6. Patient date of birth;

7. Patient sex;

8. Race and ethnicity;

9. Patient medical record or chart number;

10. Adjusted total charges and components of those charges;

11. Primary and secondary sources of payment;

12. Insured's policy number;

13. Principal and other diagnoses;

14. Principal and other procedures;

15. Date of principal procedure;

16. Attending physician license number; and

17. Other physician license number, if applicable.

(b) Each hospital and each freestanding ambulatory surgery center shall submit to OHCI 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 OHCI.

(c) After collection of each full calendar year of data, OHCI shall analyze the completeness and accuracy of the reporting and usefulness of each data element. Based on this analysis, OHCI 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 OHCI be added to the uniform patient billing form.

(3) TIME OF SUBMISSION. (a) Within 45 calendar days after the end of each calendar quarter, each hospital and each freestanding ambulatory surgery center shall submit to OHCI the surgical data specified in sub. (2) for all ambulatory patient discharges.

(b) An extension of the time limits specified under par. (a) may be granted by OHCI only when need for additional time is adequately justified by the hospital or freestanding ambulatory surgery center. 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 OHCI 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) FORMAT. (a) Each hospital and each freestanding ambulatory surgery center shall submit ambulatory patient surgical data electronically with physical specifications, format and record layout prescribed in a technical manual issued by OHCI.

(b) Upon written request by a hospital or freestanding ambulatory surgery center, OHCI shall provide consultation to enable the requester to submit ambulatory patient surgical data according to OHCI's specifications.

(5) REVIEW OF AMBULATORY PATIENT SURGICAL DATA PRIOR TO SUBMISSION. As provided under s. 153.40, Stats., prior to submitting ambulatory patient surgical data to OHCI, each hospital or freestanding ambulatory surgery center shall review the data. The review shall consist of checks for accuracy and completeness which are designed by OHCI or designed by the hospital or freestanding ambulatory surgery center and approved by OHCI.

(6) VERIFICATION OF AMBULATORY PATIENT SURGICAL RECORD DATA BY PHYSICIAN PRIOR TO SUBMISSION. (a) The surgeon performing the principal procedure shall verify, within a calendar month after an ambulatory patient is discharged from the hospital or freestanding ambulatory surgery center, that the patient's principal and secondary diagnoses and the primary and secondary surgical procedures were as specified in the patient's medical record. 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 or freestanding ambulatory surgery center, 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 or freestanding ambulatory surgery center shall submit the ambulatory patient surgical data noting the lack of verification by the physician.

(7) REVIEW OF AMBULATORY PATIENT SURGICAL DATA AFTER SUBMISSION. (a) OHCI shall check the accuracy and completeness of all submitted ambulatory patient surgical data.

(b) If OHCI determines the data to be unacceptable, OHCI may return the unacceptable data to the facility, and the facility shall resubmit the required data.

(c) OHCI shall edit submitted data and record all errors or probable errors for each ambulatory patient discharge and submit the errors to the facility.

(d) All data resubmissions and revisions required as a result of the checks performed in pars. (a) to (c) shall be corrected and resubmitted to OHCI within 10 working days after a facility's receipt of the unacceptable data.

(e) Acceptable data submissions shall be integrated into the case level data base.

(f) The process specified in pars. (a) to (d) may be performed as many times as necessary for OHCI to determine that the data are accurate and complete.

(g) Ambulatory patient records data resubmitted by hospitals and freestanding ambulatory surgery centers shall be grouped with the appropriate amendments or additions. Additional ambulatory patient records data from the same calendar quarter as the revised data may be submitted with the revised data.

(h) After receipt of data revisions and additional records, OHCI shall aggregate each facility's data and shall send a copy to the facility. Each facility shall review the aggregated data for accuracy and completeness

and shall supply OHCI within 10 working days after receipt of the data any corrections or additions to the data at the patient discharge level.

(i) Within the same 10-working day period under par. (h), the chief executive officer or designee of each hospital or freestanding ambulatory surgery center shall submit to OHCI a signed statement affirming that the data submitted have been verified pursuant to subs. (5) and (6), that any corrections to the data have been made 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.; r. and recr. (1) and (2) (a) (intro), r. (2) (a) 8., 10. to 13., renum. (2) (a) 9. and 14. to 22. to be 8. to 12. and 14. to 18. and am. 11., a. (2) (a) 13., am. (6) (a) and (7) (e), Register, January, 1991, No. 421 eff. 2-1-91; am. (1) (intro.), (2) (a) (intro.), 1. to 3., (b), (c) (intro.) and 3., (5) (intro.), (6), (7) (a), r. (2) (a) 8. and (3) (a), renum. (2) (a) 9. to 18., (3) (b) and (c), (4) (d) and (f), (7) (b) to (e) to be (2) (a) 8. to 17., (3) (a) and (b), (4) (a) and (b), (7) (d), (g) to (i) and am. (3) (a) and (b), (4) (a) and (b), (7) (d), (g) to (i), cr. (7) (b), (c), (e) and (f), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.22 Hospital financial data. (1) DEFINITION. In this section, "mental health institute" has the meaning given in s. 51.01 (12), Stats.

(1m) REPORTING REQUIREMENT. (a) All hospitals shall report financial data to OHCI in accordance with this section and with OHCI instructions that are based on guidelines from the 2nd edition (1990) of the *Audits of Providers of Health Care Services* published by the American institute of certified public accountants, generally accepted accounting principles and the national annual survey of hospitals conducted by the American hospital association.

(b) The data to be reported shall include the following revenue and expenses:

1. Net revenue from service to patients;

2. Other revenue;

3. Total revenue;

4. Payroll expenses;

5. Nonpayroll expenses;

6. Total expenses;

7. Nonoperating gains and losses;

8. Net income;

9. Gross revenue from service to patients and its sources;

10. Deductions from gross revenue from service to patients and its sources, including contractual adjustments, charity care and other noncontractual deductions; and

11. Expenses for education activities approved by medicare under 42 CFR 412.113 (b) and 412.118 as excerpted from total expenses.

(c) The data to be reported shall include the following asset, liability and fund balance data:

1. Unrestricted assets;

2. Unrestricted liabilities and fund balances; and

3. Restricted hospital funds.

(d) The data to be reported shall include for the current fiscal year and the previous fiscal year:

1. Total gross revenue figures;

2. Total net revenue figures;

3. The dollar difference between gross and net revenue figures; and

4. The amount of the dollar difference between gross and net revenue figures attributable to a price change, the amount attributable to a utilization change and the amount attributable to any other cause.

(2) SOURCE OF DATA. (a) Except for mental health institutes, each hospital shall submit to OHCI an extract of the data requested by OHCI from its final audited financial statements. If the data requested do not appear on the audited financial statements, the hospital shall gather the data from medicare cost reports, notes to the financial statements or other internal hospital financial records. A hospital does not have to alter the way it otherwise records its financial data in order to comply with this section.

(b) A mental health institute shall submit to OHCI an extract of the data requested by OHCI from either its audited or unaudited financial statements. Data from audited financial statements shall be used if they are available. If the data requested do not appear on the financial statements, the hospital shall gather the data from medicare cost reports, notes to the financial statements or other internal hospital financial records.

(3) REPORTING RESPONSIBILITY. (a) 1. Except for a mental health institute, each hospital shall submit data specified under sub. (1m) (b).

2. If a hospital is jointly operated in connection with a nursing home, home health agency or other organization, the hospital shall submit the required data from sub. (1m) (b) for the hospital unit only.

3. A mental health institute shall submit at least the dollar amounts for the items under sub. (1m) (b) that are available from the state fiscal system.

(b) 1. Except for a mental health institute or a county-owned psychiatric or alcohol and other drug abuse hospital, each hospital shall submit data specified under sub. (1m) (c).

2. If a hospital is jointly operated in connection with a nursing home, home health agency or other organization, the hospital shall report the required data from sub. (1m) (c) for the hospital unit only. If the hospital unit data cannot be separated from the total facility data, the hospital shall report the data for the total facility.

3. Mental health institutes and county-owned psychiatric or alcohol and other drug abuse hospitals are not required to submit any data specified under sub. (1m) (c).

(4) SUBMISSION SCHEDULE. (a) *Due date.* For each fiscal year, a hospital shall annually submit to OHCI, no later than 120 calendar days following the close of the hospital's fiscal year, the dollar amounts of the financial data, as specified in this section.

(b) *Extension of submittal date.* 1. Except as provided in subd. 2, OHCI may grant an extension of a deadline specified in this section for submission of hospital financial data only when need for additional time is adequately justified by a 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 OHCI 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.

2. OHCI may grant an extension of a deadline specified in this section for submission of hospital financial data by a mental health institute for up to 90 calendar days upon written request.

(5) FORMAT FOR DATA SUBMISSION. Each hospital shall submit to OHCI the financial data specified in this section in a format provided by OHCI.

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

(b) After OHCI has made any revisions under par. (a) in the data for a particular hospital, OHCI shall send to the hospital a copy of all data variables submitted by that hospital to OHCI or subsequently corrected by OHCI. The hospital shall review the data for accuracy and completeness and shall supply to OHCI 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 or designee of each hospital shall submit to OHCI a signed statement affirming that any corrections to the data have been made, and that the data are accurate and complete to the best of his or her knowledge.

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; renum. (1) to be (1) (a) and am., cr. (1) (b), Register, January, 1991, No. 421, eff. 2-1-91; r. and recr. Register, March, 1992, No. 435, eff. 4-1-92; renum. (1) to be (1m) and am. (1m) (a) (intro.), cr. (1), am. (2), (3) (a) 1. and 3., (b) 1. and 3., (4) to (6), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.23 Hospital charges by charge element. 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; renum. from HSS 120.24 and am., cr. (2) to (5), Register, March, 1992, No. 435, eff. 4-1-92; r. Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.24 Data for annual survey of hospitals. (1) REPORTING REQUIREMENT. (a) By December 7 of each year, each hospital shall submit to OHCI, in the format specified by OHCI, the following data requested by OHCI and the American hospital association for the annual survey of hospitals:

1. Type of hospital control;

2. Type of service that best describes the hospital;

3. Accreditation and certification;

4. Existence of contracts with prepaid health plans, including health maintenance organizations, and other alternative health care payment systems;

5. Provision of selected inpatient, ancillary and other services;

6. Location of services provided;

7. Utilization of selected services;

8. Number of beds and inpatient utilization for the total facility, including beds set up and staffed, admissions, discharges and days of care;

9. Inpatient utilization by government payers for the total facility;

10. Number of beds and utilization by selected inpatient services;

11. Swing-bed utilization, if applicable, including number of swing beds, admissions and days of care;

12. Long-term care utilization, if applicable, including beds set up and staffed, discharges and days of care;

13. Medical staff information, including availability of contractual arrangements with physicians in a paid capacity, total number of active or associate medical staff by selected specialty and number of board certified medical staff by selected speciality; and

14. Number of personnel on a hospital's payroll, including hospital personnel, trainees and nursing home personnel by occupational category and by full-time or part-time status.

(b) OHCI may change the due date specified in par. (a) (intro.) and if it does so, it shall notify each hospital of the change at least 30 days before the data are due.

(c) OHCI may grant an extension of a deadline specified in this section only when need for additional time is adequately justified by a 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 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.

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

(b) After OHCI has made any revisions under par. (a) in the data for a particular hospital, it shall send the hospital a copy of all data variables submitted by that hospital to OHCI or subsequently corrected by OHCI. The hospital shall review the data for accuracy and completeness and shall supply OHCI 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 or designee of each hospital shall submit to OHCI a signed statement affirming that any corrections to the data have been made, and that the data are accurate and complete to the best of his or her knowledge.

History: Cr. Register, March, 1992, No. 435, eff. 4-1-92; am. (1) (a), r. (1) (b) (intro.) and (3), renum. (1) (b) 1. to 14., (2) (a) and (b) and (4) to be (1) (a) 1. to 14., (1) (b) and (c), and (2) and am. (1) (b), (c) and (2), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.25 Uncompensated health care services. (1) PLAN. Every hospital shall annually submit to OHCI a plan for providing uncompensated health care services in the format prescribed by OHCI. 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 obtaining uncompensated health care services from the hospital in its most recently completed fiscal year, and the total accrued charges for those services, as determined by:

1. The number of patients whose accrued charges were attributed to charity care in that fiscal year;

2. The total accrued charges for charity care, based on revenue foregone at full established rates, in that fiscal year;

3. The number of patients whose accrued charges were determined to be a bad debt expense in that fiscal year; and

4. The total bad debt expense, as obtained from the hospital's final audited financial statements in that fiscal year;

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

1. The hospital's projected number of patients anticipated to obtain charity care for that fiscal year;

2. The hospital's projected total charges attributed to charity care for that fiscal year;

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

4. The hospital's projected total bad debt expense 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 total accrued charges for the most recently completed fiscal year; and

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

(2) SUBMISSION SCHEDULE. (a) *Due date.* Each hospital shall submit the plan required under sub. (1) no later than 120 calendar days following the close of its fiscal year.

(b) *Extension of submittal date.* OHCI may grant an extension of a deadline specified in this section only when need for additional time is adequately justified by a 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 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.

(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 OHCI 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 believed to be under obligation at the hospital and the date or dates the obligation or obligations will be satisfied.

History: Cr. Register, March, 1990, No. 411, eff. 4-1-90; am. (1) (b) (intro.), (2) (c) and (6) (c), Register, January, 1991, No. 421, eff. 2-1-91; r. and recr. Register, March, 1992, No. 435, eff. 4-1-92; am. (1) (intro.), (c) (intro.), (d) 5., (2) and (3), Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.26 Hospital price increases; notice and hearing. (1) PURPOSE. This section implements s. 153.08, Stats.

(2) DEFINITIONS. In this section:

(a) "Annualized percentage" means an estimate of the percentage increase in a hospital's gross revenue due to a price increase in charges for patient services for the 12-month period beginning with the effective date of the price increase.

(b) "Change in the consumer price index" means the percentage increase or decrease in the consumer price index, as defined in s. 16.004 (8) (e) 1, Stats.

(c) "Class 1 notice" means the publication of a notice at least once in the official newspaper designated under s. 985.04 or 985.05, Stats., or in a newspaper likely to give notice to interested persons in the area where the hospital is located.

(d) "Reportable price increase" means a change in a hospital's prices that will cause the hospital's gross revenue from patient services for the 12-month period following the effective date of the price changes to exceed the change in the consumer price index for the 12-month period ending on December 31 of the preceding year over the 12-month period ending on December 31 of the year prior to the preceding year.

(3) NOTICE AND HEARING REQUIRED. (a) Before a hospital implements a reportable price increase, it shall publish a class 1 notice of the proposed price increase and hold a public hearing as provided in this section.

(b) When computing the change in a hospital's gross revenue from patient services for purposes of determining whether a proposed price increase is reportable, a hospital shall include any additional revenue at-

tributable to a price increase, whether reportable or not, within the 12-month period preceding the effective date of the proposed price increase.

(4) TYPES OF NOTICES. (a) *Separate notices.* A hospital may publish separate class 1 notices of the public hearing and proposed price increases as follows:

1. A notice of public hearing, published at least 30 calendar days but no earlier than 45 calendar days before the proposed price increase will take effect.

2. A notice of the proposed price increase, published at least 10 calendar days before the increase will take effect.

(b) *Combined notice.* A hospital may publish a combined class 1 notice of the public hearing and proposed price increase at least 30 days before the increase will take effect but no earlier than 45 calendar days before the date of the public hearing.

(5) CONTENTS OF NOTICES. (a) *Required format.* Each notice under sub. (4) shall include a boldface heading printed in capital letters of not less than 18-point type. The text of the notice shall be printed in not less than 10-point type. Any numbers printed in the notice shall be expressed as numerals.

(b) *Notice of public hearing.* A notice under sub. (4) (a) 1 shall include, at a minimum, all of the following in the following order:

1. A heading entitled, "NOTICE OF PUBLIC HEARING ON PROPOSED HOSPITAL PRICE INCREASE FOR (name of hospital)."

2. The address of the hospital.

3. The beginning and ending dates of the hospital's fiscal year.

4. The total anticipated amount of the price increase, expressed as an annualized percentage.

5. The date, time and place of the hearing.

6. A notice that the location of the hearing is accessible to persons with disabilities.

7. The name, address and telephone number of a hospital representative who may be contacted for further information.

(c) *Notice of price increase.* A notice under sub. (4) (a) 2 shall include, at a minimum, all of the following in the following order:

1. A heading entitled, "NOTICE OF PROPOSED HOSPITAL PRICE INCREASE FOR (name of hospital)."

2. The address of the hospital.

3. The beginning and ending dates of the hospital's fiscal year.

4. The total anticipated amount of the price increase, expressed as an annualized percentage.

5. The date the price increase will take effect.

6. The effective date of the hospital's last reportable price increase and the amount of that increase, expressed as an annualized percentage.

7. The name of each charge element listed in table Ins 120.26 (5) for which the hospital proposes to increase the price. A hospital may, but need not, include any charge element for which no price increase is proposed. For each charge element listed, the hospital shall include the following information, formatted as follows:

a. Current per unit price.

b. Proposed per unit price.

c. Amount of the price change between subd. 7. a and b.

d. Percentage of the price change between subd. 7. a and b.

8. An explanation of the reason for the proposed price increase.

(d) *Combined notice of proposed price increase and public hearing.* A combined notice under sub. (4) (b) shall include, at a minimum, all of the following in the following order:

1. A heading entitled, "NOTICE OF PROPOSED HOSPITAL PRICE INCREASE AND PUBLIC HEARING FOR (name of hospital)."

2. The address of the hospital.

3. The beginning and ending dates of the hospital's fiscal year.

4. The total anticipated amount of the price increase, expressed as an annualized percentage.

5. The date the price increase will take effect.

6. The effective date of the hospital's last reportable price increase and the amount of that increase, expressed as an annualized percentage.

7. The date, time and place of the hearing.

8. A notice that the location of the hearing is accessible to persons with disabilities.

9. The name, address and telephone number of a hospital representative who may be contacted for further information.

10. A list of charge elements and information about them, formatted as required under par. (c) 7.

11. An explanation of the reason for the proposed price increase.

Table Ins 120.26 (5)

HOSPITAL CHARGE ELEMENTS

ROOM AND BOARD — PRIVATE
General classification
Medical/surgical/gynecology
Obstetrics
Pediatric
Psychiatric
Hospice
Detoxification
Oncology
Other

ROOM AND BOARD — SEMIPRIVATE TWO BED
General classification
Medical/surgical/gynecology
Obstetrics
Pediatric
Psychiatric
Hospice
Detoxification
Oncology
Other

NURSERY
General classification
Newborn
Premature
Neonatal intensive care unit
Other

INTENSIVE CARE
General classification
Surgical
Medical
Pediatric
Psychiatric
Post intensive care unit
Burn care
Trauma
Other

CORONARY CARE
General classification
Myocardial infarction

INCREMENTAL NURSING CHARGE RATE
General classification
Nursery
Intensive care
Coronary care

OTHER IMAGING SERVICES
Mammography, excluding physician fees

EMERGENCY ROOM
General classification—based on highest volume, excluding physician fees

LABOR ROOM/DELIVERY
General classification
Labor
Delivery
Circumcision
Birthing center
Other

PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS
General classification
Electroshock treatment
Milieu therapy
Play therapy
Other

PSYCHIATRIC/PSYCHOLOGICAL SERVICES
General classification
Rehabilitation
Day care
Night care
Individual therapy
Group therapy
Family therapy
Biofeedback
Testing
Other

(6) AFFIDAVIT OF PUBLICATION. A hospital that publishes any notice under sub. (5) shall require the newspaper in which it is published to furnish the hospital with an affidavit of publication attached to a copy of the notice clipped from the paper. The affidavit shall state the name of the newspaper and the date of publication and shall be signed by the editor, publisher, printer or proprietor, or by the printer or proprietor's lead worker or principal clerk. Within 14 calendar days after the hospital

receives the affidavit of publication, it shall transmit to OHCI the affidavit with the notice clipped from the newspaper attached.

(7) CONDUCTING A PUBLIC HEARING. (a) *Location.* No sooner than 15 calendar days after a notice is published under sub. (4) and no later than 15 calendar days before the effective date of the proposed price increase, a public hearing under this section shall be held in accordance with the procedure specified in s. 153.08 (2) (b), Stats., at a location that is accessible to persons with disabilities.

(b) *Responsibilities of presider.* The person presiding shall do all of the following:

1. Introduce any hospital staff and board members present.

2. Outline the proposed price increase, its expected impact on health care costs, any expected improvement in the local health care delivery system resulting from the increase and any other issue relating to the proposed increase.

3. Permit members of the public to present oral or written testimony or both and, if necessary, ask questions of a presenter whose comments are not clear or understandable.

4. Close the public hearing at the time specified in the notice of hearing, if any. If no closing time was specified in the notice of hearing, the presider shall close the hearing no earlier than one hour after the end of the last testimony by a member of the public.

(c) *Recording minutes.* 1. The hospital shall record accurate minutes of the public hearing, which shall include the total number of the hospital's management staff, the total number of members of the hospital's governing board and the total number of members of the public in attendance, the total number of members of the public who presented oral and written testimony and a summary of both the oral and written testimony and any responses to the testimony by the hospital's representatives.

2. The hospital shall provide OHCI with a copy of the minutes within 10 calendar days after the date of the public hearing.

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; am. (1), (2) (c), (3) to (5) (a), (d) to (i) and (6), Register, January, 1991, No. 421, eff. 2-1-91; corrections made under s. 13.93 (2m) (b) 7, Stats., Register, March, 1992, No. 435; r. and recr. Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.28 Reporting status changes required. (1) In this section, "facility" means a hospital or freestanding ambulatory surgery center.

(2) A facility shall report to OHCI any of the following within 45 days after the event occurs:

(a) The opening of a new facility.

(b) The closing of the facility.

(c) The merger of 2 or more facilities.

(d) A change in the name of the facility.

(e) A change of the facility's address.

(f) A change in the identity of the chief executive officer or chief administrative officer of the facility.

(g) A change in the beginning and ending dates of the facility's fiscal year.

History: Cr. Register, February, 1995, No. 470, eff. 3-1-95.

Ins 120.30 Freestanding ambulatory surgery center responsibility to report patient surgical data. History: Cr. Register, January, 1991, No. 421, eff. 2-1-91; r. Register, February, 1995, No. 470, eff. 3-1-95.

Subchapter III — Other Health Care Provider Reporting Requirements

Ins 120.40 Other health care provider responsibility to report profile and charge information. (1) APPLICABILITY. This section applies to the following health care providers:

(a) Chiropractors licensed under s. 446.02, Stats.;

(b) Counselors, alcohol and other drug abuse, certified under s. HSS 105.23;

(c) Dentists licensed under ch. 447, Stats.;

(d) Nurse anesthetists licensed under s. 441.06, Stats., and certified by either the council of certification of nurse anesthetists or the council on recertification of nurse anesthetists;

(e) Nurse midwives licensed under s. 441.15, Stats.;

(f) Nurse practitioners licensed under s. 441.06, Stats., and certified under s. HSS 105.20 (1);

(g) Nurses, psychiatric, licensed under s. 441.06, Stats., and who meet the qualifications for a registered nurse under s. HSS 61.96 (1) (b);

(h) Occupational therapists certified under ch. 448, Stats.;

(i) Optometrists licensed under ch. 449, Stats.;

(j) Physical therapists licensed under ch. 448, Stats.;

(k) Physicians licensed under ch. 448, Stats., to practice medicine or osteopathy;

(l) Physician assistants certified under ch. 448, Stats.;

(m) Podiatrists licensed under ch. 448, Stats., to practice podiatry or podiatric medicine or surgery;

(n) Psychologists licensed under ch. 455, Stats.; and

(o) Other health care providers certified or eligible for certification under ch. HSS 105.

(2) REPORTING RESPONSIBILITY. (a) Following the consultation required under par. (c), OHCI may require each health care provider under sub. (1) to report to OHCI, as specified under subs. (3) and (4), the following historical profile and qualification information:

1. Name of the provider and address or addresses of main practice or employment;

2. Date of birth;

3. License or certification information, if applicable, including date of initial licensure or certification;

4. Specialty, board certification and recertification information, if applicable;

5. Active status;

6. Formal education and training;

7. Whether the provider renders services to medicare and medical assistance patients and, if applicable, whether the provider has signed a medicare participation agreement indicating that she or he accepts assignment on all medicare patients;

8. Whether the provider participates in a voluntary partnercare program specified under s. 71.55 (10), Stats., in which assignment is accepted for low-income elderly;

9. Current names and addresses of facilities at which the provider has been granted priveleges, if applicable; and

10. Licensure or certification revocation or suspension information, if applicable.

(b) *Charge information.* Following the consultation required under par. (c), OHCI may require each health care provider specified in sub. (1) to report to OHCI the usual and customary charges for frequently occurring procedures.

(c) *Required consultation.* OHCI shall consult with each applicable health care provider group under sub. (1), through a technical advisory committee or trade association, before OHCI collects data directly from that health care provider group.

(3) SOURCE OF DATA. (a) *Wisconsin department of regulation and licensing.* The information requested about each health care provider in this section shall be obtained through data already contained in the data base maintained by the department of regulation and licensing. If the information requested in sub. (2) is not available from the department of regulation and licensing, or if the information is not available at the desired time interval, OHCI shall require the health care provider to submit that information directly to OHCI or its designee in a format prescribed by OHCI.

(b) *Health care provider.* If a health care provider specified in sub. (1) is not in the data base maintained by the department of regulation and licensing, OHCI shall require the health care provider to submit the information in sub. (2) directly to OHCI or its designee in a format prescribed by OHCI.

(4) SUBMISSION SCHEDULE. (a) *Due date.* OHCI shall require that information requested under sub. (2) be submitted at least on a biennial basis according to a schedule developed by OHCI. OHCI may require that the requested information be submitted on an annual basis according to a schedule developed by OHCI.

(b) *Extension of submittal date.* OHCI may grant an extension of a deadline specified in this section for submission of health care provider information only when need for additional time is adequately justified by a health care provider specified in sub. (1). 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 OHCI 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. Health care providers who have been granted an extension shall submit their data directly to OHCI.

Note: Health care providers who are required to send their information directly to OHCI should use the following address: Office of Health Care Information, P. O. Box 7984, Madison, Wisconsin 53707-7984, or deliver the communications to 121 East Wilson Street, Madison, Wisconsin.

History: Cr. Register, March, 1992, No. 435, eff. 4-1-92; am. (1) (d), (2) (a) (intro.), (b) and (c), (3) and (4), Register, February, 1995, No. 470, eff. 3-1-95.