All Provider

Certification and Ongoing Responsibilities

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Contacting Wisconsin Medicaid

Web Site	***dhfs.wisconsin.gov/***
The Web site contains information for providers and recipients about the following: • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets.	Available 24 hours a day, seven days a week
Automated Voice Response System	**(800) 947-3544** **(608) 221-4247**
The Automated Voice Response system provides computerized voice responses about the following: • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information.	Available 24 hours a day, seven days a week
Provider Services	**(800) 947-9627** **(608) 221-9883**
Correspondents assist providers with questions about the following: • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification.	Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Division of Health Care Financing **Electronic Data Interchange Helpdesk**	**(608) 221-9036** **e-mail: *wiedi@dhfs.state.wi.us***
Correspondents assist providers with *technical* questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions software.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Web Prior Authorization Technical Helpdesk	**(608) 221-9730**
Correspondents assist providers with Web PA-related *technical* questions about the following: • User registration. • Passwords. • Submission process.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Recipient Services	**(800) 362-3002** **(608) 221-5720**
Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns.	Available 7:30 a.m. - 5:00 p.m. (M-F)

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Handbook Organization

The following tables show the organization of this All-Provider Handbook and list some of the topics included in each section. It is essential that providers refer to service-specific publications for information about service-specific program requirements.

Certification and Ongoing Responsibilities
• Certification and recertification. • Change of address or status. • Documentation requirements. • Noncertified providers. • Ongoing responsibilities. • Provider rights. • Provider sanctions. • Recipient discrimination prohibited. • Release of billing information.

Claims Information
• Follow-up procedures. • Good Faith claims. • Preparing and submitting claims. • Reimbursement information. • Remittance information. • Submission deadline. • Timely filing appeals requests.

Coordination of Benefits
• Commercial health insurance. • Crossover claims. • Medicare. • Other Coverage Discrepancy Report, HCF 1159. • Primary and secondary payers. • Provider-based billing.

Covered and Noncovered Services
• Collecting payment from recipients. • Covered services. • Emergency services. • HealthCheck "Other Services." • Medical necessity. • Noncovered services.

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Informational Resources
• Electronic transactions. • Eligibility Verification System. • Maximum allowable fee schedules. • Forms. • Medicaid Web site. • Professional relations representatives. • Provider Services. • Publications.

Managed Care
• Covered and noncovered HMO and SSI MCO services. • Enrollee HMO and SSI MCO eligibility. • Enrollment process. • Extraordinary claims. • HMO and SSI MCO claims submission. • Network and non-network provider information. • Provider appeals.

Prior Authorization
• Amending prior authorization (PA) requests. • Appealing PA decisions. • Grant and expiration dates. • Prior authorization for emergency services. • Recipient loss of eligibility during treatment. • Renewal requests. • Review process. • Submitting PA requests.

Recipient Eligibility
• Copayment requirements. • Eligibility categories. • Eligibility responsibilities. • Eligibility verification. • Identification cards. • Limited benefit categories. • Misuse and abuse of benefits. • Retroactive eligibility.

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Preface

This All-Provider Handbook is issued to all Medicaid-certified providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care on a fee-for-service basis. Refer to the Managed Care section of this handbook for information about state-contracted managed care organizations.

Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/.*
- *dhfs.wisconsin.gov/badgercare/.*

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
  - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

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Certification

Providers may obtain service-specific Medicaid certification packets from the Provider section of the Medicaid Web site.

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in HFS 105, Wis. Admin. Code.

Obtaining Certification Packets

Providers interested in becoming certified by Wisconsin Medicaid are required to complete a certification packet, which includes, but is not limited to, the following:

- General certification information.
- Certification criteria.
- Terms of Reimbursement.
- Provider Application Information and Instructions, HCF 11003.
- Provider Agreement.
- Deletion from Publications Mailing List form, HCF 11015.
- Electronic billing information.

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Providers may obtain service-specific Medicaid certification packets from the Provider section of the Medicaid Web site.

Providers without Internet access may request a certification packet(s) by doing one of the following:

- Contacting Provider Services at (800) 947-9627 or (608) 221-9883.
- Sending a request in writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Written requests for certification packets must include the following:

- Each applicant's/provider's name, address, and telephone number.
- Type of provider (e.g., physician, physician clinic or group, speech-language pathologist, hospital) *or* the type of services the provider intends to provide.
- The number of certification packets requested and each applicant's/provider's name. (A certification packet must be completed for each applicant/provider.)

Note: Certification materials, including provider agreements, are periodically revised; submission of outdated materials may delay certification.

Certification for Multiple Services

Providers who offer a variety of services may be required to complete a separate Medicaid certification packet for each specified service/provider type. If a Medicaid-certified provider begins offering a new service *after* they have become initially certified, it is recommended that he or she contact Wisconsin Medicaid to inquire if another application must be completed.

Certification for Multiple Locations

The number of Medicaid certifications allowed or required per location is based on licensure, registration, certification by a state or federal agency, or an accreditation association identified in the Wisconsin Administrative Code.

When requesting a Medicaid certification packet, providers with multiple locations should inquire if multiple applications must be completed.

Completing Certification Materials

To become Medicaid certified, providers are required to:

- Meet all certification requirements for their provider type.
- Submit a properly completed provider application, provider agreement, and other forms, as applicable, that are included in the certification packet.

Providers should carefully complete the certification materials and send all applicable documents demonstrating that they meet the stated Medicaid certification criteria. Providers may call Provider Services for assistance with completing these materials.

Providers should mail completed certification materials to the address indicated on the application. Sending certification materials to any other Wisconsin Medicaid address may cause a delay.

Provider Agreement

As part of the application for certification, providers are required to sign a provider agreement with the Department of Health and Family Services. By signing a provider agreement, providers acknowledge that they are required by law to comply with Medicaid rules, applicable state and federal laws relating to Wisconsin Medicaid, and official written policy communicated in Medicaid publications.

Provider agreements, unless terminated, remain in full force and in effect for a maximum of one year from the date the provider is accepted in the program. In the absence of a notice of termination by either party, the agreement is automatically renewed and extended for a period of one year, as cited in HFS 105.02(8), Wis. Admin. Code.

Refer to "Recertification" in this chapter for more information about renewing provider agreements.

Terms of Reimbursement

The certification packet includes Wisconsin Medicaid's "Terms of Reimbursement," which describes the methodology by which providers are reimbursed for services provided to Medicaid recipients. Providers should retain a copy of the Terms of Reimbursement in their files. However, the Terms of Reimbursement are subject to change during a certification period.

Effective Date of Medicaid Certification

Provider certification is one step in determining whether Wisconsin Medicaid can reimburse a covered service. Only services that are provided on or after a provider's certification effective date are reimbursable by Wisconsin Medicaid. Claims for nonemergency services furnished prior to the certification date are not reimbursed by Wisconsin Medicaid.

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Earliest Effective Date

The earliest Medicaid certification effective date a provider may receive is the date Wisconsin Medicaid receives notification from the provider of his or her intent to provide services. A provider may notify Wisconsin Medicaid of the intent to provide services in the following ways:

- *Provider requests a certification packet in advance.* Providers may request a certification packet by calling Provider Services or by sending a written request. See "Obtaining Certification Packets" in this chapter for more information.
- *Provider sends unsolicited certification materials.* Unsolicited certification materials are certification packets that are not requested in advance (e.g., obtained from the Medicaid Web site).

Provider certification is one step in determining whether Wisconsin Medicaid can reimburse a covered service.

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The enrollment process for Medicare is separate from Wisconsin Medicaid's certification process.

The date the provider notifies Wisconsin Medicaid of his or her intent to provide services may be the provider's earliest effective date as long as the following requirements are met:

- The provider meets all applicable licensure, certification, authorization, or other credential requirements applicable for Wisconsin Medicaid on the date of the notification.
- Applications requested in advance are properly completed and received within 30 days of the date the certification packet was mailed to the provider.
- Unsolicited certification materials are properly completed on the initial date of receipt.

If Wisconsin Medicaid receives a provider's incomplete or unclear application within 30 days of the date the certification packet was mailed to the provider or unsolicited certification materials are incomplete or unclear when initially received, the provider will be granted one 30-day extension. This extension allows a provider additional time to obtain proof of certification (such as license verifications or transcripts). Wisconsin Medicaid must receive a response from the provider within 30 days from the date on the letter requesting the missing information or item(s).

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If the provider does not send complete information within the original 30-day deadline or the 30-day extension, the provider's initial effective date will be based on the date Wisconsin Medicaid receives the provider's properly completed certification materials.

Group Certification Effective Dates

Since group billing provider numbers are assigned as a billing convenience, groups (except providers of mental health services) may submit a written request to obtain a group billing number with a certification effective date back 365 days from the effective date assigned. Providers should mail these requests to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Refer to "Provider Numbers" in this chapter for more information on group billing numbers.

Request for Change of Effective Date

If providers believe their initial certification effective date is incorrect, they may request a review of the effective date. The request should include documentation that indicates the certification criteria that were incorrectly considered. Requests for changes in certification effective dates should be sent to Provider Maintenance.

Medicare Enrollment

Wisconsin Medicaid requires certain types of providers to be Medicare enrolled as a condition for Medicaid certification. This requirement is specified in the certification packets for these provider groups.

The enrollment process for Medicare is separate from Wisconsin Medicaid's certification process. Providers applying for both Medicare enrollment and Medicaid certification are encouraged to apply for Wisconsin Medicaid certification *at the same time* they apply for Medicare enrollment, even though Medicare enrollment must be finalized first. By applying for Medicare enrollment and Medicaid certification simultaneously, it may be possible for Wisconsin Medicaid to assign a Medicaid certification effective date that is the same as the Medicare enrollment date.

Refer to the Coordination of Benefits section of this handbook for more information on Medicare enrollment.

Materials for New Providers

Newly certified providers receive Medicaid publications including handbooks and *Wisconsin Medicaid and BadgerCare Updates*. Certain providers may opt not to receive these materials by completing the Deletion from Publications Mailing List form in the certification packet.

Providers are still bound by Wisconsin Medicaid's rules, policies, and regulations even if they choose not to receive Medicaid publications on an ongoing basis. Most all Medicaid publications are available for viewing and downloading on the Medicaid Web site.

Provider Numbers

When Wisconsin Medicaid certifies a provider, it assigns an eight-digit provider number to the new provider. Providers receive written notification of their provider number and the Medicaid certification effective date in the mail.

Wisconsin Medicaid issues all providers — whether individuals, agencies, or institutions — a provider number to submit claims (and other forms, as appropriate) to Wisconsin Medicaid for services provided to eligible Medicaid recipients. A provider number belongs solely to the person, agency, or institution to whom it is issued. It is illegal for a Medicaid-certified provider to use a provider number belonging to another Medicaid-certified provider.

Wisconsin Medicaid issues four types of provider numbers. Each type has specific designated uses and restrictions. The types are:

- Billing performing provider number.
- Nonbilling performing provider number.
- Group billing number that requires a performing provider.
- Group billing number that does not require a performing provider.

Providers should refer to their certification packets or service-specific publications to identify what types of provider numbers they may apply for or be assigned.

Billing Performing Provider Number

Wisconsin Medicaid issues a billing performing provider number to providers that allows them to identify themselves on claims (and other forms) as either the biller of services or the performer of services.

Nonbilling Performing Provider Number

Wisconsin Medicaid issues nonbilling performing provider numbers to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a nonbilling performing provider number cannot submit claims to Wisconsin Medicaid directly, but have reimbursement rates established for their provider type. Claims that require a nonbilling performing provider number must include the billing provider number of the supervising provider or group provider.

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Group Billing Numbers

A group billing provider number is issued primarily as an accounting convenience. A provider submitting claims with a group billing number receives one reimbursement, one Remittance and Status Report, and the 835 Health Care Claim Payment/Advice for covered services performed by individual providers within the group.

Individual providers within certain groups are required to be Medicaid certified because these groups are required to identify the performing provider number of the individual provider who performed the service on claims. Claims with these group billing provider numbers submitted *without* a performing provider number are denied.

Other groups (e.g., physician pathology, radiology groups, rehabilitation agencies) are

It is illegal for a Medicaid-certified provider to use a provider number belonging to another Medicaid-certified provider.

not required to indicate a performing provider number on claims.

Providers submitting claims with a group billing provider number should refer to their certification packets or service-specific publications to determine whether or not a performing provider number is required on claims.

Automatic recertification in Wisconsin Medicaid occurs without any provider action.

Provider Type and Specialty Changes

A provider who wants to add a certification type or make a change to his or her certification type should contact Provider Services.

Recertification

Providers are recertified annually by either active recertification or automatic recertification.

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Active Recertification

Active recertification, initiated by Wisconsin Medicaid in writing, requires providers to return recertification materials within a specified time frame. If providers fail to return recertification materials by the deadline indicated, their Medicaid certification will end.

Depending on the provider type, active recertification occurs every one to three years.

Active recertification ensures that Wisconsin Medicaid has accurate provider data and allows for changes in certification requirements, when applicable.

If a provider does not return recertification materials to Wisconsin Medicaid by the deadline and *less than* 365 days have passed since the provider's certification has ended, a provider is required to submit the recertification materials to be reinstated. A lapse in Medicaid certification will occur and providers will not receive reimbursement for services that are performed from the time certification ended through the time that certification was reinstated.

If a provider does not return recertification materials to Wisconsin Medicaid and *more than* 365 days have passed since the provider's certification has ended, a provider is required to submit a new certification packet to be reinstated. A lapse in Medicaid certification will occur and providers will not receive reimbursement for services that are performed from the time the certification ended through the time that certification was reinstated.

Automatic Recertification

Automatic recertification in Wisconsin Medicaid occurs without any provider action.

Automatic recertification occurs every year, unless active recertification is required, in which case providers will be notified in writing by Wisconsin Medicaid.

Reinstating Certification

Providers whose Medicaid certification has ended for any reason other than sanctions or failure to be recertified may have their certification reinstated as long as all licensure and certification requirements are met. The criteria for reinstating certification vary, depending upon the reason for the cancellation and when the provider's certification ended.

If it has been less than 365 days since a provider's certification has ended, the provider is required to submit a letter *or* the Provider Change of Address or Status form, HCF 1181, stating that he or she wishes to have his or her Medicaid certification reinstated. The completion instructions and Provider Change of Address or Status form are located in Appendices 1 and 2 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

If it has been more than 365 days since a provider's certification has ended, the provider is required to submit a new certification packet.

Border-Status Certification

A provider in a state that borders Wisconsin may be eligible for border-status certification. Border-status providers need to notify Wisconsin Medicaid in writing that it is common practice for recipients in a particular area of Wisconsin to seek their medical services.

Exceptions to this policy include:

- Nursing homes and public entities (e.g., cities, counties) outside Wisconsin are not eligible for border status.
- All out-of-state independent laboratories are eligible to be border-status providers regardless of location in the United States.

Providers who have been denied Medicaid certification in their own state are automatically denied certification by Wisconsin Medicaid unless they were denied because the services they provide are not a covered benefit in their state.

Certified border-status providers are subject to the same program requirements as in-state providers, including coverage of services and prior authorization (PA) and claims submission procedures. Reimbursement is made in accordance with Wisconsin Medicaid policies.

Refer to "Obtaining Certification Packets" in this chapter for more information. Refer to HFS 105.48, Wis. Admin. Code, for more information about out-of-state providers.

Noncertified In-State Providers

Wisconsin Medicaid reimburses noncertified in-state providers for providing emergency medical services to a Medicaid recipient or providing services to a recipient during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers rendering the same service.

Claims from noncertified in-state providers must be submitted with an In-State Emergency Provider Data Sheet, HCF 11002. The In-State Emergency Provider Data Sheet provides Wisconsin Medicaid with minimal tax and licensure information.

The In-State Emergency Provider Data Sheet can be downloaded and printed from the Medicaid Web site or requested by contacting Provider Services.

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Out-of-State Providers

Out-of-state providers are limited to those providers who are licensed in the United States (and its territories), Mexico, and Canada. Out-of-state providers are required to be licensed in their own state of practice.

Wisconsin Medicaid reimburses out-of-state providers for providing emergency medical services to a Medicaid recipient or providing services to a recipient during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers providing the same service.

Certified border-status providers are subject to the same program requirements as in-state providers, including coverage of services and prior authorization (PA) and claims submission procedures.

Claims from noncertified out-of-state providers must be submitted with an Out-of-State Provider Data Sheet, HCF 11001.

Out-of-state providers are reimbursed for services provided to eligible Wisconsin Medicaid recipients in either of the following situations:

- The service was provided in an emergency situation.
- Prior authorization was obtained from Wisconsin Medicaid *before* the service was provided. Refer to the Prior Authorization section of this handbook for more information about obtaining PA and referrals to out-of-state providers.

Claims from noncertified out-of-state providers must be submitted with an Out-of-State Provider Data Sheet, HCF 11001. The Out-of-State Provider Data Sheet provides Wisconsin Medicaid with minimal tax and licensure information.

The Out-of-State Provider Data Sheet can be downloaded and printed from the Medicaid Web site or requested by contacting Provider Services.

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Out-of-State Youth Program

The Out-of-State Youth (OSY) program is responsible for health care services provided to Wisconsin children placed outside the state in foster and subsidized adoption situations. These children are eligible for Medicaid coverage. The objective is to assure that these children receive quality medical care.

Out-of-state providers not located in border-status-eligible communities may qualify as border-status providers if they deliver services as part of the OSY program. However, providers who have border status as part of the OSY program are reimbursed only for services provided to the specific foster care or subsidized adopted child. In order to receive reimbursement for services provided to other Wisconsin Medicaid recipients, the provider is required to follow rules for out-of-state noncertified providers.

For subsidized adoptions, benefits are usually determined through the adoption assistance agreement and are provided by the state where the child lives. However, some states will not provide Medicaid coverage to children with state-only funded adoption assistance. In these cases, Wisconsin will continue to provide Medicaid coverage.

Out-of-State Youth providers are subject to the same regulations and policies as other certified border-status providers. For more information about OSY, call Provider Services or write to Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Out-of-State Youth
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Ending Participation in Wisconsin Medicaid

Refer to the Provider Rights chapter of this section for more information on procedures for ending participation in Wisconsin Medicaid.

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Ongoing Responsibilities

Entering new information on a claim form or PA request is *not* adequate notification of change and may result in denied claims.

Throughout each section of the All-Provider Handbook, responsibilities for which providers are held accountable are described. Medicaid-certified providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to Medicaid recipients as private-pay patients.
- Complying with all state and federal laws related to Wisconsin Medicaid.
- Obtaining prior authorization (PA) for services, when required.
- Notifying recipients in advance if a service is not covered by Wisconsin Medicaid and the provider intends to collect payment from the recipient for the service.
- Maintaining accurate medical and billing records.
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers, who are required to retain records for a minimum of six years from the date of payment.
- Billing only for services that were actually provided.
- Allowing a recipient access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.
- Keeping provider information (i.e., address, business name) current.
- Notifying Wisconsin Medicaid of changes in ownership.
- Responding to Medicaid recertification notifications.
- Safeguarding recipient confidentiality.
- Verifying recipient eligibility.
- Keeping up-to-date with changes in program requirements as announced in Medicaid publications.

Keeping Information Current

Providers are required to notify Wisconsin Medicaid in writing of changes, including the following:

- Address — physical/mailing or payee/billing.
- Telephone number, including area code.
- Business name.
- Contact name.
- Federal Tax ID number (Internal Revenue Service number).
- Group affiliation.
- Licensure.
- Medicare provider number.
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.

Requests to change an individual provider's file must be signed by the provider. Requests to change a clinic or facility's provider file must be signed by an individual authorized to sign on behalf of the clinic or facility.

Failure to notify Wisconsin Medicaid of any changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event that provider mail is returned to Wisconsin Medicaid for lack of a current address.

Entering new information on a claim form or PA request is *not* adequate notification of change and may result in denied claims.

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Changes in Address or Status

Providers are required to send a written notice of changes (e.g., provider or payee address changes) or status as they occur. Wisconsin Medicaid encourages providers to use the Provider Change of Address or Status form, HCF 1181, to notify Wisconsin Medicaid of changes. The completion instructions and Provider Change of Address or Status form are located in Appendices 1 and 2 of this section for photocopying and may also be downloaded and printed from the Medicaid Web site.

For all other changes, providers are required to send written notice to Wisconsin Medicaid prior to the effective date of the change to the following address:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

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Notify the Bureau of Quality Assurance of Changes

Providers licensed or certified by the Bureau of Quality Assurance (BQA) are required to notify the BQA of changes to physical address, changes of ownership, and facility closures by calling (608) 266-8481.

Providers licensed or certified by the BQA are required to notify the BQA of these changes *before* notifying Wisconsin Medicaid. The BQA will then forward the information to Wisconsin Medicaid.

Change in Ownership

As cited in HFS 105.02, Wis. Admin. Code, new certification materials, including a provider agreement, must be completed whenever a change in ownership occurs, except for nursing homes. Wisconsin Medicaid defines a "change in ownership" as when a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility. Examples of a change in ownership include:

- A sole proprietorship transfers title and property to another party.
- Two or more corporate clinics or centers consolidate and a new corporate entity is created.
- There is an addition, removal, or substitution of a partner in a partnership.
- An incorporated entity merges with another incorporated entity.
- An unincorporated entity (sole proprietorship or partnership) becomes incorporated.

Note: When a change of ownership occurs for a nursing home, the provider agreement is automatically assigned to the new owner.

The following provider types require Medicare enrollment and/or BQA certification for Wisconsin Medicaid certification change in ownerships:

- Ambulatory surgery centers.
- End-stage renal disease service providers.
- Federally qualified health centers.
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- Rural health clinics.

All changes in ownership must be reported in writing to Wisconsin Medicaid and new certification materials must be completed *before* the effective date of the change. The affected provider numbers should be noted in the letter. When the change in ownership is complete, the provider(s) will receive written notification of his or her provider number and

All changes in ownership must be reported in writing to Wisconsin Medicaid and new certification materials must be completed *before* the effective date of the change.

A provider is required to prepare and maintain truthful, accurate, complete, legible, and concise medical documentation and financial records according to HFS 106.02(9)(a), Wis. Admin. Code.

the new Medicaid certification effective date in the mail.

Providers with questions about change in ownership should contact Provider Services at (800) 947-9627 or (608) 221-9883.

Repayment Following Change in Ownership

Medicaid-certified providers who sell or otherwise transfer their business or business assets are required to repay Wisconsin Medicaid for any erroneous payments or overpayments made to them by Wisconsin Medicaid. If necessary, the provider to whom a transfer of ownership is made will also be held liable by Wisconsin Medicaid for repayment. Therefore, prior to final transfer of ownership, the provider acquiring the business is responsible for contacting Wisconsin Medicaid to ascertain if he or she is liable under this provision.

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The provider acquiring the business is responsible for making payments within 30 days after receiving notice from the Department of Health and Family Services (DHFS) that the amount shall be repaid in full.

Providers may send inquiries about the determination of any pending liability on the part of the owner to the following address:

Division of Health Care Financing
Bureau of Health Care Program Integrity
PO Box 309
Madison WI 53701-0309

Wisconsin Medicaid has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to s. 49.45(21), Wis. Stats., for complete information.

Documentation Requirements

A provider is required to prepare and maintain truthful, accurate, complete, legible, and concise medical documentation and financial records according to HFS 106.02(9)(a), Wis. Admin. Code. This applies to *all* claims submitted to Wisconsin Medicaid. ***A dated clinician's signature must be included in all medical notes for all services performed.*** Refer to Appendix 3 of this section for more information about record retention and maintenance. Providers should also refer to their service-specific publications for additional documentation requirements.

Providers are required to retain records for a minimum of five years from the date of payment, except rural health clinic providers who should retain records for a minimum of six years from the date of payment.

Ending participation as a Wisconsin Medicaid provider does not end a provider's responsibility to retain and provide access to fully maintained records unless an alternative arrangement of record retention and maintenance has been established. Refer to the Provider Rights chapter of this section for more information about ending participation in Wisconsin Medicaid.

Reviews and Audits

The DHFS periodically reviews provider records. The DHFS has the right to inspect, review, audit, and photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Safeguarding Recipient Confidentiality

Wisconsin Medicaid supports recipient rights regarding the confidentiality of health care and other Medicaid-related records, including a Medicaid recipient's billing information or medical claim records. A Medicaid recipient has a right to have this information safeguarded and the provider is obligated to protect that right. Therefore, use or disclosure of any information concerning applicants and

Medicaid recipients for any purpose not connected with Wisconsin Medicaid administration is prohibited unless authorized by the recipient.

To comply with the standards, providers are required to follow the procedures outlined in this chapter to ensure the proper release of this information. Medicaid providers, like other health care providers, are also subject to other laws protecting confidentiality of health care information including, but not limited to, the following:

- Sections 146.81 - 146.84, Wis. Stats., Wisconsin health care confidentiality of health care information regulations.
- 42 USC s. 1320d - s. 1320d-8 (federal Health Insurance Portability and Accountability Act of 1996) and accompanying regulations.

Release of Billing Information to Government Agencies

Providers are permitted to release recipient information without informed consent when a written request is made by the DHFS or the federal Department of Health and Human Services to perform any function related to Medicaid administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under Medicaid confidentiality regulations to report suspected misuse or abuse of Medicaid benefits to the DHFS, as well as to provide copies of the corresponding patient health care record.

Records Requests

Requests for billing or medical claim information regarding services reimbursed by Wisconsin Medicaid may come from a variety of individuals including attorneys, insurance adjusters, and recipients. Providers are required to notify Wisconsin Medicaid by contacting Provider Services when releasing billing information or medical claim records relating to charges for Medicaid-covered services except:

- When the recipient is a dual eligible (i.e., recipient is eligible for both Medicare and Wisconsin Medicaid) and is requesting materials pursuant to *Medicare* regulations.
- When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to Wisconsin Medicaid.

Requests for Billing Information or Medical Claim Records

The following are different situations a provider may encounter and the appropriate actions for each situation:

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- *Request for a recipient's billing information or medical claim records from a Medicaid recipient or authorized person acting on behalf of the recipient* — The provider should send a copy of the requested billing information or medical claim records, along with the name and address of the requester, to the following address:

  Wisconsin Medicaid
  Coordination of Benefits
  6406 Bridge Rd
  Madison WI 53784-6220

  Wisconsin Medicaid will process and forward the requested information to the requester.

- *Request for a recipient's billing information or medical claim records from an attorney, insurance company, or power of attorney* — The provider should do the following:

  1. Obtain a release signed by the recipient or authorized representative.
  2. Furnish the requested material to the requester, marked "BILLED TO WISCONSIN MEDICAID" or "TO

Providers are permitted to release recipient information without informed consent when a written request is made by the DHFS or the federal Department of Health and Human Services to perform any function related to Medicaid administration, such as auditing, program monitoring, and evaluation.

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to Wisconsin Medicaid.

BE BILLED TO WISCONSIN MEDICAID," with a copy of the release signed by the recipient or authorized representative. Approval from Wisconsin Medicaid is not necessary.

3. Send a notice of the material furnished to the requester to Coordination of Benefits at the previously listed address with a copy of the signed release.

- *Request for a recipient's billing information or medical claim records from a managed care enrollee* — If any of the previous requests involve a recipient enrolled in a Medicaid state-contracted managed care organization (MCO), the provider is required to do the following:

  1. Obtain a release signed by the recipient or authorized representative.
  2. Send a copy of the letter requesting the information, along with the release signed by the recipient or authorized representative, directly to the MCO.

  The MCO makes most benefit payments and is entitled to any recovery that may be available. Refer to the Managed Care section of the Medicaid Web site for a complete list of MCOs.

- *Request for an itemized statement from a dual eligible* — Pursuant to HR 2015 (Balanced Budget Act of 1997) s. 4311, a dual eligible has the right to request and receive an itemized statement from his or her *Medicare*-certified health care provider. The Act requires the provider to furnish the requested information to the recipient. The Act *does not* require the provider to notify Wisconsin Medicaid.

For More Information

For additional information about requests for billing information or medical claim records, providers should call Provider Services.

Providers may also write to the following address:

Division of Health Care Financing
Coordination of Benefits
PO Box 309
Madison WI 53701-0309

Recipient Discrimination Prohibited

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to Wisconsin Medicaid, including:

- Title VI of the Civil Rights Act of 1964.
- The Age Discrimination Act of 1975.
- Section 504 of the Rehabilitation Act of 1973.
- The Americans with Disabilities Act (ADA) of 1990.

Refer to Appendix 4 of this section for more detailed information about the laws protecting recipients from discrimination.

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers that employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also required to comply with the DHFS Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

Providers may obtain copies of the DHFS Affirmative Action and Civil Rights Compliance Plan (including the Letter of Assurance and other forms) and instructions by referring to the Affirmative Action and Civil Rights Compliance Office section of the DHFS Web site at *dhfs.wisconsin.gov/civilrights/* or by calling the Affirmative Action and Civil Rights

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Compliance Officer at (608) 266-9372. Providers may also write to the following address:

AA/CRC Office
1 W Wilson St Rm 561
PO Box 7850
Madison WI 53707-7850

No applicant or recipient can be denied participation in Wisconsin Medicaid or be denied benefits or otherwise subjected to discrimination in any manner under Wisconsin Medicaid on the basis of race, color, national origin or ancestry, sex, religion, age, disability, or association with a person with a disability.

Note: Limiting practice by age is not age discrimination and specializing in certain conditions is not disability discrimination. For further information, see 45 CFR Part 91.

For more information on the acts protecting recipients from discrimination, refer to the civil rights compliance information in Wisconsin Medicaid's Eligibility and Benefits booklet, PHC 10025. The booklet is given to new Medicaid recipients by county/tribal social or human services agencies and is available on the Medicaid Web site. Potential Medicaid recipients can request the booklet by calling Recipient Services at (800) 362-3002 or (608) 221-5720.

Accommodating Recipients with Disabilities

All providers, including Medicaid providers, operating an existing public accommodation have requirements under Title III of the ADA of 1990. Refer to Appendix 4 of this section for more information.

Allowing Recipient Access to Records

Providers are required to allow recipients access to their health care records, including those related to Medicaid services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Monitoring Contracted Staff

Under a few circumstances (e.g., for personal care and case management services), providers may contract with non-Medicaid certified agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractor's services. Providers should refer to service-specific publications for more information about contracted staff.

When contracting services, providers are required to monitor the contracted agency to ensure that the agency is meeting recipient needs and adhering to Medicaid requirements.

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Providers are also responsible for informing a contracted agency of Medicaid requirements. Providers should refer those with whom they contract for services to Medicaid publications for program policies and procedures. Medicaid publications include, but are not limited to, the following:

- Wisconsin Administrative Code.
- *Wisconsin Medicaid and BadgerCare Updates*.
- The All-Provider Handbook and service-specific handbooks.

Providers should encourage contracted agencies to visit the Medicaid Web site regularly for the most current information.

Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractor's services.

Provider Rights

If providers choose to limit the number of Medicaid recipients they see, they cannot accept a Medicaid recipient as a private-pay patient.

Medicaid-certified providers have certain rights including, but not limited to, the following:

- Limiting the number of Medicaid recipients they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- Collecting payment from a recipient under limited circumstances. Refer to the Covered and Noncovered Services section of this handbook for information about situations when a provider may collect payment from a recipient.
- Refusing services to a recipient if the recipient refuses or fails to present a Medicaid identification card. However, possession of a Forward card does not guarantee eligibility (e.g., the recipient may not be eligible, may be eligible only for limited benefits, or the Forward card may be invalid). Providers may contact Provider Services at (800) 947-9627 or (608) 221-9883 to confirm the current eligibility of the recipient. Refer to the Recipient Eligibility section of this handbook for more information on verifying eligibility.

Limiting the Number of Recipients

If providers choose to limit the number of Medicaid recipients they see, they cannot accept a Medicaid recipient as a private-pay patient. Providers should instead refer the recipient to another Medicaid provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Ending Participation in Wisconsin Medicaid

Providers other than home health agencies and nursing facilities may terminate participation in Wisconsin Medicaid according to HFS 106.05, Wis. Admin. Code.

Providers choosing to withdraw from Wisconsin Medicaid should promptly notify their recipients to give them ample time to find another Medicaid provider.

When withdrawing, the provider is required to:

- Give Wisconsin Medicaid a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

If the provider fails to specify an effective date in the notice of termination, Wisconsin Medicaid may terminate the provider on the date the notice is received.

Additional Requirements for Certain Providers

Home health agencies and nursing facilities have additional requirements to end participation in Wisconsin Medicaid.

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Home Health Agencies

A provider certified as a home health agency may end participation in Wisconsin Medicaid according to the following requirements:

- Wisconsin home health agency licensing requirements in s. 50.49, Wis. Stats., and HFS 133, Wis. Admin. Code.
- Federal Medicare conditions of participation in 42 CFR Part 484.

Nursing Facilities

A provider certified as a nursing facility may end participation in Wisconsin Medicaid according to the requirements in s. 50.03(14)(e), Wis. Stats.

Requesting Discretionary Waivers and Variances of Wisconsin Administrative Code Rules

In rare instances, a provider or recipient may apply for, and the Division of Health Care Financing (DHCF) will consider applications for, a discretionary waiver or variance of certain rules in HFS 102-105, 107, and 108, Wis. Admin. Code. Refer to HFS 106.13, Wis. Admin. Code, for rules that will not be considered for a discretionary waiver or variance.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in HFS 107, Wis. Admin. Code.

Requirements for a Discretionary Waiver or Variance

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DHCF. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action which the provider proposes.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

The DHCF may also require additional information from the provider or the recipient prior to acting on the request.

Application for a Discretionary Waiver or Variance

The DHCF may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

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- The waiver or variance will not adversely affect the health, safety, or welfare of any recipient.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a recipient, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in HFS 107, Wis. Admin. Code.

Providers are not entitled to administrative hearings for billing disputes.

state plan, the federal Centers for Medicare and Medicaid Services, and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to:

Division of Health Care Financing
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Hearing Requests

A provider who wishes to contest a Department of Health and Family Services (DHFS) action or inaction for which due process is required under ch. 227, Wis. Stats., may request a hearing by writing to the Division of Hearings and Appeals.

A provider who wishes to contest Wisconsin Medicaid's notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by Wisconsin Medicaid) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting the DHFS's decision to withhold payment.

Refer to ch. HFS 106, Wis. Admin. Code, for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, the DHFS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

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Provider Rights

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Provider Sanctions

The Department of Health and Family Services (DHFS) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, the DHFS finds reliable evidence of fraud or willful misrepresentation.

Withholding Payments

The Department of Health and Family Services (DHFS) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, the DHFS finds reliable evidence of fraud or willful misrepresentation.

"Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

The DHFS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

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Intermediate Sanctions

According to HFS 106.08(3), Wis. Admin. Code, the DHFS may impose intermediate sanctions on providers who violate certain Medicaid requirements. Common examples of sanctions that the DHFS may apply include the following:

- Review of the provider's claims before payment.
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization.
- Restricting the provider's participation in Wisconsin Medicaid.
- Requiring the provider to correct deficiencies identified in a DHFS audit.

Prior to imposing any alternative sanction under this section, the DHFS will issue a written notice to the provider in accordance with HFS 106.12, Wis. Admin. Code.

Any sanction imposed by the DHFS may be appealed by the provider under HFS 106.12, Wis. Admin. Code. Providers may appeal a sanction by writing to the Division of Hearings and Appeals.

Involuntary Termination

The DHFS may suspend or terminate the Medicaid certification of any provider according to HFS 106.06, Wis. Admin. Code.

The suspension or termination may occur if both of the following apply:

- The DHFS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny recipients access to Wisconsin Medicaid services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose certification is terminated by the DHFS. Refer to HFS 106.07, Wis. Admin. Code, for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of certification with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Sanctions for Collecting Payment from Recipients

Under state and federal laws, if a provider inappropriately collects payment from an eligible Medicaid recipient, or authorized person acting on behalf of the recipient, that provider may be subject to program sanctions including termination of Medicaid certification. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC s. 1320a-7b(d) or s. 49.49 (3m), Wis. Stats.

Refer to the Covered and Noncovered Services section of this handbook for narrow exceptions on when providers may collect payment from recipients.

Refer to the Covered and Noncovered Services section of this handbook for narrow exceptions on when providers may collect payment from recipients.

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Appendix

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Appendix 1
Provider Change of Address or Status Completion Instructions

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(A copy of the Provider Change of Address or Status Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID
PROVIDER CHANGE OF ADDRESS OR STATUS COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Non-submission of changes in address or status may result in incorrect reimbursement, misdirected payment, claim denial, or suspension of payments.

Provision of the information requested on this form is mandatory; however, the use of this version of the form is voluntary. Providers may develop their own version of this form as long as it includes all the information on this form.

INSTRUCTIONS
If a request is made to change an individual provider's file, Wisconsin Medicaid requires the individual provider's signature on the Wisconsin Medicaid Provider Change of Address or Status form, HCF 1181. Signature stamps are not allowed.

Complete all areas of the form affected by change. A change in ownership, group affiliation, federal tax identification number (Internal Revenue Service [IRS] number), etc., must be reported to Wisconsin Medicaid before the change. A change in address must be reported immediately after moving.

SECTION I — PROVIDER INFORMATION
The information in this section pertains to the provider who performs Medicaid services and the location where the services are performed. Wisconsin Medicaid mails provider publications to this address.

Element 1 — Name — Provider
This is a required field. Enter the individual provider's first name, middle initial, and last name, or the name of the clinic or facility.

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Element 2 — Name — Contact Person
If the contact person is different from the provider, enter his or her first name, middle initial, and last name.

Element 3 — Wisconsin Medicaid Provider Number
This is a required field. Enter the provider's eight-digit Medicaid identification number. Do not enter any other numbers or letters. The provider number given must match the provider name listed in this section.

Element 4 — Medicare Provider Number
If applicable, enter the provider's Medicare identification number. Enter the provider's Medicare identification number for the same services billed under the Wisconsin Medicaid provider number (e.g., hospital, physician clinic, and home health.) Providers without a Medicare identification number are not required to complete this field.

Element 5 — Attention
Enter the complete name of the person or department (e.g., billing) to whom provider publications should be directed.

Element 6 — Telephone Number — Provider
This is a required field. Enter the provider's telephone number, including the area code.

Elements 7-10 — Physical Address — Provider
Enter the provider's complete physical work address (street, city, state, and zip code). This address is the location where services are primarily provided. If the address is a rural route, indicate the fire number and directions to the provider's physical location in the space below the address field. A P.O. Box number alone is not acceptable.

SECTION II — PAYEE AND TAX INFORMATION
Wisconsin Medicaid mails reimbursement checks and Remittance and Status (R/S) Reports to the address listed in this section.

Element 11 — Name — Payee
Enter the payee's first name, middle initial, and last name, or the name of the office, clinic, facility, or place of business. The payee's name could be the same as the provider name listed in Section I, but do not write "same" in this field.

Element 12 — Attention

Enter the complete name of the person or department (e.g., billing) where reimbursement checks and R/S Reports should be directed.

Elements 13-16 — Address — Payee

Enter the payee's complete address (street, city, state, and zip code). The payee address could be the same as the one listed in Section I. A P.O. Box number alone is acceptable.

Element 17 — IRS Number — Payee

Enter the payee's IRS number. The IRS number listed must belong to the payee name provided in order to match IRS files. If the payee's name changes, the IRS number must be provided. (For individuals, the IRS number may either be an Employee Identification Number or a Social Security number.)

Element 18 — IRS Number Effective Date

Enter the date (MM/DD/YYYY) that the IRS number became effective.

Element 19 — Signature — Provider

The provider's signature is always required on all requests to change the provider file. The provider's signature (first name, middle initial, and last name) must appear here. Signature stamps and electronic signatures are not acceptable.

Element 20 — Date Signed

This is a required field. Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed.

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Appendix 2

Provider Change of Address or Status (for photocopying)

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(A copy of the Provider Change of Address or Status form is located on the following page.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1181 (Rev. 08/05)

STATE OF WISCONSIN
HFS 105.02(1), Wis. Admin. Code

WISCONSIN MEDICAID
PROVIDER CHANGE OF ADDRESS OR STATUS

Instructions: Type or print clearly. Before completing this form, read the Provider Change of Address or Status Completion Instructions, HCF 1181A.

SECTION I — PROVIDER INFORMATION			
1. Name — Provider (required)	2. Name — Contact Person (if different than provider)		
3. Wisconsin Medicaid Provider Number (required)	4. Medicare Provider Number		
5. Attention	6. Telephone Number — Provider (required)		
7. Physical Street Address — Provider (P.O. Box alone not allowed)	8. City	9. State	10. Zip Code
If provider address is a rural route, indicate the fire number and directions to the provider's physical location.			

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SECTION II — PAYEE AND TAX INFORMATION			
11. Name — Payee	12. Attention		
13. Street Address — Payee	14. City	15. State	16. Zip Code
17. Internal Revenue Service (IRS) Number — Payee	18. IRS Number Effective Date		
19. **SIGNATURE** — Provider (required)	20. Date Signed (required)		

Mail to:
Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

For more information, contact Provider Services at (800) 947-9627 or (608) 221-9883.

Appendix 3
Documentation Requirements

All providers who receive payment from Wisconsin Medicaid, including Medicaid managed care organizations (MCOs), are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to HFS 106.02(9)(a), Wis. Admin. Code. This required maintenance of records is typically required by any third-party insurance company and is not unique to Wisconsin Medicaid.

Record Retention Period

Providers are required to retain documentation including medical and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers, who are required to retain records for a minimum of six years from the date of payment.

Preparation and Maintenance of Records

A provider is required to prepare and maintain truthful, accurate, complete, legible, and concise medical documentation and financial records according to HFS 106.02(9)(a), Wis. Admin. Code. In addition to medical and financial records, the provider's documentation is required to include the following:

1) The full name of the recipient.
2) The identity of the person who provided the service to the recipient.
3) An accurate, complete, and legible description of each service provided.
4) The purpose of and need for the services.
5) The quantity, level, and supply of service provided.
6) The date of service.
7) The place where the service was provided.
8) The pertinent financial records.

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Medical Records

A dated clinician's signature must be included in all medical notes. According to HFS 106.02(9)(b), Wis. Admin. Code, a provider is required to include in a recipient's medical record the following written documentation, as applicable:

1) Date, department, or office of the provider, and provider name and profession.
2) Chief medical complaint or purpose of the service(s).
3) Clinical findings.
4) Diagnosis or medical impression.
5) Studies ordered, such as laboratory or X-ray studies.
6) Therapies or other treatments administered.
7) Disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care (POC) or treatment provided.
8) Prescriptions, POC, and any other treatment plans for the recipient received from any other provider.

Financial Records

According to HFS 106.02(9)(c), Wis. Admin. Code, a provider is required to maintain the following financial records in written or electronic form:

1) Payroll ledgers, cancelled checks, bank deposit slips, and any other accounting records prepared by the provider.
2) Billings to Wisconsin Medicaid, Medicare, a third-party insurer, or the recipient for all services provided to the recipient.

Appendix 3
(Continued)

3) Evidence of the provider's usual and customary charges to recipients and to persons or payers who are not recipients.
4) The provider's schedules for patient appointments and the provider's schedules for recipient supervision, if applicable.
5) Billing claim forms for either manual or electronic billing for all health services provided to the recipient.
6) Records showing all persons, corporations, partnerships, and entities with an ownership or controlling interest in the provider.
7) Employee records for those persons currently employed by the provider or who have been employed by the provider at any time within the previous five years. Employee records are required to include the employee's name, salary, job qualifications, position description, job title, dates of employment, and the employee's current home address or the last known address of any former employee.

Other Documentation

According to HFS 106.02(9)(d), Wis. Admin. Code, providers are required to do the following:

1) Maintain documentation of all information received or known by the provider of the recipient's eligibility for services under Wisconsin Medicaid, Medicare, or any health care plan. This includes, but is not limited to, an indemnity health insurance plan, an HMO or SSI MCO, a preferred provider organization, a health insurance organization, or other third-party payer of health care.
2) Retain all evidence of claims for reimbursement, claim denials and adjustments, remittance information, and settlement or demand billings resulting from claims submitted to Wisconsin Medicaid, Medicare, or other health care plans.
3) Retain all evidence of prior authorization (PA) requests, cost reports, and supplemental cost or medical information submitted to Wisconsin Medicaid, Medicare, and other third-party payers of health care. This includes the data, information, and documentation necessary to support the truthfulness, accuracy, and completeness of the requests, reports, and supplemental information.

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Availability of Records to Authorized Personnel

The Wisconsin Division of Health Care Financing (DHCF) has the right to inspect, review, audit, and reproduce provider records pursuant to HFS 106.02(9)(e), Wis. Admin. Code. The DHCF periodically requests provider records for compliance audits to match information against Wisconsin Medicaid's information on paid claims, PA requests, and eligibility. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHCF staff member(s).

Wisconsin Medicaid reimburses providers $0.06 per page for the cost of reproducing records requested by the DHCF to conduct a compliance audit. A letter of request for records from the DHCF will be sent to a provider when records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between the DHCF and a provider, such as reproduction costs for submitting PA requests and claims.

Also, state-contracted MCOs, including HMOs and SSI MCOs, are not reimbursed for the reproduction costs covered in their contract with the Department of Health and Family Services.

The reproduction of records requested by the Peer Review Organization (PRO) under contract with the DHCF is reimbursed at a rate established by the PRO.

Appendix 3
(Continued)

Confidentiality

Wisconsin Medicaid applicants and recipients have a right to have personal information safeguarded. The provider is obligated to protect that right. Therefore, use or disclosure of any information concerning applicants and recipients of Wisconsin Medicaid for any purpose not connected with Wisconsin Medicaid administration is prohibited unless authorized by the applicant or recipient.

Included in the Wisconsin Medicaid administration are those contacts with third-party payers that are necessary for pursuing third-party payment. Also included is the release of information as ordered by the court.

Any person violating this regulation may be fined an amount from $25 up to $500 or imprisoned in the county jail from 10 days up to one year, or both, for each violation.

A provider is not subject to civil or criminal sanctions when releasing records and information regarding Wisconsin Medicaid applicants or recipients if such release is for purposes directly related to Wisconsin Medicaid administration or if authorized in writing by the applicant or recipient. Refer to the Ongoing Responsibilities chapter of this section for more information about releasing billing information to government agencies.

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Appendix 4
Civil Rights Compliance (Nondiscrimination)

All persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability. Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990 require that all health care benefits under Wisconsin Medicaid be provided on a nondiscriminatory basis.

Any of the following actions may be considered discriminatory treatment when based on race, color, national origin, disability, or association with a person with a disability:

- Denial of aid, care, services, or other benefits.
- Segregation or separate treatment.
- Restriction in any way of any advantage or privilege received by others. (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility.
- Refusing to provide an oral language interpreter to persons who are considered limited English proficient (LEP) at no cost to the LEP individual in order to provide meaning access.
- Not providing translation of vital documents to the LEP groups who represent five percent or 1,000, whichever is smaller, in the provider's area of service delivery.

Title VI of the Civil Rights Act of 1964

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This act requires that all health care benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program.
- Providing services in a manner different from those provided to others under the program.
- Aggregating or separately treating clients.
- Treating individuals differently in eligibility determination or application for services.
- Selecting a site that has the effect of excluding individuals.
- Denying an individual's participation as a member of a planning or advisory board.
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner.

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or

service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means (1) any person who has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans with Disabilities Act of 1990

Under Title III of the ADA, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make his or her goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense).
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens.
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations.
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation.

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Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements.

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