

Policy and Procedure Milwaukee County Behavioral Health Division SAIL	Date Issued 1/1/2010	Section Wiser Choice	Policy Number QA-6	Page 1
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## 1. POLICY:

It is the policy of the Behavioral Health Division (BHD) that Providers must obtain prior authorization before rendering any service and seeking reimbursement from BHD for a client in the Wiser Choice Program.

## 2. PROCEDURE:

A. After a client has made an informed choice of Provider, the Central Intake Unit (CIU) staff or Recovery Support Coordinator (RSC) will submit an initial authorization request to the Behavioral Health Division (BHD) for approval. If the request is supported by the information in the comprehensive screen completed by the CIU or the Single Coordinated Care Plan completed by the RSC and if resources are available, BHD will approve the request, thus creating a prior authorization.

B. Clinical or Recovery Support Service Providers are required to return the Provider Feedback Form (PFF) to the originating CIU (or Wait List Manager, for wait listed clients) for initial clinical or ancillary services within:

- 1 business day after planned appointment, i.e. client showed for service, or
- Within 1 business day if Provider was able to see the client before the scheduled appointment and/or
- If the client fails to show for the initial appointment after 10 business days have passed, the provider must submit the PFF documenting that the client was a 'no show' to the referring CIU.
- If client presents for services, after submitting a no show PFF, contact the referring CIU for a new authorization.

Failure to return the form within this time frame will result in negating the initial authorization request and denial of payment by BHD. Should the CIU receive your Provider Feedback Form late, your agency will be paid for services beginning the date of receipt of the form. PFF's will not be backdated. **Services provided without prior authorization will not be reimbursed by BHD.**

C. Authorizations will be for a particular service or group of services and a specific number of units and time period. Within 2 weeks of the lapse date, providers are required to submit a request for the extension of services and/or change in level of care. BHD will approve or deny these reauthorization requests.

1. If there is an RSC assigned to the client, the RSC agency will submit a Service Authorization Request (SAR) to BHD within two business days of receiving the ASAM from the clinical treatment provider and/or a service extension request from the RSS provider, following the team meeting. If the client has no RSC, the provider will submit the request directly to BHD.
2. The SAR/SCCP, ASAM or RSS service request must be accurate and submitted in a timely manner or it will be denied.
3. The Provider may contact BHD Administrative Coordination Staff one week prior to the authorization lapse date to inquire about the status of the request.

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4. If the authorization service request has not been approved in CMHC by the lapse date, it is the provider's responsibility to contact BHD Administrative Coordination Staff immediately.
  5. Failure to follow these policies may result in a lapsed period of authorization for which your agency risks nonpayment of services rendered.
- E. Emergent/urgent cases in Dimensions 1, 2, or 3 of the ASAM must be referred to the appropriate emergency provider (i.e. detoxification, emergency room, or Psychiatric Crisis Services). Emergent/urgent cases in other Dimensions of the ASAM shall follow the process outlined above in letter "C". The Provider may provide additional clinical supports within the limits of the existing authorization to the client until the SAR is processed and a final determination is rendered.
1. The RSC may request additional ancillary services and notify BHD by writing "Urgent" on the request for ancillary services to mitigate the emergent/urgent needs of the client as the SAR is processed.
- F. Clinical Providers will be notified by BHD of both approvals and denials through the "Authorization View" in the CMHC Client History and the advisement, which is faxed to the Provider. The Provider has two business days to submit clarifying documentation to the BHD Administrative Coordinator identified on the "Authorization View" advisement. Documentation submitted after two business days will not be considered. BHD will reconsider requests within three business days of receipt of additional documentation and notify the Provider of the final decision through the "Authorization View" advisement. The Provider is not authorized to render new services for reimbursement during the review process.
- G. Ancillary Providers will be notified by BHD of both approvals and denials through the "Authorization View" in the CMHC Client History and the advisement, which is faxed to the Provider.

**Reviewed & Approved by:**




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