Policy and Procedure Milwaukee County Behavioral Health Division SAIL	Date Issued 1/1/2010	Section WIser Choice	Policy Number QA-8	Page 1
	Date Revised 1/1/2011	Subject: WIser Choice Billing		

1. POLICY:

It is the policy of the Behavioral Health Division (BHD) WIser Choice that Providers may only provide and bill for those services that have prior authorization, and for services that have actually been provided to the client. Providers may only bill for services after a client has received those services and progress note documentation and sign in sheet is completed for the provided services.

2. PROCEDURE:

For the WIser Choice Program, Providers should report detailed service information to BHD at least once a week.

A. Ancillary Service Providers will record detailed service information in BHD's Management Information System (CMHC) on a weekly basis. Ancillary Providers are allowed to bill up to 2 hours of additional units of service to cover the time spent attending Recovery Support Team Meetings, which should not include travel time.

B. Clinical Providers will record detailed service information in BHD's Management Information System (CMHC) on a weekly basis. Clinical Treatment Providers of day treatment, intensive outpatient and outpatient services are allowed to bill up to 1 hour of additional units of service to cover completion of the clinical assessment (in accordance with DHS 75) during the first appointment with the client. In addition, these same providers are allowed to bill up to 2 hours of additional units of service to cover the time spent attending Recovery Support Team Meetings, which should not include travel time.

C. Clinical and Ancillary Providers are not allowed to bill for:
   1. Phone calls to clients, family members, Recovery Support Coordinators, etc.
   2. A client that is not physically present for a session, a no show.
   3. A client session while the client is incarcerated in a correctional setting.

D. In order to receive payment, Providers must enter billing into CMHC within 60 days following the last day of the month in which the service was rendered and for which there is a valid prior authorization. Failure to enter billing within this prescribed timeline will result in a denial of payment.

E. An Explanation of Benefits (EOB) can be accessed under the Provider Function menu in CMHC upon the receipt of a check. Checks will be cut every two weeks to reimburse Providers for services recorded for the previous weeks.

F. Providers are required to submit in writing to BHD, Contract Management Unit, any over-payments, non-payments, or incorrect payments made to an agency. Providers must notify BHD in writing of reconciliation errors within 14 calendar days of the Explanation of Benefits (EOB). Notification must include the following:
   1. Client name and BHD generated client case number
   2. Date of service, units of service, and service code

   Failure to notify BHD with this information or within the timeline will result in non-consideration of reconciliation requests. Overpayments and incorrect payments to Providers will be deducted from future payments to the agency, so re-payment checks do not need to be sent to BHD.

G. BHD's Management Information System (CMHC) makes available to all Clinical and Ancillary Providers a variety of reports to monitor their authorization and billing, including a "Caseload Report", a "Billable Services Detail Report", an "Authorization Usage Report", an "Authorization Lapsing Report", a Provider Utilization Report, and an "Authorization Approvals / Denials / Pending" report available on a weekly basis. It is imperative that Providers utilize these reports to monitor current authorization and billing.

Reviewed & Approved by: _____

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