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MILWAUKEE COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

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Owner	Dana James
Policy Area	Wraparound (Wrap, REACH, youth CCS)-Vendor

#081 Billing Policy

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I. POLICY

It is the policy of Children's Community Mental Health Services and Wraparound Milwaukee (WM) (referred to as the Purchaser) to set billing standards that provide guidance to the Vendor/Agency (referred to as Provider) while insuring accuracy of billing, to the extent that the County's funds are utilized appropriately for providing services to youth and/or their families enrolled in the program.

II. PROCEDURE

Referral Procedure

A. A program-specific "Referral Form" must be received for each service recipient and each service code prior to the provision of service(s).

B. Provider may not be reimbursed for services provided prior to the date of the referral. The Referral Form must be maintained as part of the service recipient record. (See Policy #038 Provider Referral Form)

C. The Care Coordinator (CC) must complete a Provider Referral Form in WM's electronic system, and forward to the respective Provider.

D. Following receipt of a Provider Referral Form, Provider determines if they can adequately serve/meet the needs of the service recipient for the specified services

E. Unless otherwise identified in a WM service specific policy or procedure (i.e. Policy #036 Crisis Stabilization/Supervision Services), Providers are to respond to the CC within 48 hours of receipt of a Provider Referral Form and identify the time of the next available appointment for service and the assigned/available Direct Service Provider (DSP).

1. If it is determined that the Provider can meet the identified service recipient's needs, the CC authorizes the service(s) in WM's electronic system so that the Provider can initiate services with the service recipient.

F. In the event the family/service recipient does not respond to repeated contact attempts within 30 days of referral or the service recipient is no longer receiving services with the Provider, for whatever reason, the Provider must notify the CC immediately.

Authorization Procedure

A. Any service provided with or on behalf of an enrollee or family member of the enrollee, must be identified in a Service Authorization Request (SAR).

B. CC (or designee) enters the SAR in WM's electronic system. The SAR is approved by the CC Supervisor and/or WM program staff.

C. The CC is the primary point of contact as it relates to the issues involving service authorizations.

1. To resolve an issue with a service authorization, contact the CC via phone or email.
2. If there has been no resolution after 48 hours, the issue should be forwarded to the CC Supervisor.
3. If there is no resolution after 48 additional hours, the issue should be forwarded to WM Finance and/or Provider Network area.

D. All service requests must be authorized before the service is provided. Any service provided outside of the proper authorization will not be paid.

E. Service Authorization Requests (SARs) are available for the Vendor to view in WM's electronic system.

1. This information is available to the Vendor at any time during the month and all updates/changes are updated in real-time.
2. Vendors are strongly encouraged to verify SARs initially (after accepting a referral), after the 23rd of each month for the upcoming month (for Turnaround SARS for ongoing clients), and again at regular intervals each month to ensure that services are authorized.
3. The number of units entered on each SAR should be verified by the Provider each month.
    i. If the Provider anticipates that services will exceed the number of units authorized, the Direct Service Provider (DSP) needs to immediately request additional units to the SAR, along with the rationale for this request, to the CC for review.
    ii. Providers should ensure that additional units have been approved and entered before providing additional services.

F. Service reimbursement varies by service code. Refer to the service description and/or relevant service policy(s) for additional information about the billable services (i.e.: face-to-face services, travel, documentation, no shows or cancellations) for specific service codes.

G. When billing for a service that is authorized at a per-hour rate, the Provider must bill for the

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exact time that service was rendered, and/or to the nearest tenth of an hour increment, and/or in accordance with National Service Code (CPT/HCPCS) guidelines.

H. Regardless of the method used to bill for a rendered service, the date(s) of service for which the provider is seeking reimbursement must match the date(s) of service referenced in the service recipient's required supporting documentation maintained by the Provider/Vendor (i.e.: Progress Note, Provider Note, Signature Log and/or other documentation).

I. All billable units must be accompanied by documentation to justify the service and units. All documentation must be available and provided to WM upon request.

Billing Procedure

A. Provider is responsible for accurate billing for Covered Services.

B. Provider agrees to comply with all Purchaser policies and procedures related to service documentation requirements (include Progress Notes/Provider Notes) associated with a Covered Service, provide service documentation in consideration of billing for said Covered Service, and provide Purchaser with accurate billing for Covered Services no later than sixty (60) days following the last day of the month in which the service was rendered.

C. Unless otherwise permitted per Purchaser's policy and procedure, Provider may invoice authorized Covered Services beginning the 1st of each month following the month in which the Covered Service was provided.

D. Provider may invoice electronically using WM's electronic system, in writing using the WM Invoice Form or other paper invoice (as applicable per service description or agreement).

1. Paper invoices must be submitted via email to wrapfinance@milwaukeecountywi.gov.
2. Clean invoices/claims must contain the name of the Enrollee, name of the Service Recipient, the name of the Vendor and Direct Service Provider (DSP), specify the Covered Service provided, times and/or units of services provided by date, the unit cost and total amount invoiced.

E. Invoices/Claims will be processed by Purchaser within seven (7) days following receipt of a clean invoice/claim.

F. Provider understands and agrees that Purchaser has no obligation to pay for services billed later than sixty days following the last day of the month in which the service was rendered.

G. Purchaser reserves the right to make reductions in reimbursement rate based on lateness of billing, repeat instances of lateness, or for reasons related to noncompliance for any services billed later than this date.

H. Payment of the Contractor's invoice does not absolve Contractor from a final accounting and settlement upon submission and review of Contractor's annual audit, or from audit recoveries arising from an on-site audit of Contractor's Service Documentation in support of Covered Services billed. (Refer to Fee for Service Agreement (FFSA) or Purchase of Service Agreement (POS) contract for specifics).

I. Payment for all Covered Service is based upon the unit rate identified in Attachment A of the FFSA/POS Agreement. Rates will be in effect for the Agreement period or until amended and approved by Purchaser, in accordance to the date identified in written notification to the

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Provider, regardless of any pre-authorization for said Covered Service.

J. Purchaser reserves the right to withhold or recover payment, in whole or in part, adjust Provider's invoice, or otherwise pursue repayment when Provider fails to deliver the Covered Service in accordance to the terms of the agreement, or any other relevant Purchaser's policies and procedures.

K. If the Enrollee has health insurance that includes coverage for a service that is both reimbursable under said insurance and is also covered under the Purchaser Program, Provider must bill the third-party insurance for the Covered Service.

Compensation

A. Provider agrees to provide, within the scope of certification or competencies, Covered Service listed in Attachment A of their contract, at the rate therein and specified in accordance with Purchaser Policies and Procedures. Provider may not bill Enrollees nor their family for the Covered Service.

B. Each Direct Service Provider (DSP) must be approved by Wraparound Milwaukee prior to provision of services. Wraparound Provider Network agencies risk nonpayment for services and/or contract penalties when a DSP is not approved but is providing a covered service. Agencies may contact WM Provider Network staff if there are any questions regarding the status of a DSP. (See Policy #035 Provider Add/Drop)

C. Per the FFSA/POS Agreement: Failure of Provider to comply with Agreement requirements may result in withholding or forfeiture of any payments otherwise due Provider from County, by virtue of any County obligation to Provider, until such time as the Agreement requirements are met. Purchaser reserves the right to withhold payment or adjust Provider's invoice where Provider fails to deliver the contracted services in accordance with the terms of this Agreement, or any other relevant Purchaser's policies and procedures. Provider shall fully cooperate in all utilization review, quality assurance, and complaint/grievance procedures, and submit in a timely manner (if required) annual audit reports, corrective action plans, or any other requests for additional information by County. Purchaser may withhold payment entirely until requested or required information is received or, if applicable, until a written corrective action plan is received and approved by County.

D. Provider shall follow the principles related to Allowable Costs. In addition to allowability as determined according to the Wisconsin Department of Health Services (DHS) *Allowable Cost Policy Manual or Wisconsin Department of Children and Families Allowable Cost Policy Manual*, there is a set of Federal principles for determining allowable costs. Allowability of costs shall be determined in accordance with the cost principles applicable to the entity incurring the costs. Thus, allowability of costs incurred by non-profit organizations is determined in accordance with the provisions of OMB Uniform Guidance 2 CFR and for-profit organizations is determined in accordance with the provisions of the Federal Acquisition Regulation (FAR) at 48 CRF part 31, *Contract Cost Principles and Procedures.*

E. This is a cost reimbursement agreement. Payment for Covered Services shall be made on a unit-times-unit-rate basis with limited profit or reserve. Payments in excess of Allowable Cost plus Allowable Profit (For Profit Providers only – see item H) or Allowable Addition to Reserve (Non-Profits only – see item G) will be remitted to Milwaukee County. Final settlement of this Agreement will be based on audit. (See Section Seventeen (Audit Requirements) of the Agreement.) If the County has waived the audit requirement under Wisconsin Statute s.46.036

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for this Agreement, Provider shall submit an un-audited schedule of program revenue and expenses, compiled by a CPA licensed to practice by the State of Wisconsin, as a final accounting to determine final settlement under this Agreement.
Purchaser shall recover from Provider, money paid in excess of the conditions of this Agreement. Repayment shall be made in full within thirty (30) days after Purchaser has made written demand to Provider for repayment. Purchaser may recover repayments due to the Purchaser from any subsequent payments due to the Provider now or from future Agreements, or from any other service agreement with the County. Purchaser reserves the right to charge interest on outstanding repayments due to Purchaser from Provider as set forth in s.46.09(4)(h) of the County General Ordinances.
Allowable costs, profits and reserves are defined in the Wisconsin Department of Health Services *Allowable Cost Policy manual* (online at http://dhs.wisconsin.gov/grants/Administration/AllowableCost/ACPM.htm), and *Wisconsin Department of Children and Families Allowable Costs Policy (online at dcf.wisconsin.gov/contractsgrants/pdf/allowable_cost_manual.pdf)*.

F. Reserve (Non-Profit Providers Only)- Pursuant to s.46.036(5m) and s.49.34(5m) of Wisconsin Statutes, as affected by 1993 Wisconsin Act 38-, and subject to the limitations and conditions set forth therein, under certain circumstances, Providers can maintain a reserve funded by state programs, Department of Health Services (DHS), Department of Children and Families, Department of Work Force Development (DWD) and Department of Corrections (DOC) when revenue exceeds allowable expenses. The statutes allow reserves when the Provider is a non-profit, non-stock corporation organized under Wisconsin Statute 181 and the Provider provides Covered Services to a Participant(s)on the basis of a unit rate per unit of a Participant(s) service (units-times-rate agreements). Retained and accumulated reserves shall not be considered an allowable cost for purposes of calculating the amount of such a surplus. Purchaser reserves the right to require the Provider to repay to the Purchaser the full amount of any such surplus.

G. Prompt Payment Law- The parties agree that Section 66.0135, Wisconsin Statutes, Interest on Late Payments, shall not apply to payment for Covered Services provided hereunder.

H. Payor of Last Resort

1. Purchaser is intended to be the "payor of last resort" (DHHS Purchase of Service(POS) and Fee for Service Agreement (FFSA) - Payor of Last Resort Policy #008) after all other public and private funds restricted to the Covered Services being purchased, including medical insurance and restricted contributions, have been exhausted.
2. Payment for Covered Services shall be made in accordance with the "order of payment" requirements for the funding agency, funding program, and other collections made by the Provider for Covered Services.
3. Under no circumstances shall the Provider bill, charge, seek remuneration or compensation from or have recourse against the Participant, or any person acting on his/her/their behalf, for Covered Services provided under this Agreement.
4. Any surplus restricted program revenues (temporarily restricted net assets) are to be returned to Purchaser as unspent funds.
5. If the Provider recovers payment from third-party insurance, the Provider agrees to

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re-pay the recovered amount to Purchaser.

6. No funds within the Agreement may be used to supplant Health Insurance, other Health Maintenance Organizations, Care Management Organizations, IRIS, Family Care, Birth to Three, or Preferred Provider Organization funded services.

I. Availability of Funds

1. Should Purchaser reimbursement from state, federal or local sources not be obtained or continued at a level sufficient to allow for payment for the Covered Services, the obligations of each party may be terminated.
2. Any changes that impact on availability of funding shall be sufficient cause for Purchaser to immediately reduce the amount of payment or unit rate paid to the Provider, with or without advance notice.

Approval Signatures

Step Description	Approver	Date
	Michael Lappen: BHD Administrator	8/30/2022
	Brian McBride: ExDir2 – Program Administrator	8/30/2022
	Dana James: Integrated Services Manager- Quality Assurance	8/29/2022
	Dana James: Integrated Services Manager- Quality Assurance	8/29/2022