Provider Network Policies and Procedures

Wellpoint Care Network expects the highest quality of services to be provided to the children and families it serves. To this end, Wellpoint Care Network has created the Wellpoint Care Network Provider Description List to further describe services, outline experience and credential requirements, and detail minimum documentation standards.

As a Provider Network Agency, your Agency agrees:

- To render services in accordance with the written Referral, Service Authorization, and Provider Network Service Description List.
- To bill third-party payment providers (i.e.: Medicaid, HMO's, etc.) when the referred individual for this service is enrolled in an insurance program or Medicaid. Wellpoint Care Network agrees to pay the aforementioned rates only for those individuals/families who have been authorized and that are not approved for reimbursement through insurance or Medicaid.
- Telephone contact with Wellpoint Care Network staff, collateral contacts or service recipients, and any additional documentation are considered indirect costs that are built into the fee-for-service model. Only services provided directly to the authorized Service Recipient may be invoiced. Transportation time to and from the service location may only be invoiced as indicated in the Provider Network Service Description List.
- Wellpoint Care Network will pay for court time when an appropriate subpoena has been issued. Non-Subpoenaed court time is not billable to Wellpoint Care Network. Only actual court room time is billable.
- A service recipient's no-show or cancellation of a scheduled appointment is not considered a reimbursable activity unless otherwise noted in the Service Description List.
- Wellpoint Care Network expects providers to attend Family Team Meetings when invited. Payment will be issued for meeting time and travel time related to the attendance of a Family Team Meeting. Providers should submit the billable Family Team Meeting units on the regular monthly authorization. Additional units may be needed to cover this billable service.
- Providers must notify the case manager within 24 hours when a client is a no-show for a scheduled appointment.
- Providers are Mandated Reporters for child abuse and neglect. Providers who suspect that a child has been abused or neglected must call 220-SAFE immediately and notify the case manager.
- Agencies providing any transportation of clients must furnish Wellpoint Care Network with auto liability insurance that cover providers in their own vehicles. The minimum

liability limit is $1m. Proof of such insurance must be provided to Wellpoint Care Network. Additionally, agencies providing transportation of clients must have a Wisconsin Certified Car Seat Technician on staff, responsible for training all staff providing transportation services.

The Provider will enter case notes and units of service provided within five (5) calendar days of the date of service provision into the database system. Case notes entered in to database more than fifteen (15) calendar days after the date of service provision will result in payment of services being denied. In circumstances where Medicaid has been denied, documentation of the denial must be attached. Additionally, any outstanding billing for the year must be submitted no later than January 10 of the following year to be honored.

Service Descriptions explain what the service is and what elements compose that service according to best practice standards. The description may include a general indication of where the service is intended to take place (i.e., home, community, office, etc.) Wellpoint Care Network assumes that all services will be conducted face-to-face, confidentially, and in appropriate settings.

Experience and Credential Requirements list the minimum experience an individual person must have; in addition to a criminal background check free from substantial criminal convictions and a sex offender registry check. All persons must be approved by Wellpoint Care Network prior to providing services. Services rendered by unapproved staff will not be paid. Wellpoint Care Network will send staff approvals (and denials) in writing to the provider agency. The person who provides the service must also be authorized to do so before services are rendered.

In addition to experience and credential requirements, all staff providing services must be free from any substantial history with Child Protective Services (CPS). Providers with a CPS history, whether as a casehead or a named maltreater, will not be approved to provide services to Wellpoint Care Network clients. Provider agencies are expected to ask all applicants about their history with CPS. Wellpoint Care Network reserves the right to deny approval to providers for any CPS history or criminal background issue Wellpoint Care Network deems substantially related to the service applied for.

Wellpoint Care Network referred services are intended to assist our clients with increasing their parental protective capacities. Treatment plans and service goals must relate to increasing parenting skills and/or ensuring child safety. Services must address the impact to the family of their involvement in the child welfare system. Service providers are expected to coordinate with the team (including other providers) to actively work toward these goals.

5080 Interpretation - Telephone Contact

Set Rate: NA; Proposal Required

Billing Unit: Hour

Service Description: Translation or interpretation services (sign language, Spanish, Hmong, etc.) over the phone provided to the Service Recipient to overcome language barriers. Services may be bilingual, Deaf or Hard of Hearing or other.

Identified Service Recipient: Child or adult with language needs.

Standard Allowable Units (per month): 8

Length of Service: Ongoing to support client needs.

Experience and Credential Requirements:

- Staff need to be approved by Wellpoint Care Network prior to providing the service.

Minimum Documentation Requirements:

- Language used;
- Name of person(s) in attendance during service provision;
- Name of absent person(s) expected to participate in service provision;
- Name of interpreter;
- A basic description of the meeting/proceedings; and,
- Any additional information as appropriate.

5600 Interpretation - Translation Services

Set Rate: NA; Proposal Required

Billing Unit: Hour. Portal to portal billing is allowed (travel time is billable). No-shows are billable under this service code. Cancellations less than 24 hours are billable for the scheduled time.

Service Description: Translation or interpretation services (sign language, Spanish, Hmong, etc.) provided to the Service Recipient to overcome language barriers. Services may be bilingual, Deaf or Hard of Hearing or other.

Identified Service Recipient: Child or adult with language needs.

Standard Allowable Units: NA

Length of Service: Ongoing to support client needs.

Experience and Credential Requirements:

- Staff need to be approved by Wellpoint Care Network prior to providing the service.

Minimum Documentation Requirements:

- Language used;
- Name of person(s) in attendance during service provision;
- Name of absent person(s) expected to participate in service provision;
- Name of interpreter;
- A basic description of the meeting/proceedings; and,
- Any additional information as appropriate.

WELLPOINT CARE NETWORK, INC.

VENDOR AGENCY CONTACT & GENERAL INFORMATION

Child & Family Well-being Program – Provider Network

Agency Name:
Website Address:
Date Agency Opened:
Tax ID Number:

CONTACT INFORMATION

BUSINESS ADDRESS
Street:
City: State: Zip:
Phone: Fax:

BILLING/REMIT ADDRESS (if different than above)
Street:
City: State: Zip:
Phone: Fax:

AGENCY EXECUTIVE/CONTRACT ADMINISTRATOR
Name: Title:
Phone: Fax:
Email Address:

REFERRAL CONTACT
Name: Title:
Phone: Fax:
Email Address:

ALTERNATIVE REFERRAL CONTACT
Name: Title:
Phone: Fax:
Email Address:

BILLING CONTACT
Name: Title:
Phone: Fax:
Email Address:

MINORITY, DISADVANTAGED, FAITH BASED INFORMATION

Minority Agency
☐ African American
☐ Asian American
☐ Hispanic American
☐ At least 51% of the Board of Directors are minorities
☐ Organization is owned and operated by at least 51% minorities
☐ Other:

Disadvantaged Agency
☐ At least 51% of the Board of Directors are women
☐ Organization is owned and operated by at least 51% women

Faith Based Organization
☐ Yes ☐ No

Please provide an explanation if you respond YES to *any* of the questions below?

1. Have you or any member of management ever had a contract terminated by the State of Wisconsin, Milwaukee County, Wraparound or Community Access to Recovery Services? ☐ Yes ☐ No

   _____

2. Have you or any member of management had a license for Foster Home, Treatment Foster Care, Group Home, Residential Treatment Center revoked? ☐ Yes ☐ No

   _____

3. Have you or any member of management ever had a license to operate a daycare/childcare center revoked? ☐ Yes ☐ No

   _____

4. Has your agency's state or county license, certification or operating permit ever been revoked, suspended, or limited? ☐ Yes ☐ No

   _____

5. Is there any pending action to revoke, suspend, or limit your agency's license, certification, or operating permit? ☐ Yes ☐ No

   _____

6. Has your agency ever been canceled or denied professional liability insurance? ☐ Yes ☐ No

   _____

7. Has your agency had any malpractice claims or have been a defendant in any lawsuit in regard to any services that you provide? ☐ Yes ☐ No

   _____

OTHER ENTITIES THE AGENCY HAS PROVIDED SERVICES

Agency	Contact Name	Contact Information

LOCATION INFORMATION

Street:
City: State: Zip:
Phone: Fax:
Wheelchair accessible? ☐ Yes ☐ No
Location Hours:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

INSURANCE INFORMATION

Clinic Medicaid Number:
Please indicate the insurance networks in which you are a member:

DOCUMENTS TO BE SUBMITTED ALONG WITH APPLICATION

All the below Certificates must state Wellpoint Care Network and the Department of Family Services as Certificate Holders. Wellpoint Care Network's address must be on the certificate. The address is: 8901 West Capitol Drive, Milwaukee, WI 53222

- An Occupancy Permit or License to Operate for each location
- Certificate for General Liability must be $1,000,000 per occurrence, $2,000,000 general aggregate
- Certificate of Professional Liability mut be $1,000,000 per wrongful act, $1,000,000 general aggregate. (Abuse & Molestation Coverage can substitute Professional Liability Coverage; however, it must be stated on the declaration page)
- (*for agencies providing transportation*) – Certificate for Auto Liability must be $1,000,000 per accident

Additional documents:

- Certificate for Worker's Compensation
- Signed HIPPA Business Associate Agreement
- Signed W-9 Form
- Federal Tax ID Number letter
- Non-profit Status Confirmation (if applicable)
- Training curriculum for staff providing non-licensed or non-certified services such as parenting, home management, family interaction (visitation), etc.
- (*for agencies providing transportation)* Certificate of agency's Wisconsin Certified Car Seat Technician
- (*for agencies providing transportation for children*) – Agency's car seat inventory which includes brand name, model number, quantity, expiration date
- (*for agencies providing transportation*) – Agency's policy regarding vehicle inspection, maintenance, and insurance
- Quality Assurance Plan
- Client Grievance Procedure

Agency Agreement and Attestation

1. The agency agrees that all information in their application is correct to the best of the agency's knowledge.

2. The agency agrees that services must recognize and respect the unique needs and beliefs of individuals of diverse cultures.

3. The agency agrees that services will be provided without restrictions to sex, race, creed, or national origin.

4. The agency agrees to provide documentation of services to conform with Wellpoint Care Network and the State of Wisconsin requirements.

5. The agency agrees it will abide by all state and federal rules and regulations regarding confidentiality.

6. The agency agrees that all services it provides will meet applicable requirements and licensing regulations. If the agency is a substance abuse and/or mental health services provider, the requirements and regulations are specifically those related to Wisconsin Department of Health and Family Services Chapter HFS 75 (Community Substance Abuse Service Standards) and Chapter HFS 61 (Outpatient Mental Health Clinic).

7. The agency attests that background checks regarding criminal records, incidents of child abuse/neglect, and sex offender registry checks have been completed on all staff in accordance with the Caregiver Background Requirement and that checks are negative for criminal offenses, sexual offenses and substantiation of child abuse or neglect. Positive findings for any criminal background checks and/or abuse/neglect substantiations must be submitted with staff profiles. Decisions on whether to admit providers with criminal offenses will be made by Wellpoint Care Network based on the nature of the offense, number and recentness of offense, and pattern of offense, and will follow the requirements set forth in Wis. Stats 48.68.

8. The agency attests that it has conducted DMV background checks and provided car seat training by a Wisconsin certified car seat technician for all staff providing transport of Wellpoint Care Network clients and ensures staff transporting clients with their personal vehicles, maintain auto insurance having a minimum liability of $100,000 bodily injury per person and $300,000 bodily injury per accident.

9. The agency agrees that service delivery will be timely, efficient, and subject to evaluations made on outcome-based measures and client feedback.

10. The agency agrees that all direct service providers will receive annual mandated reporter training. Following the date of training, the agency agrees to provide Wellpoint Care Network the name of the staff person receiving the training and the date training was provided.

11. The agency agrees that it will report all suspected child maltreatment to the Division of Milwaukee Child Protective Services by calling (414)220-7233 and informing the appropriate case worker.

12. The agency agrees to use Wellpoint Care Network billing system (Care Manager) for submitting claims for payment of services provided by submitting progress notes in the system within 15 calendar days following the date of service provision.

13. The agency agrees that Wellpoint Care Network is the payor of last resort and will not reimburse for services that are MA or insurance eligible for clients who are MA or insurance eligible.

14. The agency understands that if providing transportation services, all drivers must receive training on appropriate car seat installation by a Wisconsin Certified Car Seat Technician.

15. The agency understands that any misrepresentation in this application may result in disqualification from participation in Wellpoint Care Network Provider Network, and legal action or fiscal sanctions may be taken as determined appropriate by Wellpoint Care Network or their designated representatives.

Agency Executive Signature	Date

Civil Rights Compliance Assurances

As a condition of funding under this agreement, _____provides the following assurances:

1. Services will be provided without discrimination in compliance with Title IV of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IV and XVI of the Public Health Service Act, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981, and the Americans with Disabilities Act (ADA) of 1990.
2. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, religion, sex, disability, or age. This policy covers eligibility for and access to service delivery and treatment in all program and activities.
3. If staff with special translation or sign language skills are not available, _____ , will provide staff with special translation or sign language skills training or will find persons who are available within a reasonable time and who can communicate with non-English speaking or hearing-impaired clients.
4. Staff will receive training in sensitivity to persons with disabilities and sensitivity to cultural characteristics.
5. Programs will be made accessible as appropriate in compliance with the ADA. Information materials will be posted and/or available in languages and formats appropriate to the needs of the client population.
6. No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race, religion, color, sex, national origin or ancestry, handicap (as defined in Section 504 and the ADA), physical condition, developmental disability, (as defined in s.51.05(5), Wis. Stats.), arrest or conviction record (in keeping with the S.111.321, Wis. Stats.), sexual orientation, marital status, or military participation. All employees are expected to support goals and programmatic activities relating to nondiscrimination in employment.
7. The Equal Opportunity Policy, the name of the Equal Opportunity Coordinator, and the discrimination compliant process shall be posted in conspicuous places available to applicants and clients of services, and applicants for employment and employees. The complaint process will be according to the Department of Health and Family Services' standards.
8. _____agrees to comply with civil rights monitoring reviews, including the examination of records and relevant files maintained by the agency, as well as interviews with staff, clients, and applicants for services, subcontractors, and referral agencies.

Agency Executive Signature	Date

Please complete this form to have future payments directly deposited into your company's bank account.

Payee/Vendor Name _____

Address _____

City, State Zip _____

Telephone _____

Contact Name _____

Contact E-mail _____

(for ACH remittance notification)

Select one: _____ New Enrollment_____ Financial Institution or Account Change

Bank Name _____

Branch (if applicable)_____

City, State Zip _____

Transit/Routing Number _____ _____ _____ _____ _____ _____ _____ _____ _____

Bank Account Number _____

Account Type (check one) _____ Checking Account ____ Savings Account

Minority Owned _____ Woman Owned _____ Veteran Owned _____

I, the undersigned, authorize Wellpoint Care Network to deposit payments directly to the account indicated above and to correct any errors which may occur from the transactions. I also authorize the financial institution named above to post these transactions to that account. This authorization will remain in force until SaintA receives written notice of cancellation from me. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Signature _____ Date _____

Name (printed) _____ Date _____

Mail the completed form to Accounts Payable at 8901 W. Capitol Dr., Milwaukee, WI 53222 or email to apayable@wellpoint.org.