Group Health Cooperative of South Central Wisconsin

Policy and Procedure

Title: BadgerCare Plus Provider Claim Appeals
Responsible Party: Government Programs Contract Administrator
Div/Dept/Serv Area: Compliance
Policy Number: CMP.BCP.002 **Date of Issue:** 11/01/2019

PURPOSE:

The purpose of this policy is to provide the claims appeal procedure for providers, vendors, and facilities (Providers) who have rendered services to a Group Health Cooperative of South Central Wisconsin (GHC-SCW) BadgerCare Plus member.

POLICY:

1. GHC-SCW's contract with the State of Wisconsin Department of Health Services (the Department) to provide BadgerCare Plus services states that GHC-SCW must accept written appeals from Providers within 60 days of the initial payment and/or nonpayment notice, or notice of audit/recoupment.

2. The Department requires that a claims appeal for services provided to a GHC-SCW BadgerCare Plus member must first be appealed through GHC-SCW's appeals process before a Provider can appeal to the Department.

3. GHC-SCW must acknowledge the receipt of each formal written appeal received from providers within 10 calendar days.

4. GHC-SCW must respond in writing within 45 days from date of postmark on the letter. The notification must include the member's name, Medicaid Member ID number, date of service, date of payment and/or nonpayment.

5. GHC-SCW must provide notification to the provider of the outcome of the formal appeal.

6. GHC-SCW must submit to the Department, on a quarterly basis, a provider appeal log and data summary containing the following:

    a. Name of the provider
    b. Type of service;
    c. Date of services;
    d. Amount of claim;
    e. Date claim was denied;
    f. Date of receipt of the appeal;
    g. Date of the Decision;
    h. Appeal decision by the MCO;
    i. Reason for the decision;
    j. Total number of appeals denied for the reporting period;
    k. Total number of appeals upheld for the reporting period;
    l. Total number of appeals received year start to date of report;
    m. Percent of appeals denied year start to date of report as percent of total appeals received; and
    n. Percent of appeals upheld year start to date of report as percent of total appeals received.

    The provider appeal log and data summary must be submitted to the Department within 45 days of the end of each quarter.

7. A provider, vendor, or facility may take the below actions regarding a submitted claim. However, these actions are **NOT** considered official provider appeals:

    a. Reconsideration of a Claim: A request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors.
    b. Resubmission of a Claim: A claim or a portion of a claim that was denied is resubmitted through the claims process with changed or added information.

PROCEDURE:

Section 1: Appealing to GHC-SCW.

A provider, vendor, or facility can file an official claims appeal by completing the below steps:

1. Send a letter, fax, or electronic transmission to GHC-SCW clearly marked "Appeal."
2. Include the GHC-SCW claim ID, date of service, member's name, and the member's GHC-SCW ID or Medicaid ID.
3. Clearly state the reason(s) the claim is being appealed, including all documentation necessary to support the reason.
4. If your reason is medical in nature, GHC-SCW will advise if medical records are required and need to be submitted with the appeal.
5. Address the appeal to GHC-SCW Claims Department, Attention Provider Appeals.
6. All BadgerCare Plus/Medicaid appeals must be submitted to GHC-SCW within 60 days of the initial denial or payment notice.
7. If GHC-SCW fails to respond the Provider within 45 days, or the Provider is not satisfied with GHC-SCW's response to the appeal, the Provider may appeal to the Department.

Section 2: Appealing to The Department

If the procedure as noted in Section 1 has not been completed, the Department will not consider the Provider's appeal. Please complete Section 1 prior to the procedure described in Section 2. Please reference ForwardHealth Online Handbook topics #384 and #385 for additional information by visiting (https://www.forwardhealth.wi.gov/WIPortal/Default.aspx).

1. The Provider must submit appeals to the Department in writing within 60 days of the date on GHC-SCW's final decision notice, or in the case of no response, within 60 days from the 45 day timeline allotted for GHC-SCW to respond.
2. A decision to uphold the HMO's original payment denial or to overturn the denial will be made based on the documentation submitted for review. Failure to submit the required documentation or submitting incomplete/insufficient documentation may lead to an upholding of the original denial. The decision to overturn GHC-SCW's denial must be clearly supported by the documentation.

3. Providers may use the Department's form when submitting an appeal for State review. All elements of the form must be completed or listed in the letter if the form is not used. The form with instructions is available at the following website: https://www.dhs.wisconsin.gov/library/F-12022.htm

4. Providers are required to submit legible copies of all of the following documentation, regardless of whether the Managed Care Program Provider Appeal form or their own appeal letter is used. Incomplete appeals will not receive Departmental review and will be returned and the denial upheld. The appeal packet must contain:

    a. A copy of the original claim submitted to GHC-SCW. If applicable, include a copy of all corrected claims submitted to GHC-SCW.
    b. A copy of all of GHC-SCW's payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial.
    c. A copy of the provider's written appeal to GHC-SCW.
    d. A copy of the GHC-SCW's response to the appeal.
    e. A copy of the medical record for appeals regarding coding issues, medical necessity, or emergency determination. Providers should only send relevant medical documentation that supports the appeal. Large records submitted with no indication will not be reviewed. Large documents should be submitted on a CD.
    f. A copy of any contract language that supports your appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial. Contract language submitted with no indication will not be reviewed.
    g. Any other documentation that supports the appeal (e.g., commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort).

5. Providers should notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which they have submitted an appeal. Notification should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record.

Appeals to the Department should be sent to the following address:

BadgerCare Plus and Medicaid SSI
Managed Care Unit-Provider Appeal
P.O. Box 6470
Madison, WI 53716-0470
Fax Number : 608-224-6318

Section 3: Department Provider Appeal Decision

Approved Provider Appeal:

1. GHC-SCW shall abide by the Department's decision, and promptly adjudicate the claim.

Denied Provider Appeal:

1. GHC-SCW shall send an Adverse Benefit Determination to the impacted Member per:

    a. ECFR § 438.404:Timely and adequate notice of adverse benefit determination,
        - *(c) Timing of notice.* The MCO, PIHP, or PAHP must mail the notice within the following timeframes
            - (2) For denial of payment, at the time of any action affecting the claim.

2. The Adverse Benefit Determination notice for a denied provider claim is only required in circumstances where the provider's claim appeal has been denied by both GHC-SCW's and the Department's provider appeal process.

3. The Government Contract and Program Integrity Analyst shall utilize the "BC+ Adverse Determination - Provider Denied Claim" letter to notify members.