

User Guide

Provider Appeals Portal

March 11, 2024



WISCONSIN DEPARTMENT
of HEALTH SERVICES

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1 Introduction

This user guide provides information about how providers can use the Provider Appeals portal to enter, store, view, and report on data entered into the portal. This user guide provides detailed information about the Provider Appeals portal including how to:

- Navigate the portal.
- Create a new appeal.
- Create tasks.
- Monitor queues.
- Perform standard searches.
- Create and share saved advanced searches.

For questions not covered in this guide, users can call the ForwardHealth Provider Services Managed Care Unit at 800-760-0001.

1.1.1 Platforms

The Provider Appeals portal is available using the following platforms:

- Desktop
- Google Chrome (preferred browser)

2 Getting Started

This user guide provides information about how providers can use the Provider Appeals portal to enter, store, view, and report on data entered into the portal.

Note: When using the portal, it is important that the pop-up blocker be turned off. Some key features such as search results may be configured to be displayed as a new pop-up window.

2.1 Access the Provider Appeals Portal

1. Access the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/>.

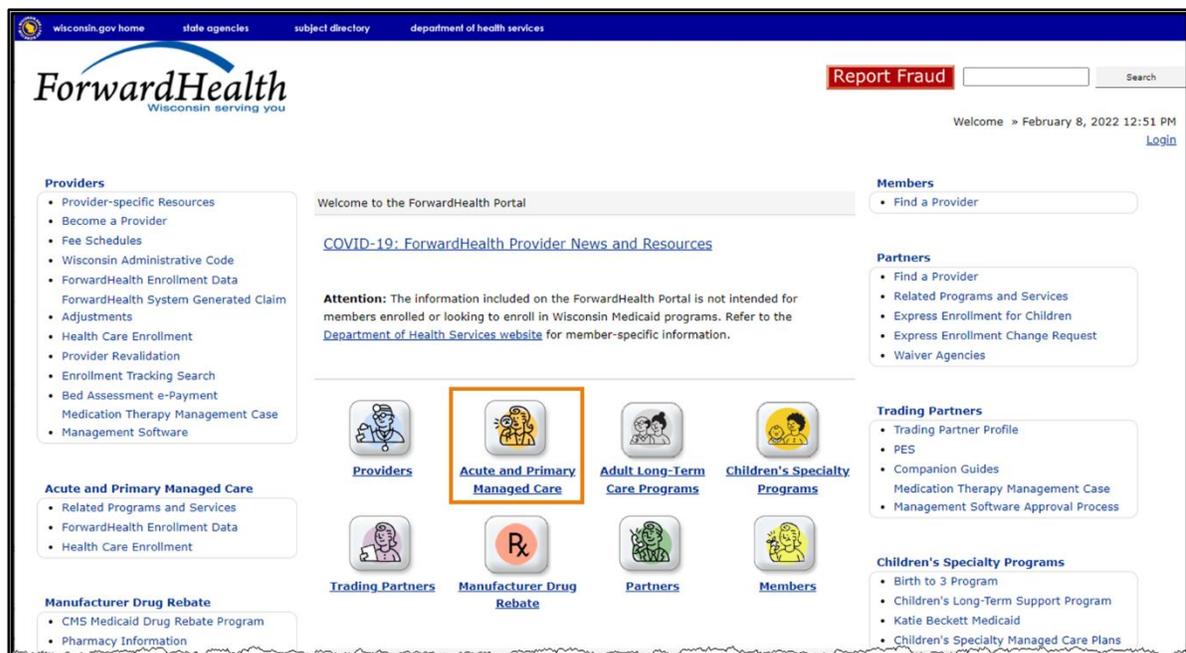


Figure 1 ForwardHealth Portal Homepage

- On the ForwardHealth Portal homepage, click the **Acute and Primary Managed Care** icon. The Acute and Primary Managed Care page will be displayed.

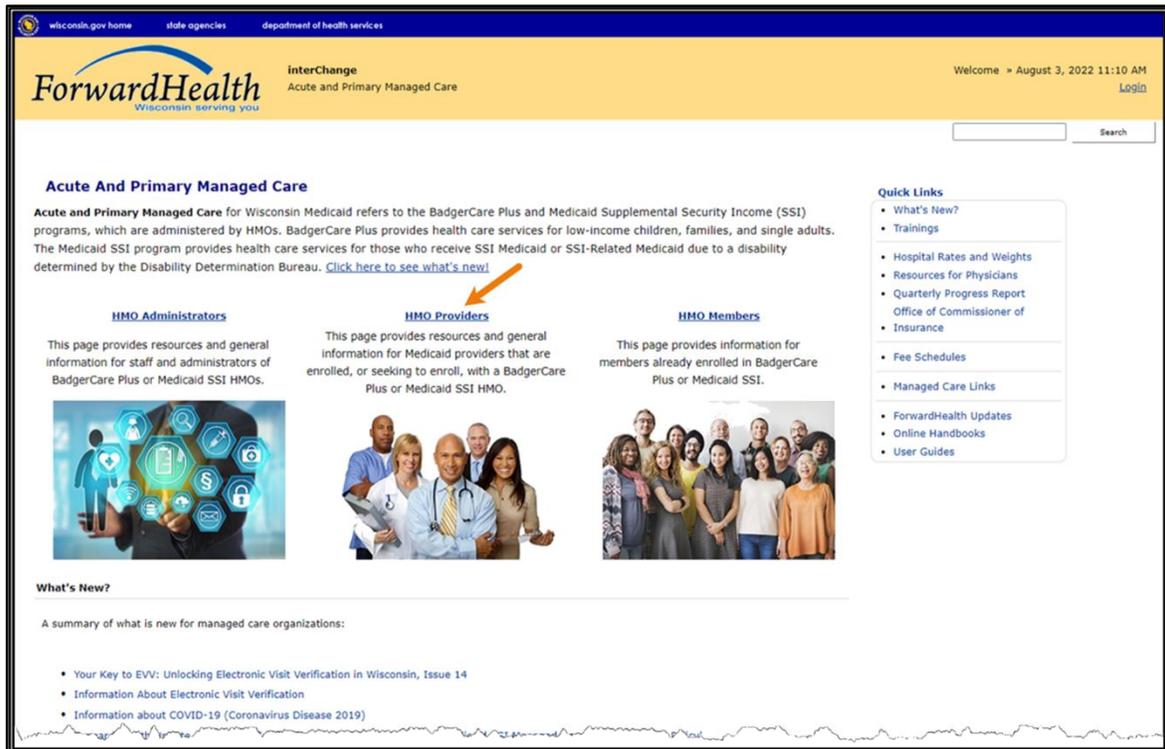


Figure 2 Acute and Primary Managed Care Page

3. Click **HMO Providers**. The HMO Providers page will be displayed.

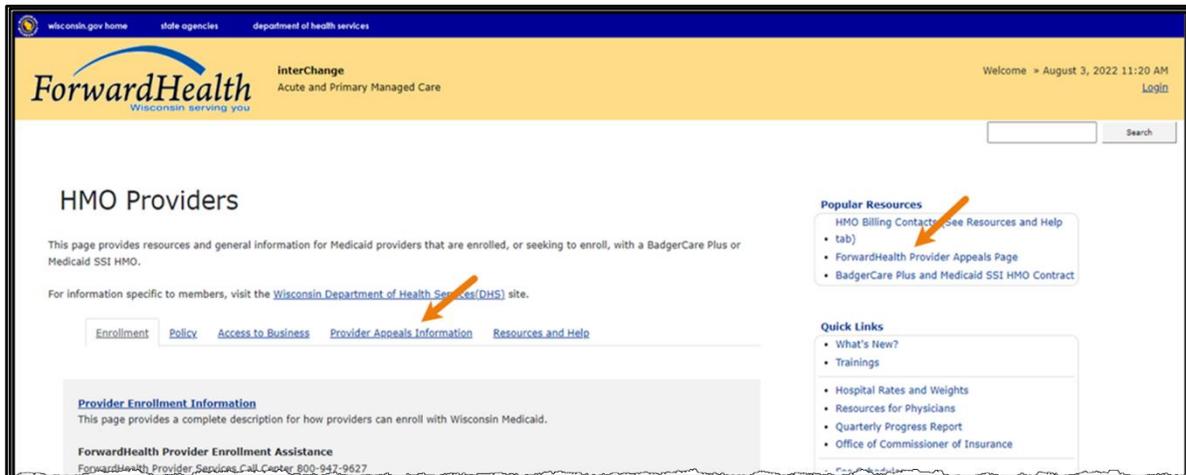


Figure 3 HMO Providers Page

4. Click **Provider Appeals Information** to display the provider appeals information links. Note: Users can also click the **ForwardHealth Provider Appeals Page** link under the Popular Resources box on the HMO Providers page and move to [Step 6](#).

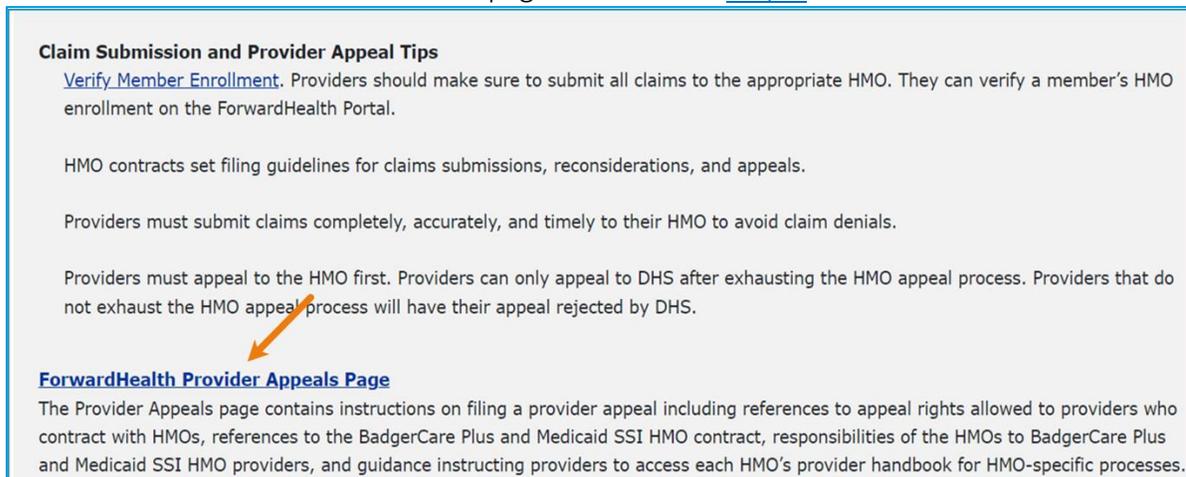


Figure 4 Provider Appeals Information Links

- Click **ForwardHealth Provider Appeals Page**. The BadgerCare Plus/Medicaid SSI HMO Provider Appeals or Children’s Specialty Managed Care Prepaid Inpatient Health Plan Provider Appeals page will be displayed.

wisconsin.gov home state agencies department of health services

Welcome » September 1, 2022 1:10 PM Login

BadgerCare Plus or Medicaid SSI HMO Provider Appeals

BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care Prepaid Inpatient Health Plan Provider Appeals

The [BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care Prepaid Inpatient Health Plan \(PIHP\) Contracts](#) outline the appeal rights allowed to ForwardHealth providers who contract with HMOs/PIHPs. The contract includes the responsibilities the HMOs/PIHPs have to BadgerCare Plus/Medicaid SSI HMO or children's specialty managed care PIHP providers, including the right to appeal a non-payment or partial payment, and the steps the provider must take to appeal a decision to ForwardHealth.

For current information on how to file an appeal with a BadgerCare Plus/Medicaid SSI or children's specialty managed care PIHP member's HMO, refer to that HMO's/PIHP's provider handbook. Some HMOs/PIHPs provide more time to appeal than others. Providers must exhaust all appeal options with the HMO/PIHP before filing an appeal to ForwardHealth. Providers may not appeal to ForwardHealth until after they have already appealed to the HMO/PIHP.

Quick Links

- Provider Appeals portal
- Provider Appeals Portal User Guide
- Provider Appeals Portal for BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP Provider Appeal Submission Training

Appeal Deadlines

When a provider submits an appeal to the HMO/PIHP, the HMO/PIHP has 45 days to respond to their appeal. As a reminder, if the provider does not provide evidence of an appeal to the HMO/PIHP, ForwardHealth will reject the appeal.

If...	Then...
The HMO/PIHP denies the provider's appeal, The HMO/PIHP does not respond by the 45-day deadline,	The provider has 60 calendar days from the date of the HMO's/PIHP's denial to submit their appeal to ForwardHealth. The provider has 60 calendar days from the 45-day deadline to submit their appeal to ForwardHealth.

Required Documentation

The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the HMO's/PIHP's denial.

Providers are required to submit appeals to ForwardHealth through the [Provider Appeals portal](#). Information regarding registering for a Provider Appeals portal account is [available](#). The following information/documentation must be submitted/attached in required fields:

- The original claim submitted to the HMO/PIHP and all corrected claims submitted to the HMO/PIHP
- All of the HMO's/PIHP's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial
- The provider's written appeal to the HMO/PIHP
- The HMO's/PIHP's response to the provider's appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal (Providers should only submit relevant documentation that supports the appeal. Large medical records submitted with no indication of where supporting information is found will not be reviewed.)
- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated (Contract language submitted with no indication of where supporting information is found will not be reviewed, and the denial will be upheld.)
- Any other documentation that supports the provider's appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only relevant documentation should be included.

Managed Care Online Handbook Topics

Providers can find additional information about managed care claims in the [Claims chapter](#) of the Online Handbook or in one of the topics listed below:

- Appeals to BadgerCare Plus/ Medicaid SSI HMOs or Children's Specialty Managed Care Prepaid Inpatient Health Plans (#384)
- Appeals to ForwardHealth (#385)
- Claims Submission (#386)
- Extraordinary Claims (#387)
- Medicaid as Payer of Last Resort (#388)
- Provider Appeals (#389)

Below is a list of Online Handbook topics that address common situations that lead to denied claims. Providers may want to review the topic relevant to their appeal:

- When the HMO/PIHP refuses to provide a service to a member—Enrollee Grievances(#393)
- Provider responsibility when submitting a claim—Accuracy of Claims (#516)
- Provider responsibility for record documentation—Preparation and Maintenance of Records (#203)
- Verification of member managed care enrollment when scheduling an appointment and before delivering a service—Enrollment Verification on the Portal (#4901)
- Allowed payment acceptance amounts—Acceptance of Payment (#258)
- Contract precedence—Managed Care Contracts (#402)
- Coordination of benefits between HMO/PIHP and commercial insurance coverage—Claims for Services Denied by Commercial Health Insurance (#844)
- Services and resources available to providers—Resources Reference Guide (#4456)

Other Resources

Providers should contact the member's HMO/PIHP for questions regarding a specific claim or for more information on the HMO's/PIHP's appeal process.

To check the status of an appeal submitted to ForwardHealth, providers can:

- Access the [Provider Appeals portal](#).
- Call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Figure 5 BadgerCare Plus/Medicaid SSI HMO Appeals or Children’s Specialty Managed Care Prepaid Inpatient Health Plan Provider Appeals Page

- Click one of the Provider Appeals portal links. The Provider Appeals Portal Login page will be displayed.

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Provider Appeals portal Login

If you are a returning user, please enter your username and password below.

Username

Password

Go!

Forgot Password

Request ForwardHealth Provider Appeals portal Access

For first time users, select one of the following options to register for an account.

HMO Registration

Provider Registration

*If you are third party administrator or out-of-state provider, call the EDI Help Desk at 866-416-4979 or send an email to VEDSWIEDI@wisconsin.gov to begin registration.

[About](#) | [Contact](#) | [Privacy Notice](#)

Wisconsin Department of Health Services

Figure 6 Provider Appeals Portal Login Page

7. If desired, the user can bookmark the Provider Appeals Portal Login page for future use in Google Chrome by using the following steps:

a. Click the bookmark icon.

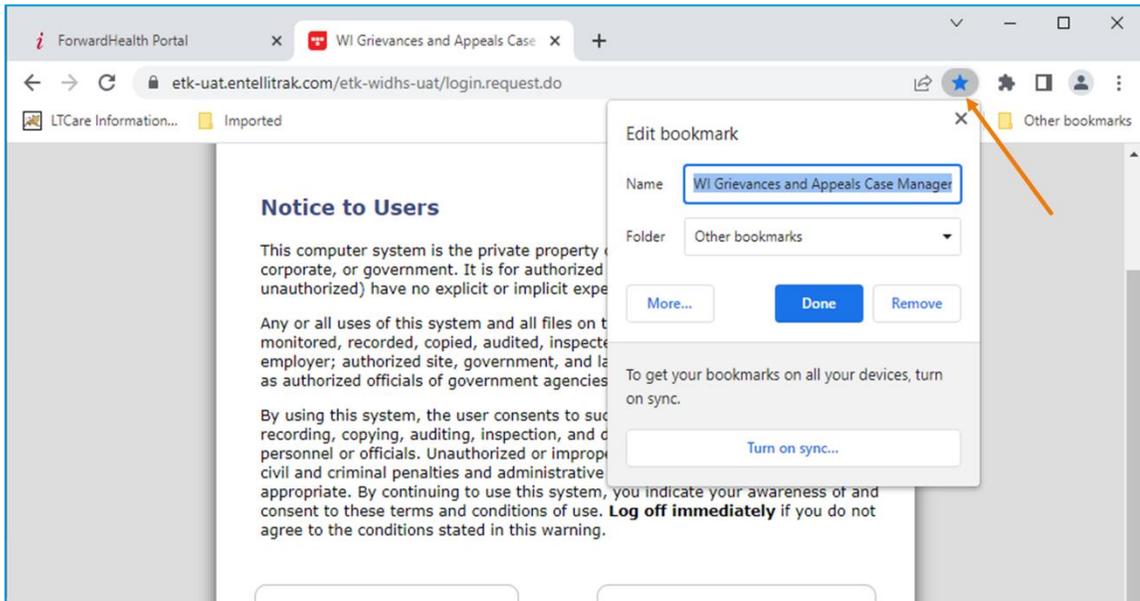


Figure 7 Bookmark Icon

b. Select the appropriate folder from the drop-down menu and click **Done**.

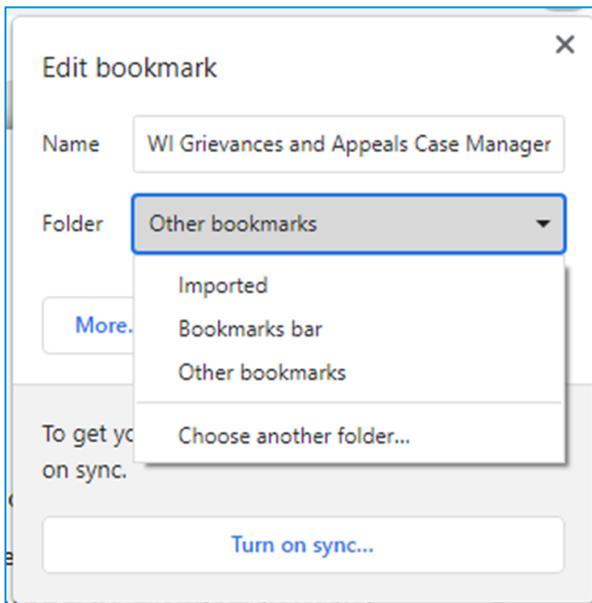


Figure 8 Bookmark Folder

- c. Click the folder and the link will be added.



Figure 9 Bookmark Link

2.1.1 Logging in to the Provider Appeals Portal

1. To log in to the portal, the user must have completed registration and received an assigned username and password.
2. Enter username.
3. Enter password. Note: When logging in to the portal, the password is masked for security purposes. The username and password are case sensitive.
4. Click **Go!**
 - If the password is expired since the last login, the user will need to provide their username and click **Search User**. The user must correctly answer security questions and then will be prompted to reset their password. Passwords should be at least eight characters long; must contain a combination of uppercase and lowercase letters, numbers, and special characters; and should be different from the last 10 passwords.
 - If the user does not enter the correct username and password combination, an error message will be displayed that the username and/or password is incorrect. If the user is unsuccessful after three login attempts, the account is locked.
 - If an account is locked, a user must call the Electronic Data Interchange (EDI) Help Desk at 866-416-4979 or send an email to VEDSWIEDI@wisconsin.gov.
5. After successfully logging in to the portal, the user will be taken to the homepage that has a list of all appeals relevant to them.

2.1.2 Logging out of the Provider Appeals Portal

Log out of the portal by clicking the **Sign Out** link that appears in the menu above the navigation tabs at the top left of the screen.

2.1.3 Password Expiration

The user's password will expire after 60 days. To reset a password, a user should click **Forgot Password** on the login page. The user will be required to answer their Security Questions. Upon accurately answering the Security Questions, a temporary PIN will be emailed to the email address with which the user previously completed registration. For this reason, it is advised not to use a group email address when registering, but rather an individual's work email address. The user will receive an email reminder every day within 10 days of the expiration date. If a user

successfully logs in within 10 days of the expiration date, there will also be a pop up reminding them to reset their password.

Email reminders sent to a group email address do not indicate the user account that is expiring for security reasons. If a user registers their Provider Appeals portal account with a group email address, the 10-day email reminder will be sent to the group email address without indicating which specific user’s account is expiring. Once the account within the 10-day expiration timeframe is reset, the email reminders will cease.

Users can also stop the reoccurring password reminders from being received by resetting their password. After logging in, hover over the My Account tab and select **Password**. Users can reenter their current password and create a new password abiding by the new password restrictions.

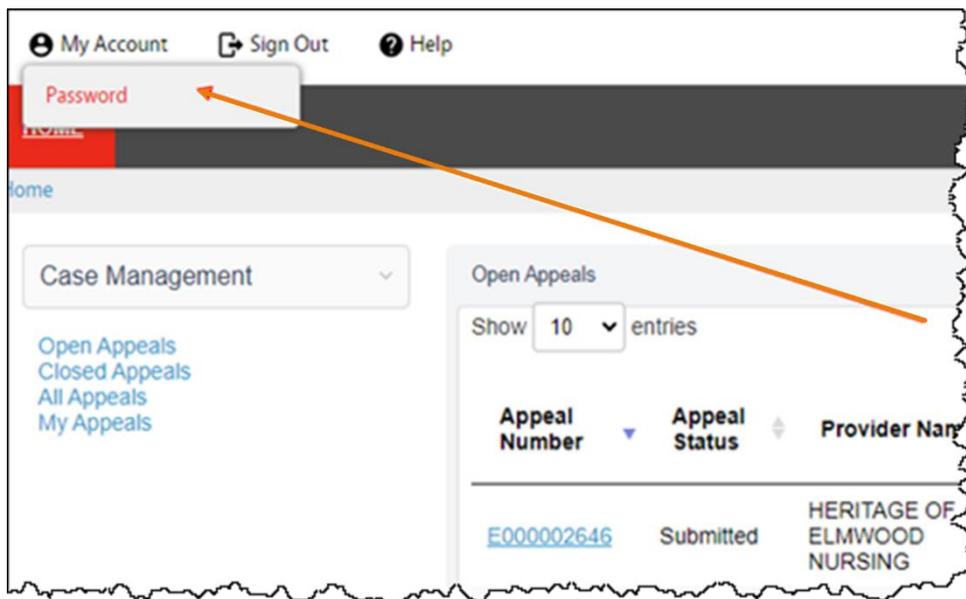


Figure 10 My Account Tab—Select Password

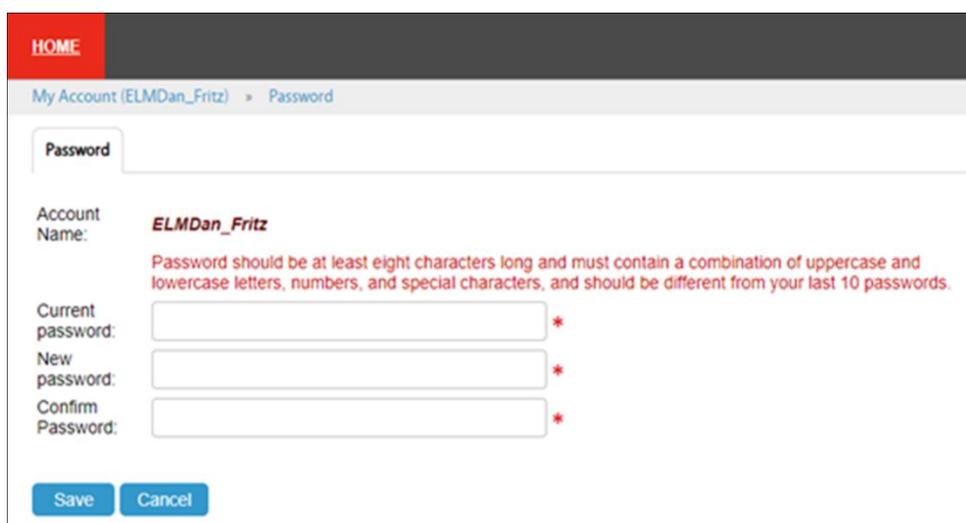


Figure 11 Create a New Password Screen

2.2 User Registration

2.2.1 Provider Registration

1. Click **Provider Registration** on the landing page. The portal displays a registration form.

The screenshot shows a web form titled "User Registration" with a sub-heading "Provider User Registration". Below the title, it states "Required Fields are Indicated with an Asterisk *". The section is titled "Provider Demographic Information" and contains the following fields:

- Is the Provider a Behavioral Treatment, Blood Bank, Personal Care Agency, or Specialized Medical Vehicle? * (Radio buttons for Yes and No, with No selected)
- National Provider Identifier (text input field)
- Medicaid Provider ID (text input field)
- Primary Taxonomy Code (text input field)
- Provider ZIP+4 Code * (text input field)
- Financial Payer * (dropdown menu)
- TIN (text input field)
- Date of Service * (calendar icon and text input field with placeholder "mm/dd/yyyy")

A blue "Search Provider" button is located at the bottom right of the form.

Figure 12 Provider User Registration Form—Provider Demographic Information

2. Fill out the required provider fields under the Provider Demographic Information section:
 - In addition to the required fields indicated with an asterisk, Medicaid Provider ID or both National Provider Identifier (NPI) and Primary Taxonomy Code must be entered to search for a provider.
 - The provider zip+4 code entered must match the provider’s mailing address on file with ForwardHealth. Either five digits or 10 digits, in #####-#### format, must be entered. If the last four digits are unknown, “-0000” can be entered.

3. Click **Search Provider**. A Confirm Demographics box will be displayed. Note: If there are errors, a message will display “Provider not found.” Verify the provider information was entered correctly and each field matches exactly what is in ForwardHealth. If there are still errors after these checks, call the EDI Help Desk at 866-416-4979 or send an email to VEDSWIEDI@wisconsin.gov.

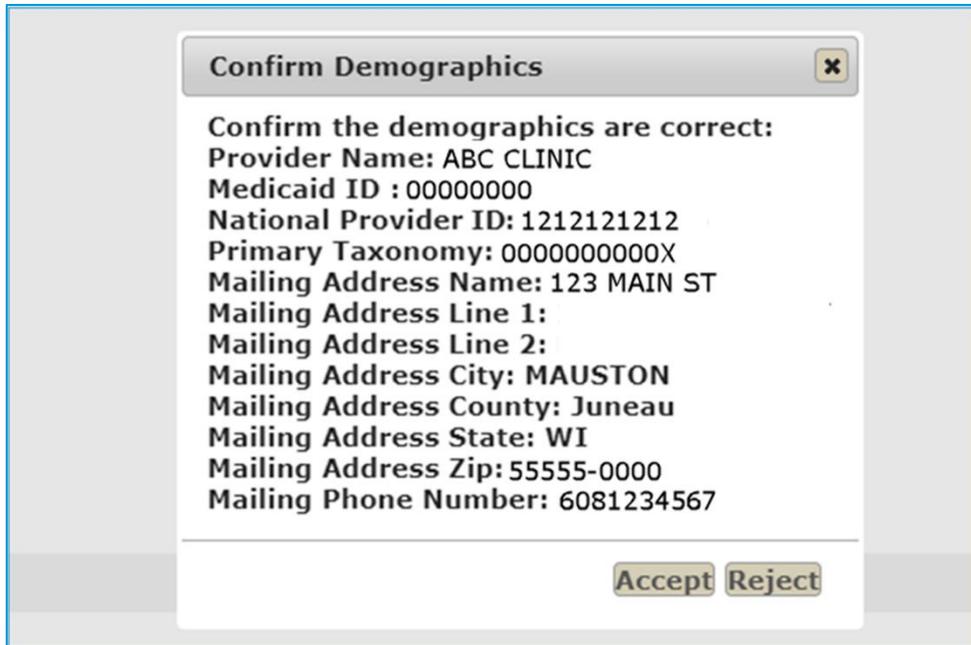


Figure 13 Confirm Demographics Page—Provider Registration

4. Click **Accept**. The provider data will be populated.

Note: The user can click **Reject** to return to the provider registration page and enter different information. By clicking **Reject**, the data that was previously searched will not be populated.

5. Complete the remaining required fields under the Contact Information section.

Figure 14 Provider Registration Form—Contact Information

6. Click **Submit**. If there are errors, a message will be displayed at the top of the page and the user will not be allowed to submit until the errors are corrected. If there are no issues, a pop-up confirming the successful submission and next steps is displayed.

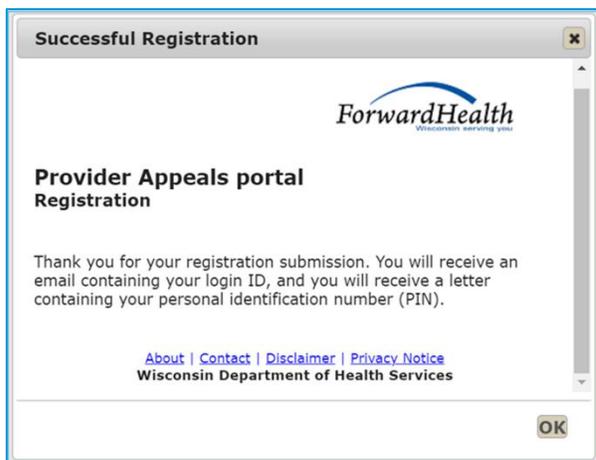


Figure 15 Provider Registration Confirmation

7. An email is sent to the user-entered email address that contains the username.

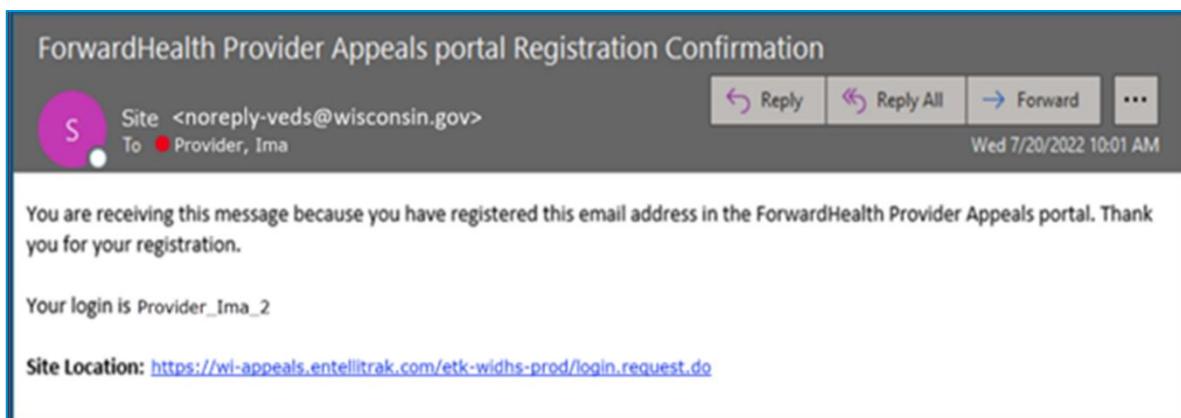


Figure 16 Email Notification—Provider Username After Successful Registration

8. A PIN letter will be mailed to the mailing address on file for the registered provider. Once the user receives the letter and logs in using the username (email) and PIN (mailed letter), the user will be required to change their password and set up security questions.

Note: PIN letters for both providers and third-party administrators will be mailed to the same address. If working remotely, arrangements should be made to retrieve the PIN letter from the organization’s mailing address where the PIN letter was sent. Third-party administrators will be unable to complete registration until they receive the PIN letter from their contracted provider:

- The PIN should be entered as the Current Password.

- The new password should be at least eight characters long; must contain a combination of uppercase and lowercase letters, numbers, and special characters; and should be different from the last 10 passwords.

This password has expired. You must change your password to continue using this application.

Password should be at least eight characters long and must contain a combination of uppercase and lowercase letters, numbers, and special characters, and should be different from your last 10 passwords.

Current password

New password

Confirm Password

Change Password

Cancel

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Figure 17 Password Reset After Successful First Login Using PIN

- Once the user’s password has been reset, the user will need to answer five security questions. If the user forgets or loses their password, the security questions will be used to validate their identity and allow them to reset their password. The user should ensure to select questions to which they will readily know the answers but that are not common knowledge.

Figure 18 Security Question Setup After Successful Password Reset

2.2.2 HMO Registration

- Click **HMO Registration** on the landing page. The portal displays a registration form.

Figure 19 HMO User Registration Form—HMO Demographic Information

2. Fill out the required MCO ID field under the HMO Demographic Information section.
3. Click **Search MCO**. A Confirm Demographics box will be displayed. Note: If any demographics are inaccurate, consult with the HMO Managed Care Analyst to update the HMO Contact Data sheet.

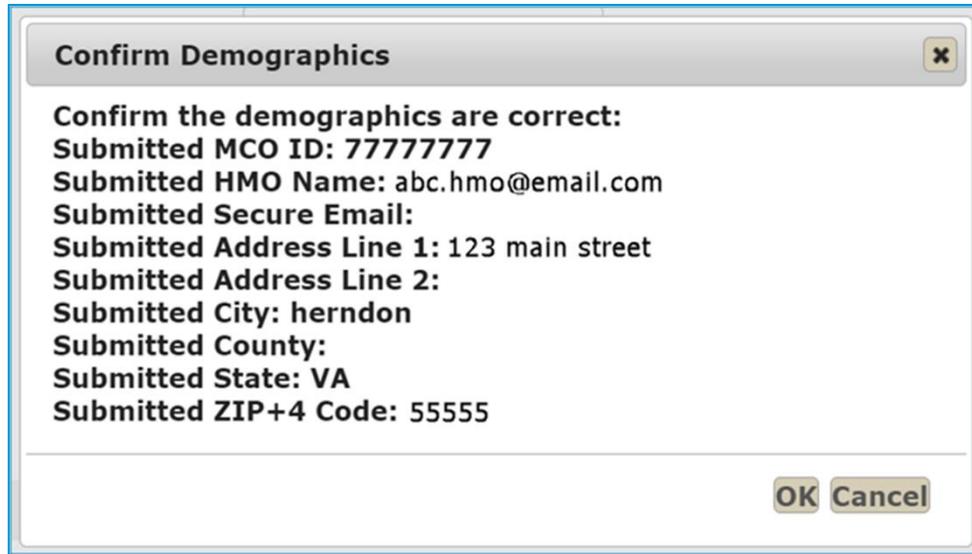


Figure 20 Confirm Demographics Page—HMO Registration

4. Click **OK**. The HMO data will be populated.

5. Complete the remaining required fields under the HMO Contact Information section.

HMO Contact Information

Secure Email *

First Name *

Last Name *

Title *

Contact Phone Number (10 digits, no hyphens or parentheses) *

Mailing Address if different from HMO Address

Address Line 1

Address Line 2

City

County

State

ZIP+4 Code

Figure 21 HMO Registration Form—HMO Contact Information

6. Click **Submit**.

- If there are errors, a message will be displayed at the top of the page and the user will not be allowed to submit until the errors are corrected.
- If there are no issues, a pop-up confirming the successful submission and next steps is displayed.

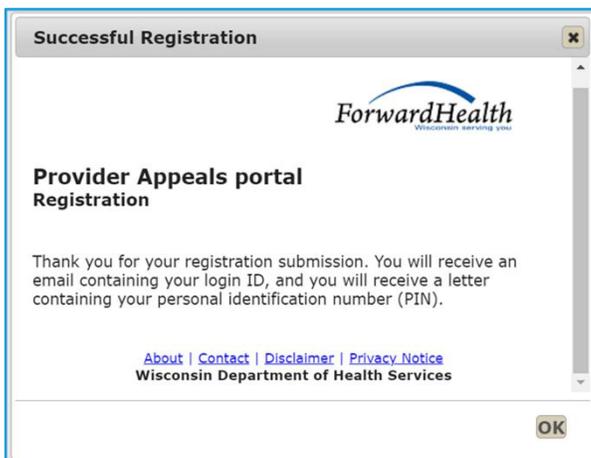


Figure 22 HMO Registration Confirmation

- An email is sent to the user-entered email address that contains the username.

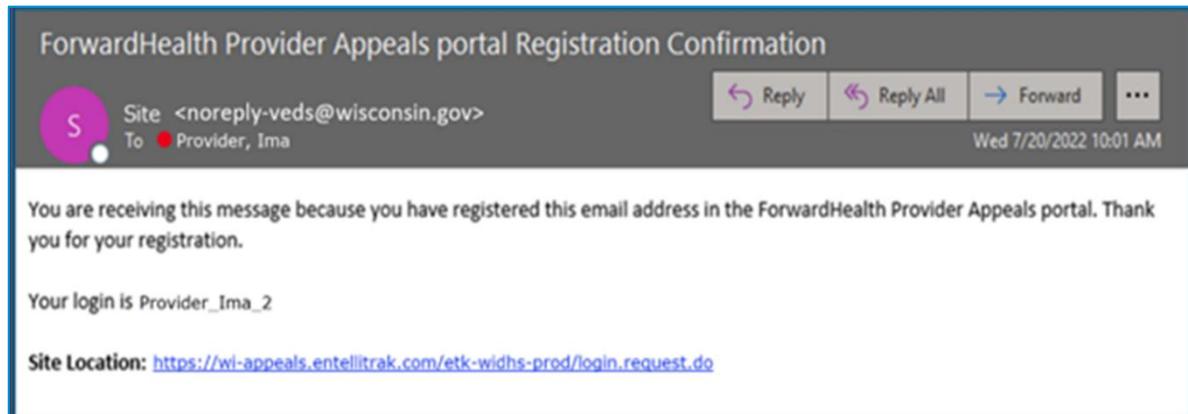


Figure 23 Email Notification—HMO Username After Successful Registration

- A PIN letter will be mailed to the mailing address on file for the registered HMO. Once the user receives the letter and logs in using the username (email) and PIN (mailed letter), the user will be required to change their password and set up security questions.
 - The PIN should be entered as the Current password.

- The new password should be at least eight characters long; must contain a combination of uppercase and lowercase letters, numbers, and special characters; and should be different from the last 10 passwords.

This password has expired. You must change your password to continue using this application.

Password should be at least eight characters long and must contain a combination of uppercase and lowercase letters, numbers, and special characters, and should be different from your last 10 passwords.

Current password

New password

Confirm Password

Change Password

Cancel

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Figure 24 Password Reset After Successful First Login Using PIN

- Once the user’s password has been reset, the user will need to answer five security questions. If the user forgets or loses their password, the security questions will be used to validate their identity and allow them to reset their password. The user should ensure to select questions to which they will readily know the answers but that are not common knowledge.

Security Questions

Security Question 1

Answer

Security Question 2

Answer

Security Question 3

Answer

Security Question 4

Answer

Security Question 5

Answer

Figure 25 Security Question Setup After Successful Password Reset

2.2.3 Third-Party Administrator or Out-of-State Provider Registration

1. Third party administrators or out-of-state providers must call the EDI Help Desk at 866-416-4979 or send an email to VEDSWIEDI@wisconsin.gov to begin registration. The user will need the following information to register over the phone. **Do not email this information:**
 - Medicaid Provider ID **or** both NPI and Primary Taxonomy Code
 - Provider ZIP+4 Code (The provider zip+4 code entered must match the provider's mailing address on file with ForwardHealth. Either five digits or 10 digits, in #####-#### format, must be entered. If the last four digits are unknown, "-0000" can be entered.)
 - Date of Service (DOS) (to submit a Provider Appeal.)
2. Upon successful registration, an email is sent to the registered email address that contains the username.

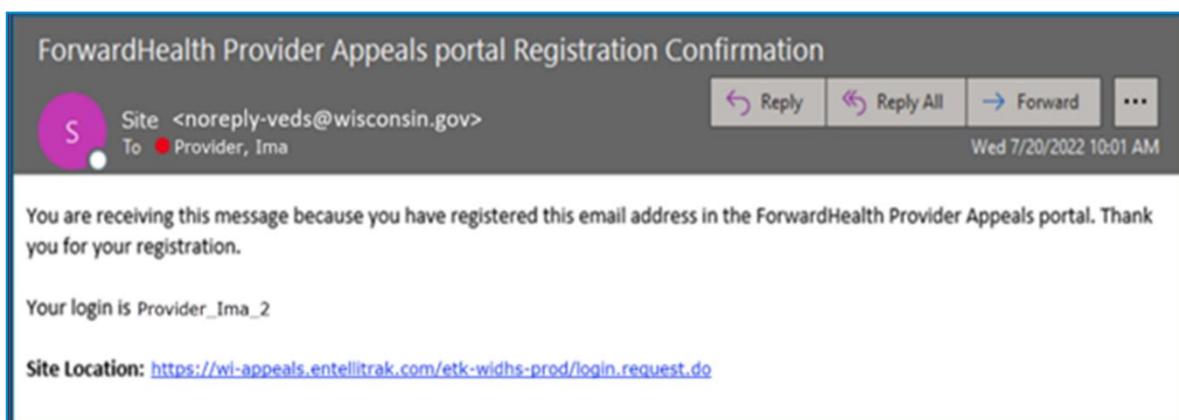


Figure 26 Email Notification—Third-Party Administrator Username After Successful Registration

3. A PIN letter will be mailed to the mailing address on file for the registered provider. Contact the provider directly to obtain the PIN information.
4. Once the user logs in using the username (email) and PIN (mailed letter to Provider), the user will be required to change their password and set up security questions:
 - The PIN should be entered as the Current password.

- The New Password should be at least eight characters long; must contain a combination of uppercase and lowercase letters, numbers, and special characters; and should be different from the last 10 passwords.

This password has expired. You must change your password to continue using this application.

Password should be at least eight characters long and must contain a combination of uppercase and lowercase letters, numbers, and special characters, and should be different from your last 10 passwords.

Current password

New password

Confirm Password

Change Password

Cancel

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Figure 27 Password Reset After Successful First Login Using PIN

- Once the user’s password has been reset, the user will need to answer five security questions. If the user forgets or loses their password, the security questions will be used to validate their identity and allow them to reset their password. The user should ensure to select questions to which they will readily know the answers but that are not common knowledge.

Security Questions

Security Question 1

Answer

Security Question 2

Answer

Security Question 3

Answer

Security Question 4

Answer

Security Question 5

Answer

Figure 28 Security Question Setup After Successful Password Reset

3 Provider Appeal Workflow

This section will cover the flow of a Provider Appeal from submission to closure.

3.1 Create and Submit a New Provider Appeal

1. Create a new provider appeal by clicking the **Create New Appeal** button from the home screen.

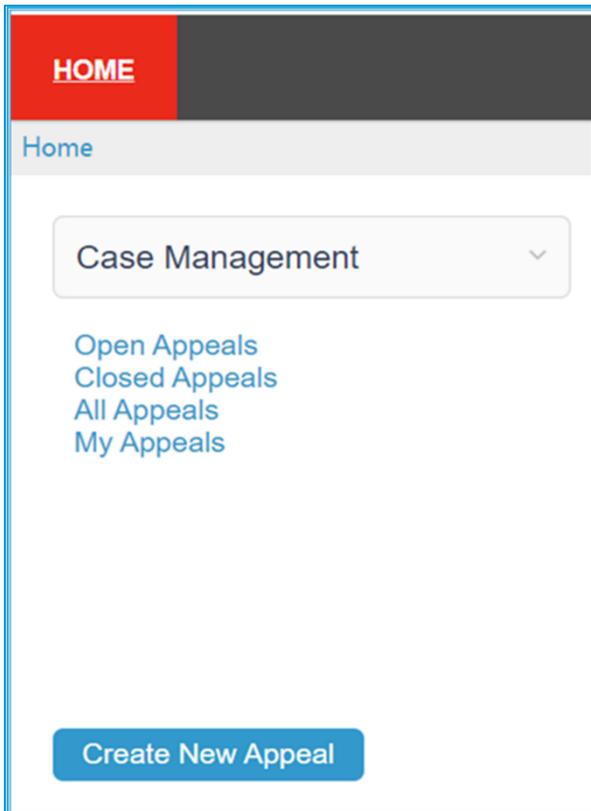


Figure 27 Create a New Provider Appeal

- Click the drop-down menu and select Provider Appeal in the Case Type box.

The screenshot shows a web interface with a dark header containing the word 'HOME'. Below the header is a light grey bar with the text 'New Case/Appeal'. The main content area features a label 'Case Type *' followed by a dropdown menu that currently displays 'Provider Appeal'. Below this is a blue button labeled 'Save'.

Figure 28 Select Case Type

- Click **Save**.
- The next screen will display an assigned appeal number (1 and 2), and the provider information that was used to initially register. The Case Status is “Not Submitted.”

The screenshot shows a web page titled 'Tracking Inbox > Case/Appeal (E000000000)'. At the top right, there is an 'Assignment:' dropdown menu set to 'Provider Efiler/Portal - [User]'. On the left, there is a 'Case/Appeal' sidebar. The main content area displays provider information: 'Provider Name: ABC CLINIC / NPI: 0000000000 / Medicaid ID:00000000 / Primary Taxonomy Number: 0000000000X E000000000'. A 'Printer Friendly Format' button is visible. Below the text is a table:

Case Type	Case Status
Provider Appeal	Not Submitted

Figure 29 Assigned Case Number

- Fill out the required provider fields in the first section of the form:

The screenshot shows a form section with the following elements:

- A question: 'Is the provider a Behavioral Treatment, Blood Bank, Personal Care Agency or Specialized Medical Vehicles?' with radio buttons for 'Yes' and 'No' (the 'No' button is selected).
- Input fields for: 'NPI', 'Medicaid Provider ID', 'Primary Taxonomy Code', 'ZIP+4 Code *', 'Financial Payer *' (with a dropdown arrow), and 'Date of Service *' (with a calendar icon and '(mm/dd/yyyy)' format).
- A blue button labeled 'Search Provider' at the bottom right.

Figure 30 First Section of Provider Appeal Case Form

- Select Yes or No to the question “Is the provider a Behavioral Treatment, Blood Bank, Personal Care Agency or Specialized Medical Vehicles?”
 - In addition to the required fields indicated with an asterisk, Medicaid Provider ID or both NPI and Primary Taxonomy Code must be entered to search for a provider:
 - A user may create provider appeals for any provider within the organization (that is, the providers share a tax ID number [TIN]).
 - A third-party administrator user may only create appeals for the provider with which they registered.
 - The Provider ZIP+4 code entered must match the provider’s mailing address on file with ForwardHealth. Either five digits or 10 digits, in #####-#### format, must be entered. If the last four digits are unknown, “-0000” can be entered.
 - Select Medicaid from the drop-down menu.
 - Enter the DOS in mm/dd/yyyy format. If there is a range of dates, include the earliest date in this field. Note: The user can also click the calendar icon to enter the date.
 - If there are errors, a message will display “Provider not found.” Verify the provider information was entered correctly and that each field matches exactly what is in ForwardHealth. If there are still errors after these checks, call the EDI Help Desk at 866-416-4979 or send an email to VEDSWIEDI@wisconsin.gov.
6. Click **Search Provider**. A Confirm Demographics box will be displayed.

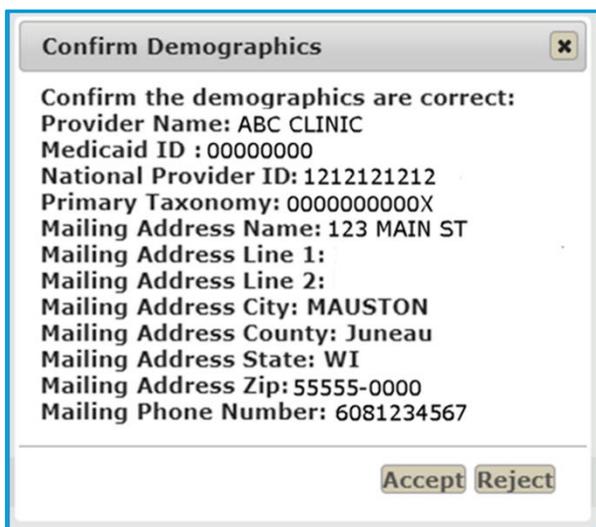


Figure 31 Confirm Demographics Page—Provider Search

- Click **Accept**. The provider data will be populated on the top of the Provider Appeal case form.

Note: The user can click **Reject** to return to the provider registration page and enter different information. By clicking **Reject**, the data that was previously searched will not be populated.

- Next, confirm the Appeal Contact Information section is populated with the provider’s contact information. Note: If any information is incorrect, the user should return to the homepage and follow the steps in the [Update Profile Information – Provider section](#).

The screenshot shows a form titled "Appeal Contact Information" with the following pre-populated data:

Appeal Contact First Name	Joe
Appeal Contact Last Name	Smith
Appeal Contact Email	Joe.Smith@email.com
Appeal Contact Phone Number	

Figure 32 Pre-Populated Appeal Contact Information

- Complete the HMO Information section.

The screenshot shows the "HMO Information" section with the following elements:

- A dropdown menu labeled "BadgerCare Plus/Medicaid SSI HMO Involved *".
- A question "Does the provider have contractual arrangement with the HMO? *" with radio buttons for "Yes" and "No".

Figure 33 HMO Information Section

- Select the BadgerCare Plus/Medicaid SSI HMO involved from the drop-down menu.
- Select **Yes** or **No** to the question “Does a provider have contractual arrangement with an HMO?”

- Complete the Member Information section.

The screenshot shows the "Member Information" section with the following elements:

- An input field for "Member ID *".
- A blue "Search Member" button.
- Input fields for "Member First Name" and "Member Last Name".

Figure 34 Member Information Section

- Enter a 10-digit member ID. If a member is not found, verify the member information in the Medicaid Management Information System (MMIS) and add leading zeros to the number, if needed.

- Click **Search Member**. A Confirm Demographics box will be displayed.

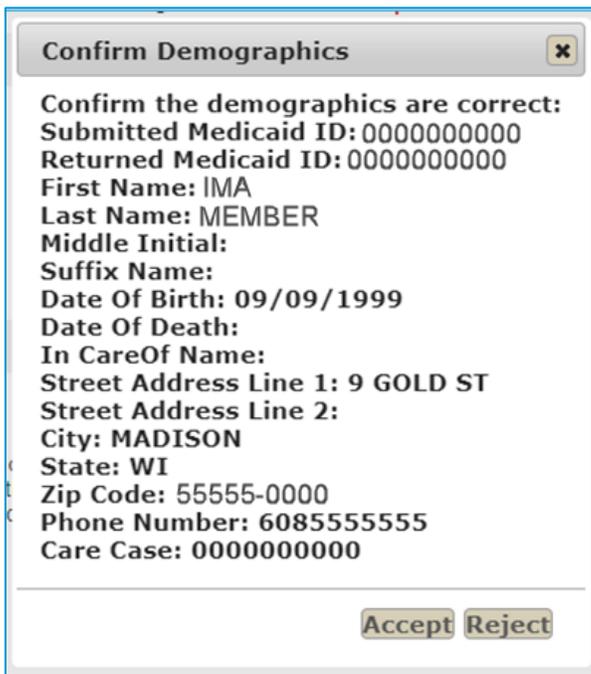


Figure 35 Confirm Demographics Page—Member Search

11. Click **Accept**. The member data will be populated in the Member Information section.

Note: Click **Reject** to return to the provider registration page and enter different information. By clicking **Reject**, the data that was previously searched will not be populated.

12. Complete the Appeal Information and final section on the Provider Appeal case form. Required fields are marked with an asterisk. Acceptable file types include .pdf, .png, .jpeg, .xls, .xlsx, .tiff, and .zip. More information can be found in the [Uploading Documents section](#).

Figure 36 Appeal Information Section

- Enter the number of members.
- If submitting appeals for more than one member, attach a spreadsheet with the following information for all members:
 - o First Name
 - o Last Name
 - o Member ID
 - o Date of Service based on the [first section of the appeal form](#).

- Select the claim type from the drop-down menu.
- Select the category from the drop-down menu.

Note: If Inpatient Claims or Inpatient Xover Claims are selected, then the ‘Date of Service To’ field is required.

- If there is more than one DOS, enter the “To” DOS in mm/dd/yyyy format. If there is only one DOS, this field can be left blank.

- Describe the reason for the appeal in the text box. Note: If more space is needed, use the **Other comments to consider** text box.
- Describe what would be considered a fair resolution to the matter in the text box. Note: If more space is needed, use the **Other comments to consider** text box.
- Add other comments to consider in the text box.

Providers are required to submit an appeal with legible copies of all of the following documentation:

Date Claim Submitted to HMO (MM/DD/YYYY) *	<input type="text"/> (mm/dd/yyyy)
Upload the original claim submitted to the HMO and all corrected claims submitted to the HMO. *	<input type="text"/> Browse
Date Remittance Issued (Denial, Reduced Payment - MM/DD/YYYY) *	<input type="text"/> (mm/dd/yyyy)
Upload all of the HMO's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial. *	<input type="text"/> Browse
Date Appeal Submitted to HMO (MM/DD/YYYY) *	<input type="text"/> (mm/dd/yyyy)
Upload the provider's written appeal to HMO *	<input type="text"/> Browse
Date HMO Rendered Appeal Decision (MM/DD/YYYY)	<input type="text"/> (mm/dd/yyyy)
Upload the HMO's response to the appeal	<input type="text"/> Browse
Upload the relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal.	<input type="text"/> Browse
Upload any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated.	<input type="text"/> Browse
Upload any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort).	<input type="text"/> Browse

[Save](#) [Submit](#)

Figure 37 Final Section of the Provider Appeal Case Form

- Enter the date the claim was submitted to the HMO in mm/dd/yyyy format.
- Upload the original claim and all corrected claims submitted to the HMO.
- Enter the date the remittance was issued in mm/dd/yyyy format.
- Upload all of the HMO's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial.
- Enter the date the appeal was submitted to the HMO in mm/dd/yyyy format.
- Upload the provider's written appeal to the HMO.
- Enter the date the HMO rendered an appeal decision in mm/dd/yyyy format.
- Upload the HMO's response to the appeal.
- Upload relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal.

- Upload any contract language that supports the provider’s appeal with the exact language that supports overturning the payment denial indicated.
- Upload any other documentation that supports the appeal.

13. Click **Save** to verify all information without submitting.

- If there are errors with the submission, Workflow Messages will be displayed at the top of the page in red text and the user will not be allowed to submit until the errors are corrected. A user will need to upload any documentation again as this is not attached to the appeal until it is successfully Saved. Note: The user cannot upload documents once the provider appeal has been saved and submitted. Any additional documentation will need to go through a coordinator to be uploaded. For additional information about the coordinator role, refer to the [Coordinator Action section](#) or [Appendix A: Portal Roles](#).

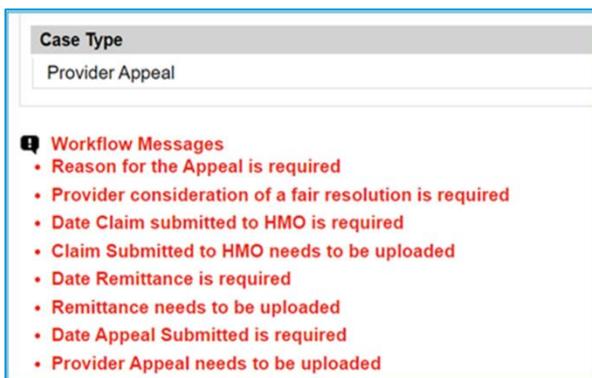


Figure 38 Sample Workflow Messages

- If there is a similar provider appeal that has already been submitted, a warning message will appear. Refer to the [Check for Duplicates section](#).

14. Click **Submit**.

15. Confirm the Case Status is in Submitted status and the **Save** and **Submit** buttons are no longer available at the bottom of the Provider Appeal case form.

3.2 Check for Duplicates

16. A banner of red text will be displayed on the top of the Provider Appeal case form that says “There may be a possible duplicate appeal for this Provider. Please research list of cases on the Provider Profile.”



Figure 39 Duplicate Provider Appeal Warning Banner at Top of Provider Appeal Case Form

17. To research potential duplicate cases, the user should use the All Appeals Case Management queue- with any of the matching fields as described in the [All Appeals Queue section](#):

- Member First Name
- Member Last Name
- Member ID

- Date of Service
- HMO

3.3 Coordinator Action

Coordinators will take action to review the appeal and request any additional information needed from either the provider or HMO.

3.4 HMO Action

Note: The following actions only apply to HMO users and are not applicable to provider users.

18. Once an appeal is ready for the HMO, it will appear on the HMO user homepage in the All Appeals or Open Appeals Case Management Queues with an Awaiting Additional Information from HMO status. Note the due date assigned to that appeal is only provided in the Open Appeals Case Management Queue:

Appeal Number	Appeal Status	Provider Name	Member First Name	Member Last Name	Created Date	Additional Information Request Date	Date Additional Information Submitted	Due Date	Decision Letter	HMO Contact
E000002488	Awaiting Additional Information from HMO	ORTHOPAEDIC CONSULTANTS LLP	WILLOW	EBZERONINE	06/28/2023	06/30/2023		07/13/2023		John Doe
E000002478	Pending Review	HERITAGE OF ELMWOOD NURSING	SKYLER	EBZERONINE	06/19/2023	06/27/2023	06/27/2023	07/10/2023		

Figure 40 Appeals Ready for HMO Action

- The Provider Appeals portal will send an email to the shared HMO email distribution list if documentation is requested for an appeal and it moves into this status. Note the due date assigned to that appeal. A reminder of an overdue task will not be sent. If needed, HMOs should request an extension before the 14th calendar day by calling the ForwardHealth Managed Care Unit at 800-760-0001 or sending an email to VEDSProviderandMCOAppeals@wisconsin.gov. If the extension is approved, the HMO will receive another email with the updated due date.

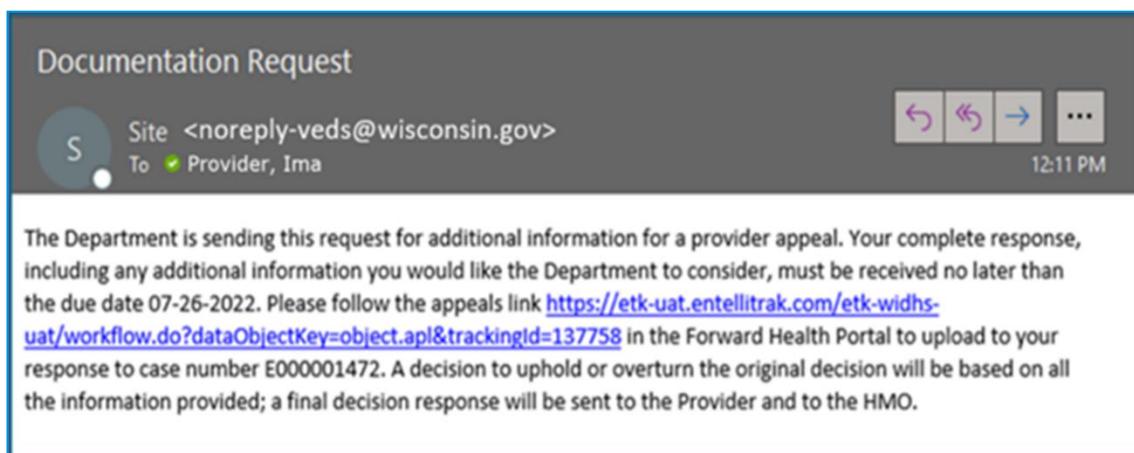


Figure 41 Documentation Request Email Sent to HMO

- To change the shared email address for the user’s HMO, go through the HMO Managed Care Analyst to update the HMO Contact Data sheet.

19. Open the provider appeal case form by clicking the Appeal Number link from the homepage or the link in the notification email. Review all appeal information including attachments.
20. Optional: The user can add their name to the HMO Appeal Contact Name field for record keeping. This will allow a user to filter appeals assigned to them using the HMO contact field on the homepage.



Figure 42 Optional HMO Appeal Contact Name Field

21. At the bottom of the Provider Appeal case form, there are three options to choose from to determine the action.

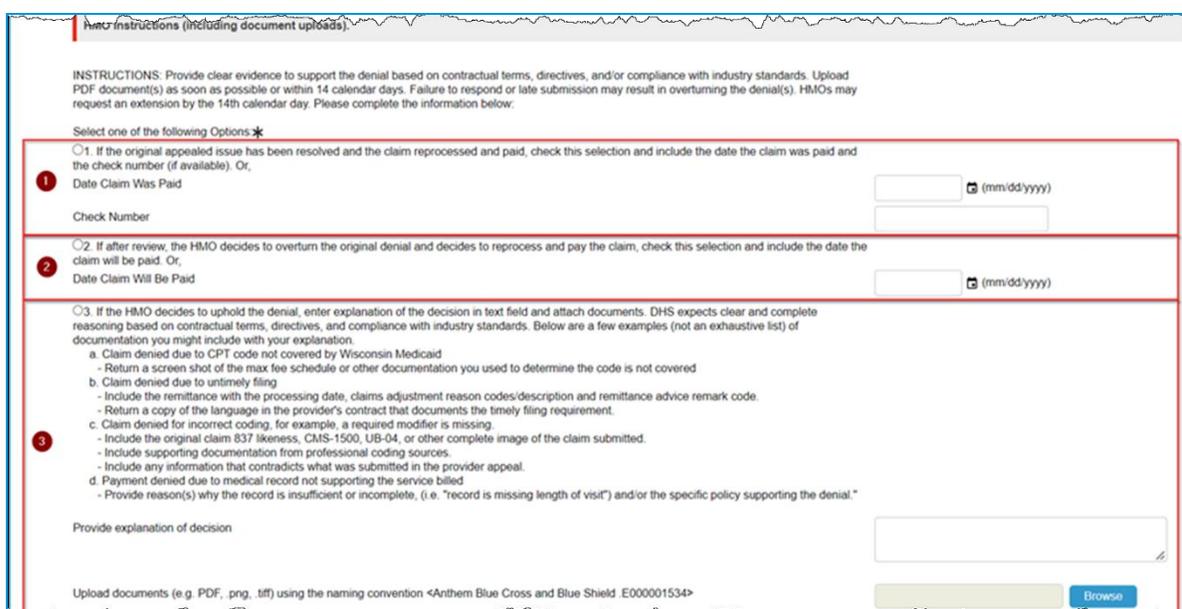


Figure 43 HMO Instructions Section of Provider Appeal Case Form

- If Option 1 is selected, enter the **Date Claim Was Paid** and **Check Number** (optional).
- If Option 2 is selected, enter the **Date Claim Will Be Paid**.
- If Option 3 is selected, enter free text in the **Provide explanation of decision** field and **Upload documents** with the requested naming convention. Note: The HMO may also enter an explanation into the **Provide explanation of decision** field for options 1 and 2.

Refer to the [Uploading Documents section](#) for additional instructions.

22. Click **Save**. If a required field is not completed, there will be a warning message pop-up or a workflow message will display in red text at the top of the screen that needs to be resolved. When an error occurs, a user will need to upload any documentation again as documentation is not attached to the appeal until it is successfully saved.

23. Click **Submit**.

24. Confirm the Case Status is in Pending Review status and the **Save** and **Submit** buttons are no longer available at the bottom of the Provider Appeal case form.

3.5 Final Coordinator Action

The coordinators will take action to review the appeal and make a final decision.

3.6 View the Decision Letter

Once the decision is made, an email notification will be sent to the provider and HMO, prompting a user to log in to view the decision letter. Note: A provider or HMO user can click the link from the email notification or open the appeal directly in the Provider Appeals portal.



Figure 44 Email Notification of Final Decision

At the bottom of the Provider Appeal case form, the decision letter will be available to view and download.

Upload the relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal.

Upload any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated.

Upload any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort).

HMO Instructions (including document uploads).

1. If the original appealed issue has been resolved and the claim reprocessed and paid, check this selection and include the date the claim was paid and the check number (if available). Or,
 Date Claim Was Paid
 Check Number

2. If after review, the HMO decides to overturn the original denial and decides to reprocess and pay the claim, check this selection and include the date the claim will be paid. Or,
 Date Claim Will Be Paid

3. If the HMO decides to uphold the denial, enter explanation of the decision in text field and attach documents. DHS expects clear and complete reasoning based on contractual terms, directives, and compliance with industry standards. Below are a few examples (not an exhaustive list) of documentation you might include with your explanation.

- a. Claim denied due to CPT code not covered by Wisconsin Medicaid
 - Return a screen shot of the max fee schedule or other documentation you used to determine the code is not covered
- b. Claim denied due to untimely filing
 - Include the remittance with the processing date, claims adjustment reason codes/description and remittance advice remark code.
 - Return a copy of the language in the provider's contract that documents the timely filing requirement.
- c. Claim denied for incorrect coding, for example, a required modifier is missing.
 - Include the original claim 837 likeness, CMS-1500, UB-04, or other complete image of the claim submitted.
 - Include supporting documentation from professional coding sources.
 - Include any information that contradicts what was submitted in the provider appeal.
- d. Payment denied due to medical record not supporting the service billed
 - Provide reason(s) why the record is insufficient or incomplete, (i.e. "record is missing length of visit") and/or the specific policy supporting the denial."

Provide explanation of decision

Upload documents (e.g. PDF, .png, .tiff) using the naming convention <Children Come First.E000002640>

Provider Decision Letter E000002640Upheld.pdf

[Notes Log](#)

Figure 45 Provider Decision Letter Displayed at Bottom of Provider Appeals Case Form

4 Navigation

4.1 Update Profile Information—Provider

1. Click the **Update Profile** link under My Pages on the left side to update profile information including contact information and services. The Demographic Info section displays information for the provider that the user registered with, and the Associated Cases section displays links to Provider Appeal case forms created by the user. Note: Fields in this section are display only.

The screenshot shows a web interface for a provider profile. At the top left is a 'Profile' tab. The main header area displays 'ABC CLINIC' and a 'Printer Friendly Format' button. Below this is a 'Profile Type' dropdown menu currently set to 'Provider'. The main content area is a table with two columns: 'Profile Type *' and 'Provider'. A red vertical bar highlights the 'Demographic Info' section. The table lists various fields such as Provider Name, NPI, Medicaid Provider ID, Primary Taxonomy Code, Provider Location Name, Financial Payer, In Care of, Address Line 1, Address Line 2, City, County of Residence, State, and ZIP+4 Code, each with its corresponding value.

Profile Type *	Provider
Demographic Info	
Provider Name	ABC CLINIC
NPI	1234567890
Medicaid Provider ID	00000000
Primary Taxonomy Code	000000000X
Provider Location Name	ABC CLINIC
Financial Payer	Medicaid
In Care of	
Address Line 1	123 MAIN ST
Address Line 2	
City	MAUSTON
County of Residence	Juneau
State	Wisconsin
ZIP+4 Code	55555-0000

Figure 46 View Demographic Info Section in Provider Profile

The Provider Contact Info section displays current information for the user. Fields in this section can be modified but will only impact new appeals created going forward.

Provider Contact Info

Please list one Provider administrative contact for DHS use.

First Name *	<input type="text" value="John"/>
Last Name *	<input type="text" value="Smith"/>
Suffix	<input type="text"/>
Title	<input type="text"/>
Contact Phone Number (10 digits, no hyphens or parentheses) *	<input type="text" value="5551234567"/>
Email *	<input type="text" value="john.smith@email.com"/>
Mailing Address (if different from Provider Address)	
Address Line 1	<input type="text"/>
Address Line 2	<input type="text"/>
City	<input type="text"/>
State	<input type="text" value=""/>
County	<input type="text" value=""/>
ZIP+4 Code	<input type="text"/>

Figure 47 Edit Provider Contact Info Section in Provider Profile

The Associated Cases section displays all appeals associated with the provider the user registered with, as well as links to the Provider Appeal case form for each.

Associated Cases	
Appeal Case ID	Date
E000001606	07/25/2022 14:43:00
E000001607	07/22/2022 14:55:00
E000001472	07/22/2022 14:50:00
E000001462	07/22/2022 14:35:07
E000001476	07/28/2022 13:53:00
E000001456	07/06/2022 18:12:00
E000001708	07/27/2022 09:47:00
E000001682	07/26/2022 11:54:00
E000001833	08/03/2022 17:49:43
E000001832	08/03/2022 17:45:00
E000001834	08/03/2022 17:53:55
E000001831	08/03/2022 17:42:09
E000001628	08/09/2022 09:51:20
E000001835	08/03/2022 17:59:55
E000001836	08/08/2022 11:51:00

Figure 48 Associated Cases Section

The Services section displays a text box field that can be edited to add notes on the services offered.

Services

Services Offered

[Save](#)

Figure 49 Services Section

4.3 Case Management Queues for Provider Users

- Upon successful login to the Provider Appeals portal, provider users have access to Case Management Queues on the left side of the screen:
 - Open Appeals—Appeals in Open status created by the user or other users from the same organization
 - Closed Appeals—Appeals in Closed status created by the user or other users from the same organization
 - All Appeals—Appeals created by the user or other users from the same organization
 - My Appeals—Appeals in Open status created by or assigned to the user

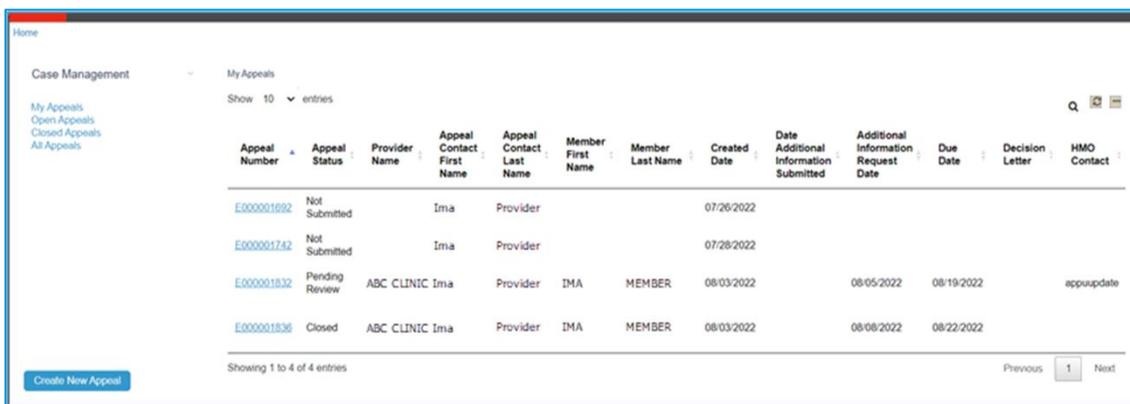


Figure 50 Provider User Home Page View

- Click the **Appeal Number** link to open the Provider Appeal case form.

4.3.1 All Appeals Queue

The Case Management Queues can filter by one or many keywords. When searching for potential duplicate appeals, utilize the search bar in the All Appeals Queue, as this will search all cases that are both open and closed.

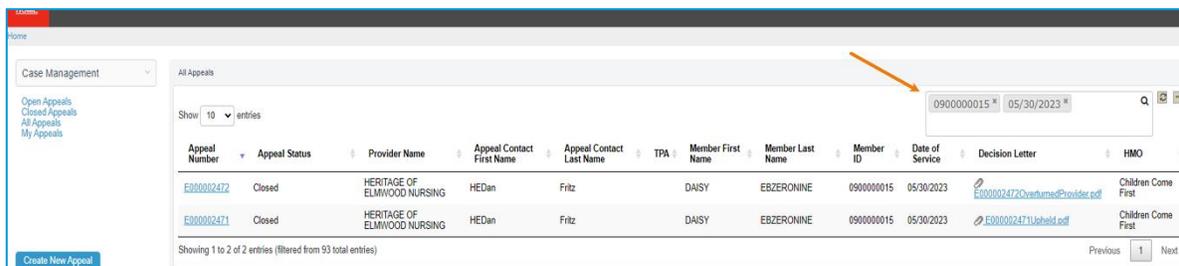


Figure 51 All Appeals Queue

4.4 Update Profile Information for HMO Users

1. Click the **Update Profile** link under My Pages on the left side to update profile information including contact information.

The screenshot shows a web interface for updating an HMO profile. At the top left is a 'Profile' tab. The main header area displays 'ABC HMO' and a 'Printer Friendly Format' button. Below this is a 'Profile Type' section showing 'HMO'. The 'Demographic Info' section contains a table of fields:

Profile Type *	HMO
Demographic Info	
County of Residence	
HMO Name	ABC HMO
HMO Secure Email	abc.hmo@email.com
Address Line 1	123 State St
Address Line 2	
City	Madison
HMO State	Wisconsin
HMO County	Dane
ZIP+4 Code	55555

The 'HMO Contact Info' section includes a note: 'Please list one HMO administrative contact for DHS use.' It contains four input fields with asterisks indicating they are required:

- HMO Contact First Name *
- HMO Contact Last Name *
- HMO Contact Title *
- Contact Phone Number (10 digits, no hyphens or parentheses) *

A 'Save' button is located at the bottom right of the form area.

Figure 58 Demographic Info and HMO Contact Info Sections in HMO Profile

- The Demographic Info section displays information for the HMO that the user registered with. Fields in this section are display only.
- The HMO Contact Info section displays current information for the user. Fields in this section can be modified but will not impact the contact information used when sending email notifications for the HMO.

Case Management Queues for HMO Users

- Upon successful login to the Provider Appeals portal, HMO users have access to Case Management queues on the left side of the screen.
 - Open Appeals—Appeals in Open status that involve the HMO of the user
 - Closed Appeals—Appeals in Closed status that involve the HMO of the user
 - All Appeals—Appeals that involve the HMO of the user

Appeal Number	Appeal Status	Provider Name	Member First Name	Member Last Name	Created Date	Additional Information Request Date	Date Additional Information Submitted	Due Date	Decision Letter	HMO Contact
E000002458	Awaiting Additional Information from HMO	ORTHOPAEDIC CONSULTANTS LLP	WILLOW	EBZERONINE	06/28/2023	06/30/2023		07/13/2023		John Doe
E000002478	Pending Review	HERITAGE OF ELMWOOD NURSING	SKYLER	EBZERONINE	06/19/2023	06/27/2023	06/27/2023	07/10/2023		

Figure 59 HMO User Homepage View

- Click the **Appeal Number** link to open the Provider Appeal case form.

4.6 Menus, Fields, and Options

4.6.1 Required Fields

Business required fields are designated with an asterisk (*) to the right of the data field. If a required field is not completed, there will be a warning message pop-up or Workflow Messages will display in red text at the top of the screen when user clicks **Save**. These messages are also referred to as workflow messages.

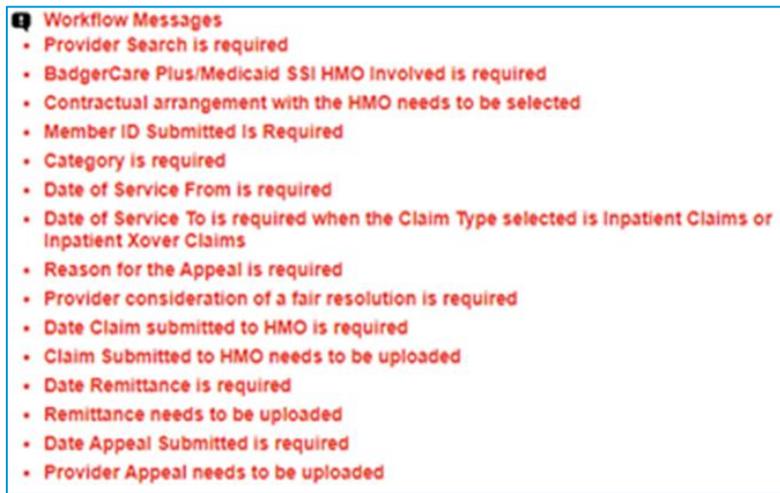


Figure 60 Required Fields

4.6.2 Uploading Documents

1. The Browse button allows the user to upload documents to the portal.

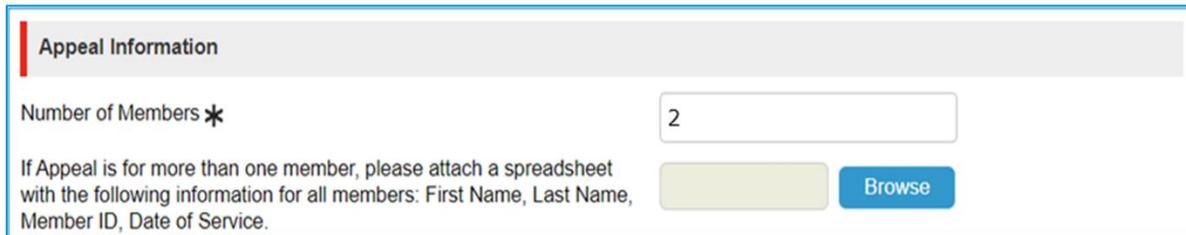


Figure 61 Browse Documents

2. When the user clicks the **Browse** button, the user will select the document to be uploaded to the appeal. The following file extensions are allowed for uploading: .pdf, .png, .jpeg, .xls, .xlsx, .tiff, and .zip

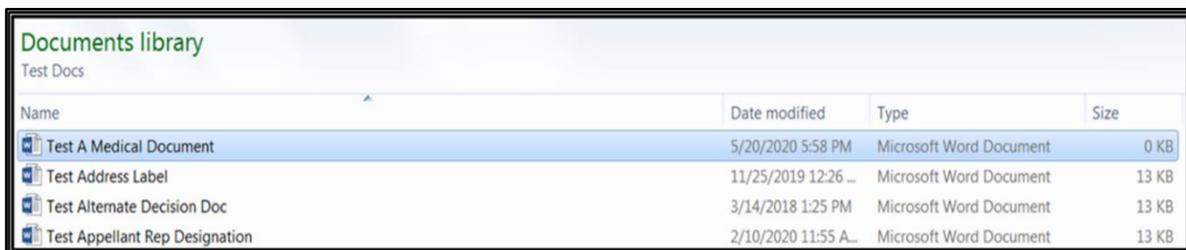


Figure 62 Select File to Upload

3. Select the file and click **Open**. The file name populates the File Name field. Note: The user may also select the file and drag it into the File Name field.

The screenshot shows a form titled "Appeal Information". It contains a field for "Number of Members" with an asterisk, where the value "2" is entered. Below this is a text instruction: "If Appeal is for more than one member, please attach a spreadsheet with the following information for all members: First Name, Last Name, Member ID, Date of Service." To the right of this text is a file selection interface showing a file named "C:\fakepath\Mem" and a blue "Browse" button.

Figure 63 Document Uploaded to Appeal

4. Complete the required and optional data elements and click **Save**. The file is uploaded to the portal when the record is saved.

This screenshot shows the same "Appeal Information" form. The "Number of Members" field still shows "2". The text instruction is the same. However, the file selection area now shows a file named "Member List.xlsx" with a document icon, indicating it has been successfully uploaded.

Figure 64 Document Successfully Saved to Appeal

Note: The user cannot upload documents once the provider appeal has been saved and submitted. Any additional documentation will need to go through a coordinator to be uploaded.

4.7 Printer-Friendly Format

The portal will display browser windows in a printer-friendly format. Clicking the **Printer Friendly Format** icon located at the top right of the screen displays the information in a printable format and opens a separate print window.



Figure 65 Printer-Friendly Format Icon

5 Additional Interface Error Messages

5.1 Member ID Not Found

If the member ID is not found in MMIS when creating an appeal and searching for a member, the portal will display Error Message 9999, “Member ID not found. Please verify Member ID was entered correctly.”

5.2 Member ID Is Found but Medicaid Management Information System Record Is Incomplete

If the member ID is found but the MMIS record is incomplete when creating an appeal and searching for a member, the portal will display Error Message 9995, “Unable to retrieve demographic information at this time. Please try again.”

5.3 Communication Error Between Provider Appeals Portal and Medicaid Management Information System

If there is a communication error between the Provider Appeals portal and MMIS when registering a user or creating an appeal and searching for a provider or member, the portal will display Error Message 9997, “Unable to retrieve demographic information at this time. Please try again.”

5.4 Provider Appeals Portal Sends Insufficient Request to Medicaid Management Information System

If there is insufficient information sent from the Provider Appeals portal to MMIS when registering a user or creating an appeal and searching for a provider or member, the portal will display Error Message 9996, “Content required to complete the Member/Provider demographics is incomplete.”

6 Appendix A: Portal Roles

Users are assigned a role when their account is set up. A role will have their permissions set for the functions the role will need within the portal that limits or allows access to main and sub records. Access levels will be set by the portal administrators:

- **Coordinator:** This user can view and update appeals and upload documents.
- **Provider/Provider eFiler:** This user has the ability to create an appeal, view appeals submitted by any users within their organization, and upload documents. This user can self-register.
- **HMO/HMO eFiler:** This user has the ability to view/edit appeals assigned to their organization and upload documents. This user can self-register.
- **Third-Party Administrator:** This user has the ability to create an appeal, view appeals they have submitted (not including all appeals submitted by the organization), and upload documents. This user cannot self-register; support is required from the EDI Help Desk and the contracted provider.

7 Appendix B: Glossary

Coordinator: A representative from the Wisconsin Department of Health Services or Gainwell Technologies as a provider appeals coordinator investigates and resolves non-payment or partial payment from the HMO insurance related to claims, provider payment disputes, and reversals within the health care industry.

Duplicate Case: If there is more than one provider appeal submitted for the same provider, member, and DOS, a warning message will appear on the case form. Refer to the [Check for Duplicates section](#) for instructions on how to handle this.

eFiler or User: This is a role (licensed separately from standard entellitrak roles) designed for external users of an entellitrak system. An efile role profile can be used when creating a new role, which limits that role's access to entellitrak functionality. In this document, an eFiler is referred to as a user.

Provider Appeal: A provider appeal is a dispute of non-payment or partial payment from the HMO.

Roles: Roles connect subjects (users and groups) to permissions, both data permissions and portal permissions. Roles are also commonly used as a determinant for page permissions, lookup filters, and display mappings as they relate to the business process.