

Managed Care HMO Provider Appeals

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Agenda

- ForwardHealth Portal
 - Managed care information on the Portal
 - HMO provider resources
 - Member enrollment verification
- Managed Care HMO Information
 - Managed Care contract
 - Managed Care - Claim Submission
- Provider Appeals
 - Appeals to HMOs and SSI HMOs
 - Appeals to ForwardHealth
 - Top Claim Denial Reasons and Reason for Appeal
- Summary

ForwardHealth Portal

ForwardHealth Portal

- Subscribe to receive email notifications for *ForwardHealth Updates*
- ForwardHealth Online Handbook
- Trainings
- Provider-specific resources



ForwardHealth Portal (Cont.)

wisconsin.gov home state agencies subject directory department of health services

ForwardHealth
Wisconsin serving you

[Report Fraud](#)

Welcome » November 1, 2016 10:25 AM [Login](#)

Providers

- Register for E-mail Subscription
- Provider-specific Resources
- Become a Provider
- Online Handbooks
- Fee Schedules
- Trainings
- Wisconsin Administrative Code
- ForwardHealth Enrollment Data
- Health Care Enrollment
- Provider Revalidation
- Enrollment Tracking Search
- Bed Assessment e-Payment
- Medication Therapy Management Case Management Software


Managed Care


- Related Programs and Services
- ForwardHealth Enrollment Data
- Health Care Enrollment


Welcome to the ForwardHealth Portal


Attention: ForwardHealth Portal supports the following browsers: Internet Explorer, Firefox and Safari.


The ForwardHealth Portal serves as the interface to ForwardHealth interChange, the new Medicaid Management Information System for the state of Wisconsin. Through this portal, providers, managed care organizations, partners, and trading partners can electronically and securely submit, manage, and maintain health records for members under their care. This Portal also provides users with access to the current health care information available.

 [Providers](#)

 [Managed Care Organization](#)

 [Partners](#)

 [Trading Partners](#)

 [Members](#)

Hot Topics

- Independent Assessments for Personal Care Services
- Resources for Dental Service Providers in Brown, Marathon, Polk, and Racine Counties
- Covered Outpatient Drug Pricing
- New Behavioral Treatment Benefit
- Incentive Payments. . . Are you Eligible?
- ForwardHealth System Generated Claim Adjustments

Members

- Member Information
- Find a Provider
- Member Contacts

Partners

- Find a Provider
- Related Programs and Services
- Express Enrollment for Children
- Express Enrollment Change Request

Trading Partners

- Trading Partner Profile
- PES
- Companion Guides
- Medication Therapy Management Case Management Software Approval Process

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Managed Care Information on the Portal

Managed Care Organizations

Managed care benefit and policy information includes:

- HMO contract
- Enrollment information
- Contact information
- Provider appeals
 - Article VIII — Appeals and Grievances
 - 1 – HMO Responsibilities
 - 2 – Provider Responsibilities

HMO Provider Responsibility

- Providers should consult their signed contract, the HMO website and resources for correct claim submission and appeal processing guidelines.
 - Each HMO determines their own requirements for timely claim filing, claim reconsideration policy, and formal appeal policy.
 - Providers should know and access all resources made available by the HMO when filing claims and appeals. Many HMOs now have electronic claim and appeal filing capability.
 - Claims and appeal documents must reach the HMO within the time frame established by the HMO. Special care should be taken to ensure enough time is allowed for the U.S. Postal Service mail handling or use a verifiable delivery method (e.g., fax, certified mail, or secure email) to deliver the documents to the HMO on time.

Member Enrollment Verification

- Providers are encouraged to verify a member's BadgerCare Plus/Medicaid SSI eligibility at the time an appointment is made and before providing services:
 - To determine enrollment for the current date.
 - To discover any limitations, commercial health insurance, Medicare or Badgercare Plus HMO coverage.
- ForwardHealth provides access to enrollment information in various ways:
 - ForwardHealth Portal.
 - 270/271 Health Care Eligibility Benefit Inquiry/Response transactions.
 - WiCall, Wisconsin's Automatic Voice Response system.
 - Commercial enrollment verification vendors (access through software, magnetic stripe card readers, and internet).



Member Enrollment Verification (Cont.)

For your reference, the enrollment verification tracking number 1700900000 verifies the enrollment information below only for the following time frame of 01/09/2017 through 01/09/2017.

Search Results

Member Information

Member ID Name
Date of Birth County
Medicare ID Address

Benefit Plan

Payer	Benefit Plan	Effective Date	End Date
MEDICAID	BC+ Standard Plan	01/09/2017	01/09/2017

Managed Care Enrollment

Provider Name	MC Program	Telephone Number	Effective Date	End Date
MOLINA HEALTHCARE	HMO - Medical/Dental	(888)999-2404	01/09/2017	01/09/2017

Non-Emergency Transportation Services Enrollment

Provider Name	Effective Date	End Date
MEDICAL TRANSPORTATION MANAGEMENT, INC	01/09/2017	01/09/2017

Member Enrollment Verification (Cont.)

Other Commercial Health Insurance

Group Number	GROUPTPL0000	Carrier Name	INSURANCE GRP
Policy Number	TPL0000	Carrier Telephone	(608)111-1111
Policy Holder	POLICY HOLDER (OTHER)	Effective Date	03/13/2012
PH Date Of Birth	10/04/1994	End Date	03/13/2012
PH Address	PO BOX 2 MADISON, WI 53705	Coverage Code	MAJOR MED

Group Number	GROUP9999	Carrier Name	INSURANCE GRP
Policy Number	TPL9999	Carrier Telephone	(608)111-1111
Policy Holder	POLICY HOLDER (OTHER)	Effective Date	03/13/2012
PH Date Of Birth	10/04/1994	End Date	03/13/2012
PH Address	PO BOX 2 MADISON, WI 53705	Coverage Code	DRUG

Managed Care HMO Information

Managed Care Contract

Managed Care Contract – Contract precedence

- The contract between the DHS and the BadgerCare Plus HMO or Medicaid SSI HMO takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by the DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs and SSI HMOs. If there is a conflict, the HMO or SSI HMO contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and SSI HMO contracts can be found on the Managed Care Organization area of the ForwardHealth Portal.
- Reference on-line handbook topic # 402 Managed Care Contracts.

Managed Care - Claim Submission

- BadgerCare Plus HMOs and Medicaid SSI HMOs have requirements for timely filing of claims.
- Providers should contact the enrollee's HMO or SSI HMO and follow the organization-specific submission deadlines.
- Many HMOs provide electronic claim/appeal submission capability for easier submission and communication.
- Reference on-line handbook topic #386 Claims Submission.

Provider Appeal

Provider Appeal

- When a BadgerCare Plus HMO or Medicaid SSI HMO denies a provider's claim, the HMO or SSI HMO is required to send the provider a notice informing the provider of the right to file an appeal. Many HMOs also send this information electronically.
- An HMO or SSI HMO network or non-network provider may file an appeal to the HMO or SSI HMO when:
 - A claim submitted to the HMO or SSI HMO is denied payment.
 - The full amount of a submitted claim is not paid.

Provider Appeal (Cont.)

- Providers are required to file an appeal with the HMO or SSI HMO **before** filing an appeal with ForwardHealth.
- There are measures in place for providers to appeal to ForwardHealth to review a decision made on an HMO appeal; however, it should not be considered a way around the initial appeals process with the HMO.
- Reference on-line handbook topic #389 Provider Appeals.

Appeal to HMOs and SSI HMOs

- Providers are required to first file an appeal directly with the BadgerCare Plus HMO or Medicaid SSI HMO within the time frame established by the HMO.
- Providers are required to include a letter explaining why the HMO or SSI HMO should pay the claim.
- The appeal should be sent to the address indicated on the HMO's or SSI HMO's denial notice, HMO website or HMO Provider Manual; this can be done through USPS or electronically.

Appeal to HMOs and SSI HMOs (Cont.)

- The HMO or SSI HMO has 45 calendar days to respond in writing to the appeal stating the decision whether or not to pay the claim.
- If the HMO or SSI HMO does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO's or SSI HMO's response, the provider may send a written appeal to ForwardHealth within 60 calendar days.
- Reference on-line handbook topic #384 Appeals to HMOs and SSI HMO's.

Appeal to ForwardHealth

- A written appeal may be submitted to ForwardHealth within 60 calendar days from either the end of the 45 calendar day timeline if the BadgerCare Plus HMO or SSI HMO does not respond or within 60 days from the date on the HMOs appeal response, not the date the response is received.
- If a provider sends an appeal directly to ForwardHealth without first filing it with the HMO or SSI HMO, the appeal will not be reviewed but will be returned to the provider.
- Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO on the date of service on the denied claim.

Appeal to ForwardHealth (Cont.)

When filing an appeal to ForwardHealth, providers may use either:

- The Managed Care Program Provider Appeal form, *F-12022 (07/2017).
- An appeal letter of their own creation that contains all of the same information that is requested on the Managed Care Program Provider Appeal form.

*Note: ForwardHealth Update 2017-22 Clarification to BadgerCare Plus and Medicaid SSI Managed Care Provider Appeals Policy – updated form and instructions.



Appeal to ForwardHealth(Cont.)

Providers are required to submit an appeal with 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:

- A copy of the original claim submitted to the HMO. If applicable, this includes a copy of all corrected claims submitted to the HMO.
- A copy of all of the HMO'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.
- A copy of the provider's written appeal to the HMO.
- A copy of the HMO response to the appeal.

Appeal to ForwardHealth (Cont.)

- 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.
- A copy of any contract language that supports the appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial.
- 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).

Appeal to ForwardHealth (Cont.)

- Appeals may be faxed to ForwardHealth at 608-224-6318 or mailed to the following address:
 - BadgerCare Plus and Medicaid SSI
 - Managed Care Unit — Provider Appeal
 - PO Box 6470
 - Madison WI 53716-0470
- Special care should be taken to ensure enough time is allowed for U.S. Postal Service mail handling to deliver the documents on time. Be sure to include any certified mail tracking verification or fax receipt verification with the appeal.
- 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 or insufficient documentation may lead to an upholding of the original denial.
- The decision to overturn an HMO's denial must be clearly supported by the documentation.

Appeal to ForwardHealth (Cont.)

- The provider and the HMO or SSI HMO will be notified in writing of the final decision:
 - If the decision is in favor of the provider, the HMO or SSI HMO is required to pay the provider within 45 calendar days of the final decision.
 - The decision is final, and all parties must abide by the decision.
- 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:
 - Notifications should be faxed to ForwardHealth at 608-224-6318.
 - This documentation will be added to the original appeal documentation to complete the record.
- Contact the Managed Care Unit through the Provider Services Call Center at 800-760-0001, option 1, to follow-up on the appeal status.
- Reference on-line handbook topic 385 Appeals to ForwardHealth.



Top Claim Denial Reasons and Reason for Appeal

- No Authorization for services.
 - Providers must consult all HMO resources to verify prior authorization requirements
 - It is the Provider's responsibility to verify a member's HMO coverage when scheduling appointment and before delivering services.
 - Enrollment Verification on the Portal (Topic #4901).
- Claim not completed correctly.
 - It is the Provider's responsibility to submit claims that are accurate and correct.
 - Accuracy of Claims (Topic #516).
- Code denied as bundled/unbundled.
 - Providers must not submit claims with unbundled codes and must comply with HMO selected Medical Coding Editor software use.
 - ClaimCheck Review (Topic # 644).

Top Claim Denial Reasons and Reason for Appeal (Cont.)

- Claim Denied as untimely:
 - Provider must file claims within timely filing guidelines as outlined in the signed contract or on HMO webpage (original, corrected, or submitted due to recoupment).
 - Claims Submission (Topic #386)
- Not supported by medical record (denial by Utilization Management).
 - Provider is responsible for correct, accurate and detailed medical record documentation to support the service provided .
 - Preparation and Maintenance of Records (Topic #203).

Top Claim Denial Reasons and Reason for Appeal (Cont.)

- Claim denied/payment reduced due to Other Insurance payment.
 - Providers must submit claims to other insurance first before filing with the HMO. Correct Coordination of Benefits (COB) between Medicaid/BadgerCare Plus HMOs and commercial insurance coverage.
 - Claims for Services Denied by Commercial Health Insurance (Topic # 844).
 - Acceptance of Payment (Topic # 258).

Summary

Summary

- Refer to your signed contract and the HMO website or Provider Manual for claim and appeal submission policy.
- Refer to ForwardHealth Online Handbook and HMO Contract for Departmental policy.
- At first point-of-contact with an HMO, locate the contact information from the contract/memorandum of understanding with the HMO:
 - HMO Provider Services.
 - HMO Field Representatives.

Summary (Cont.)

- To file an appeal, follow the HMO's appeal process/timeline.
 - Contact the HMO for question or assistance with the process.
- If the outcome of the HMO appeal is not satisfactory to the provider or if the HMO has not responded in the timeframe allowed (45 days):
 - Submit an appeal to ForwardHealth within 60 days.
 - Following ForwardHealth guidelines. See ForwardHealth on-line handbook topic #385.
 - Contact the Managed Care Unit through the Provider Services Call Center at 800-760-0001, option 1, to follow-up on the appeal status.

Questions?

Thank You