All Provider

MANAGED CARE

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Refer to the Online Handbook for current policy

wisconsin Medicaid and BadgerCare
Information for Providers
Department of Health and Family Services

Contacting Wisconsin Medicaid

Web Site	***dhfs.wisconsin.gov/***
The Web site contains information for providers and recipients about the following: • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets.	Available 24 hours a day, seven days a week
Automated Voice Response System	**(800) 947-3544** **(608) 221-4247**
The Automated Voice Response system provides computerized voice responses about the following: • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information.	Available 24 hours a day, seven days a week
Provider Services	**(800) 947-9627** **(608) 221-9883**
Correspondents assist providers with questions about the following: • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification.	Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Division of Health Care Financing **Electronic Data Interchange Helpdesk**	**(608) 221-9036** **e-mail: *wiedi@dhfs.state.wi.us***
Correspondents assist providers with *technical* questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions software.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Web Prior Authorization Technical Helpdesk	**(608) 221-9730**
Correspondents assist providers with Web PA-related *technical* questions about the following: • User registration. • Passwords. • Submission process.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Recipient Services	**(800) 362-3002** **(608) 221-5720**
Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns.	Available 7:30 a.m. - 5:00 p.m. (M-F)

Handbook Organization

The following tables show the organization of this All-Provider Handbook and list some of the topics included in each section. It is essential that providers refer to service-specific publications for information about service-specific program requirements.

Certification and Ongoing Responsibilities
• Certification and recertification. • Change of address or status. • Documentation requirements. • Noncertified providers. • Ongoing responsibilities. • Provider rights. • Provider sanctions. • Recipient discrimination prohibited. • Release of billing information.

Claims Information
• Follow-up procedures. • Good Faith claims. • Preparing and submitting claims. • Reimbursement information. • Remittance information. • Submission deadline. • Timely filing appeals requests.

Coordination of Benefits
• Commercial health insurance. • Crossover claims. • Medicare. • Other Coverage Discrepancy Report, HCF 1159. • Primary and secondary payers. • Provider-based billing.

Covered and Noncovered Services
• Collecting payment from recipients. • Covered services. • Emergency services. • HealthCheck "Other Services." • Medical necessity. • Noncovered services.

Informational Resources
• Electronic transactions. • Eligibility Verification System. • Maximum allowable fee schedules. • Forms. • Medicaid Web site. • Professional relations representatives. • Provider Services. • Publications.

Managed Care
• Covered and noncovered HMO and SSI MCO services. • Enrollee HMO and SSI MCO eligibility. • Enrollment process. • Extraordinary claims. • HMO and SSI MCO claims submission. • Network and non-network provider information. • Provider appeals.

Prior Authorization
• Amending prior authorization (PA) requests. • Appealing PA decisions. • Grant and expiration dates. • Prior authorization for emergency services. • Recipient loss of eligibility during treatment. • Renewal requests. • Review process. • Submitting PA requests.

Recipient Eligibility
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Preface

This All-Provider Handbook is issued to all Medicaid-certified providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/.*
- *dhfs.wisconsin.gov/badgercare/.*

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
  - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).

- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

General Information

This section of the All-Provider Handbook is designed to aid both managed care network providers and non-managed care network providers who work with HMO enrollees and the managed care program.

Wisconsin Medicaid Managed Care refers to the Low Income Family Medicaid and BadgerCare HMO program, the Supplemental Security Income (SSI) Managed Care Organization (MCO) program, and the several special managed care programs available. This section focuses on the Low Income Family Medicaid and BadgerCare HMO program and the SSI MCO program.

Medicaid HMOs are responsible for providing or arranging all contracted Medicaid-covered medically necessary services to enrollees.

The primary goals of the managed care programs are:

- To improve the quality of recipient care by providing continuity of care and improved access.
- To reduce the cost of health care through better care management.

Special Managed Care Programs

Wisconsin Medicaid has several special managed care programs that provide services to individuals who are elderly and/or who have disabilities. These recipients may be eligible to enroll in voluntary regional managed care programs such as Family Care, the Program of All-Inclusive Care for the Elderly, and the Wisconsin Partnership Program. Additional information on these special managed care programs may be obtained from the Managed Care section of the Wisconsin Medicaid Web site.

Low Income Family Medicaid and BadgerCare HMO Program

An HMO is a system of health care providers that provide a comprehensive range of medical services to a group of enrollees. Wisconsin Medicaid HMOs serve more than 356,000 low-income children and family members (as of June 2005). HMOs receive a fixed, prepaid amount per enrollee from Wisconsin Medicaid (called a capitation payment) to provide medically necessary services.

Medicaid HMOs are responsible for providing or arranging all contracted Medicaid-covered medically necessary services to enrollees. Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as Medicaid fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization (PA), claims submission, adjudication procedures, etc., which may differ from Medicaid fee-for-service policies and procedures. Medicaid HMO network providers should contact their HMO for more information about its policies and procedures.

SSI MCO Program

Supplemental Security Income recipients and SSI-related Medicaid recipients in Milwaukee County may be eligible to enroll in one of the SSI MCOs.

SSI MCOs provide the same benefits as Medicaid fee-for-service (e.g. medical, dental, mental health/substance abuse, vision, and prescription drug coverage) at no cost to their enrollees through a care management model. Through the care management model, each enrollee receives an initial health assessment, as well as assistance in choosing providers,

accessing social and community service options, health education programs, and treatment and follow-up information.

Supplemental Security Income recipients and SSI-related Medicaid recipients who live in other counties will continue to receive services through Medicaid fee-for-service.

Recipient Enrollment Eligibility

HMOs

Recipients of the following Medicaid subprograms are eligible for enrollment in a Medicaid HMO:

- Low Income Family Medicaid — Comprised of low-income pregnant women, children, and families with children who are less than 19 years of age.
- BadgerCare — Comprised of low-income uninsured families.
- Healthy Start — Comprised of low-income pregnant women and children.

An individual who receives the Family Planning Waiver Benefit, the Tuberculosis-Related Services Only Benefit, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a Medicaid HMO.

Information about a recipient's HMO enrollment status and commercial health insurance coverage may be verified by using Wisconsin Medicaid's Eligibility Verification System (EVS). Refer to the Recipient Eligibility section of this handbook for further information about the EVS.

SSI MCOs

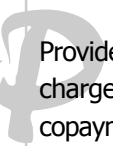
Recipients of the following Medicaid subprograms are eligible for enrollment in an SSI MCO:

- Medicaid-eligible individuals living in Milwaukee County.
- Individuals ages 19 and older, who meet the SSI and SSI-related disability criteria.
- Dual eligibles for Medicare and Medicaid.

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO.

Copayments

Providers cannot charge enrollees copayments for Medicaid-covered services except in cases where the HMO or SSI MCO do not cover services such as chiropractic and dental. When services are provided through Medicaid fee-for-service, copayments will apply.



Providers cannot charge enrollees copayments for Medicaid-covered services except in cases where the HMO or SSI MCO do not cover services such as chiropractic and dental.

Covered Services

HMOs

Although Wisconsin Medicaid requires contracted HMOs to provide all medically necessary Medicaid-covered services, the following services may be provided by Medicaid HMOs at their discretion:

- Dental.
- Chiropractic.

If the HMO does not include these services in their benefit package, the enrollee receives the services on a Medicaid fee-for-service basis. Enrollees are responsible for the copayment for services not covered by their HMO.

SSI MCOs

Wisconsin Medicaid requires contracted SSI MCOs in Milwaukee County to provide all medically necessary Medicaid-covered services, including dental. If the SSI MCO does not include services such as chiropractic, the enrollee receives these services on a Medicaid fee-for-service basis.

Managed Care Contracts

The contract between the Wisconsin Department of Health and Family Services (DHFS) and the HMO or SSI MCO takes precedence over other Medicaid provider publications.

The contract between the Wisconsin Department of Health and Family Services (DHFS) and the HMO or SSI MCO takes precedence over other Medicaid provider publications. Information contained in this and other Medicaid publications is used by the Division of Health Care Financing to resolve disputes regarding covered benefits that cannot be handled internally by HMOs and SSI MCOs. If there is a conflict, the HMO or SSI MCO contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and SSI MCO contracts can be found in the Managed Care section of the Medicaid Web site.

Noncovered Services

The following are not covered by Medicaid HMOs or SSI MCOs but are provided to enrollees on a fee-for-service basis:

- Community Support Program benefits.
- Crisis intervention services.
- Environmental lead inspections.
- Milwaukee child care coordination services.
- Prenatal care coordination services.
- School-Based Services.
- Targeted case management services.
- Transportation by common carrier (unless the HMO has made arrangements to provide this service as a benefit). Milwaukee HMOs and MCOs are mandated to provide transportation for their enrollees.

Other Managed Care Service Information

Out-of-Area Care

HMOs and SSI MCOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI MCO's service area. The HMO or SSI MCO is required to authorize the services before the services are provided, except in cases of emergency. If the HMO or SSI MCO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Prior Authorization

Medicaid HMOs and SSI MCOs may develop PA guidelines that differ from Medicaid's fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service. Contact the enrollee's HMO or SSI MCO for more information regarding PA procedures.

Emergency Services

In emergency situations, enrollees may seek medical services from providers not affiliated with the HMO or SSI MCO, if necessary. The contract between the DHFS and the HMO or SSI MCO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI MCO has a written agreement with the non-network provider, the HMO or SSI MCO is only liable to the extent Medicaid fee-for-service would be liable for an emergency situation, as defined in 42 CFR s. 438.114.

Provider Participation

Providers interested in participating in a Medicaid HMO or SSI MCO or changing HMO or SSI MCO network affiliations should contact the HMO or SSI MCO for more information. Conditions and terms of participation in an HMO or SSI MCO are pursuant to specific contract agreements

between HMOs or SSI MCOs and providers. An HMO or SSI MCO has the right to choose whether or not to contract with any provider.

Release of Billing or Medical Information

Wisconsin Medicaid supports HMO and SSI MCO enrollee rights regarding the confidentiality of health care records. Wisconsin Medicaid has specific standards regarding the release of a Medicaid HMO or SSI MCO enrollee's billing information or medical claim records. Providers should refer to the Certification and Ongoing Responsibilities section of this handbook for further information about the release of enrollee billing or medical information.

Wisconsin Medicaid has specific standards regarding the release of a Medicaid HMO or SSI MCO enrollee's billing information or medical claim records.

Enrollment Information

Recipient Enrollment in Managed Care

HMOs

Medicaid HMO enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible recipients who reside in ZIP code areas served by two or more Medicaid HMOs. Some recipients may meet criteria for exemption from Medicaid HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for recipients who reside in ZIP code areas served by only one Medicaid HMO.

Wisconsin Medicaid recipients living in areas where enrollment is mandatory are encouraged to choose their Medicaid HMO.

Wisconsin Medicaid recipients living in areas where enrollment is mandatory are encouraged to choose their Medicaid HMO. Automatic assignment to a Medicaid HMO occurs if the recipient does not choose a Medicaid HMO. Recipients in voluntary enrollment areas can choose whether or not to enroll in a Medicaid HMO. There is no automatic assignment for recipients who live within ZIP codes where enrollment is voluntary.

The Department of Health and Family Services (DHFS) contracts with an enrollment specialist who provides unbiased counseling to help recipients choose an HMO that best meets their needs. In general, all members of a recipient's immediate family eligible for enrollment must choose the same HMO.

SSI MCOs

SSI MCO enrollment is either mandatory or voluntary as follows:

- Mandatory enrollment — Most Supplemental Security Income (SSI) and SSI-related Medicaid recipients are required to enroll in an SSI MCO. A recipient may choose the SSI MCO in which he or she wishes to enroll.
- Voluntary enrollment — Some SSI and SSI-related Medicaid recipients may choose to enroll in an SSI MCO on a voluntary basis.

The DHFS contracts with an enrollment specialist who provides unbiased counseling to help recipients choose an SSI MCO that best meets their needs.

Enrollment Periods

HMOs

Recipients are sent enrollment packets that explain the HMOs and the enrollment process and provide contact information. Once enrolled, enrollees may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, he or she will be disenrolled from the HMO.

SSI MCOs

Recipients are sent enrollment packets that explain the SSI MCO's enrollment process and provide contract information. Once enrolled, enrollees may disenroll after a 60-day trial period and up to 120 days after enrollment and return to Medicaid fee-for-service if they choose.

Disenrollment and Exemption Situations

In some situations, a recipient may be exempt from enrolling in an HMO or SSI MCO. Exempted recipients receive health care under Medicaid fee-for-service. Exemptions allow recipients to complete a course of treatment with a provider who is not contracted with the recipient's HMO or SSI MCO. For example, in certain circumstances, women in high-risk pregnancies or women who are in the third trimester of pregnancy when they are enrolled in an HMO or SSI MCO *may* qualify for an exemption.

The contracts between the DHFS and the HMO/SSI MCO provide more detail on the exemption and disenrollment requirements. The current contract is available on the Wisconsin Medicaid Web site.

Enrollment Specialist

The Wisconsin Medicaid and BadgerCare Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to HMO and SSI MCO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist is available from 7:00 a.m. to 6:00 p.m., Monday through Friday, excluding holidays, at (800) 291-2002.

The Enrollment Specialist provides the following services to HMO and SSI MCO enrollees:

- Education regarding the correct use of HMO and SSI MCO benefits.
- Telephone and face-to-face support.
- Assistance with enrollment, disenrollment, and exemption procedures.

Ombudsman Program

The Wisconsin Medicaid and BadgerCare HMO and SSI MCO Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their HMO or SSI MCO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds are available Monday through Friday, excluding holidays, from 7:30 a.m. to 4:00 p.m. at (800) 760-0001 or may be contacted at the following address:

Medicaid and BadgerCare HMO/SSI MCO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by an HMO or SSI MCO. Enrollees also have the right to file a grievance when the HMO or SSI MCO refuses to provide a service. All HMOs and SSI MCOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI MCO's customer service department to resolve problems first.

If enrollees are unable to resolve problems by talking to their HMO or SSI MCO, or if they would prefer to speak with someone outside their HMO or SSI MCO, they should contact the Enrollment Specialist or the Ombudsman Program.

The contract between the DHFS and the HMO or SSI MCO describes the responsibilities of the HMO or SSI MCO and the DHFS regarding enrollee grievances.

The Wisconsin Medicaid and BadgerCare Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to HMO and SSI MCO enrollees.

Non-network Providers

Providers who do not have a contract with the enrollee's HMO or SSI MCO are referred to as non-network providers. (HMO and SSI MCO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI MCO.) Non-network providers are required to direct enrollees to HMO or SSI MCO network providers except in the following situations:

- When a non-network provider is treating an HMO or SSI MCO enrollee for an emergency medical condition as defined in the contract between the Department of Health and Family Services (DHFS) and the HMO or SSI MCO.
- When the HMO or SSI MCO has authorized (in writing) an out-of-plan referral to a non-network provider.
- When the service is not provided under the HMO's or SSI MCO's contract with the DHFS (such as dental or chiropractic services).

Non-network providers may not serve Medicaid HMO or SSI MCO enrollees as private-pay patients.

Emergencies

Non-network providers may provide services to HMO and SSI MCO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI MCO. The contract between the DHFS and the HMO or SSI MCO defines an emergency situation and includes general payment requirements. Billing procedures for emergencies may vary depending on the HMO or SSI MCO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI MCO.

Referrals

Non-network providers may at times provide services to HMO and SSI MCO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI MCO. Before services are provided, the non-network provider and the HMO or SSI MCO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs/SSI MCOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI MCO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI MCO.

Services Not Provided by Enrollee's HMO or SSI MCO

If an enrollee's HMO's or SSI MCO's benefit package does not include a Medicaid-covered service, such as chiropractic or dental services, any Medicaid-certified provider may provide the service to the enrollee and submit claims to Medicaid fee-for-service.

If an enrollee's HMO's or SSI MCO's benefit package does not include a Medicaid-covered service, such as chiropractic or dental services, any Medicaid-certified provider may provide the service to the enrollee and submit claims to Medicaid fee-for-service.

Claims Submission

Extraordinary claims are Medicaid claims for an HMO or SSI MCO enrollee that have been denied by an HMO or SSI MCO but may be paid as fee-for-service claims.

HMOs and SSI MCOs have requirements for timely filing of claims, and providers are required to follow HMO and SSI MCO claims submission guidelines. Contact the enrollee's HMO or SSI MCO for organization-specific submission deadlines.

If an HMO or SSI MCO denies a claim, providers may file an appeal with the HMO or SSI MCO. If a provider disagrees with the HMO's or SSI MCO's decision, he or she may file an appeal with Wisconsin Medicaid. Refer to the Provider Appeals chapter of this section for more information on appeals.

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most Medicaid-covered services, even when a recipient is enrolled in a Medicaid HMO or SSI MCO. Before submitting claims to Medicaid HMOs and SSI MCOs, providers are required to submit claims to other health insurance sources. Contact the enrollee's HMO or SSI MCO for more information about billing other health insurance sources. Refer to the Coordination of Benefits section of this handbook for more information about coordinating benefits with other health insurance sources.

Extraordinary Claims

Extraordinary claims are Medicaid claims for an HMO or SSI MCO enrollee that have been denied by an HMO or SSI MCO but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO or SSI MCO at the time he or she was admitted to an inpatient hospital, but then enrolled in an HMO or SSI MCO during the hospital stay. In this case, all claims related to the stay (including physician claims) should be submitted to Medicaid fee-for-service. These claims (including physician claims) must include admittance and discharge dates.
- The claims are for orthodontia/ prosthodontia services that began before HMO or SSI MCO coverage. Include a record with the claim of when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, include the following:

- A legible copy of the completed claim form, in accordance with Medicaid billing guidelines.
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation.

Submit extraordinary claims to:

Wisconsin Medicaid
Managed Care Extraordinary Claims
PO Box 6470
Madison WI 53716-0470

Provider Appeals

When a Medicaid HMO or SSI MCO denies a provider's claim, the HMO or SSI MCO is required to send the provider a notice informing him or her of the right to file an appeal.

An HMO or SSI MCO network or non-network provider may file an appeal to the HMO or SSI MCO when:

- A claim submitted to the HMO or SSI MCO is denied payment.
- The full amount of a submitted claim is not paid.

If a provider sends an appeal directly to Wisconsin Medicaid without first filing it with the HMO or SSI MCO, Wisconsin Medicaid will return the appeal to the provider.

Appeals to HMOs and SSI MCOs

Providers are required to first file an appeal directly with the HMO or SSI MCO within 60 calendar days of receipt of the initial denial. Providers are required to include a letter explaining why the HMO or SSI MCO should pay the claim. The appeal should be sent to the address indicated on the HMO's or SSI MCO's denial notice.

The HMO or SSI MCO then has 45 calendar days to respond in writing to the appeal. The HMO or SSI MCO decides whether to pay the claim and sends the provider a letter stating the decision.

If the HMO or SSI MCO does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO's or SSI MCO's response, the provider may send a written appeal to Wisconsin Medicaid within 60 calendar days.

Appeals to Wisconsin Medicaid

The provider has 60 calendar days to file an appeal with Wisconsin Medicaid after the HMO or SSI MCO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO's or SSI MCO's response.

Wisconsin Medicaid will not review appeals that were not first made to the HMO or SSI MCO. If a provider sends an appeal directly to Wisconsin Medicaid without first filing it with the HMO or SSI MCO, Wisconsin Medicaid will return the appeal to the provider.

Wisconsin Medicaid will only review appeals for enrollees who were eligible for Wisconsin Medicaid and who were enrolled in a Medicaid HMO or SSI MCO on the date of service in question.

Appeals to Wisconsin Medicaid must be made in writing and must include:

- A letter, clearly marked "APPEAL," explaining why the claim should be paid or a completed provider appeal form. Refer to Appendix 1 of this section for a copy of the Managed Care Program Provider Appeal form, HCF 12022.
- A copy of the claim, clearly marked "APPEAL."
- A copy of the provider's letter to the HMO or SSI MCO.
- A copy of the HMO's or SSI MCO's response to the provider.
- Any documentation that supports the case.

Wisconsin Medicaid will review the appeal and gather any additional information needed from the provider or the HMO/SSI MCO. Once all pertinent information is received, Wisconsin Medicaid has 45 calendar days to make a final decision.

Wisconsin Medicaid will notify the provider and the HMO or SSI MCO in writing of its final decision. If Wisconsin Medicaid decides in favor of the provider, the HMO or SSI MCO is required to pay the provider within 45 calendar days of the final decision. Wisconsin Medicaid's decision is final and all parties must abide by the decision.

Wisconsin Medicaid will notify the provider and the HMO or SSI MCO in writing of its final decision.

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 1
Managed Care Program Provider Appeal
(for photocopying)

(A copy of the Managed Care Program Provider Appeal is located on the following pages.)

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WISCONSIN MEDICAID
MANAGED CARE PROGRAM PROVIDER APPEAL

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services. The use of this form is voluntary.

Providers may send this completed form and other written complaints to:

Wisconsin Medicaid
Managed Care Appeals
PO Box 309
Madison WI 53701-0309

INSTRUCTIONS: Type or print clearly.

SECTION I — PROVIDER INFORMATION

Name — Provider Filing Appeal	Telephone Number — Provider Filing Appeal	Name — HMO / SSI MCO Involved
Address — Provider Filing Appeal (Street, City, State, Zip Code)		Name and Telephone Number — Contact Person

SECTION II — ENROLLEE INFORMATION

Name — Medicaid HMO / SSI MCO Enrollee	Medicaid Identification Number	Date of Service

SECTION III — DESCRIPTION OF PROBLEM

Describe the problem in detail. Use additional paper, if necessary. Attach copies of any supporting documentation relevant to the problem.

(*Continued)*

SECTION III — DESCRIPTION OF PROBLEM (Continued)

Insert date the appeal was sent to HMO / SSI MCO or claim reconsideration was requested.	Insert date the appeal / reconsideration request was denied by HMO / SSI MCO.

What response was received from the HMO / SSI MCO? Attach a photocopy of any relevant correspondence.

What does the provider consider to be a fair resolution of this matter?

SECTION IV — SIGNATURE

This information is accurate to the best of my knowledge. A copy of this information may be forwarded to the Medicaid HMO/SSI MCO involved.

SIGNATURE — Provider	Date Signed

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