



**Title:** BadgerCare Plus Provider Claim Appeals

**Policy Number:** CMP.BCP.002

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## **Section 2: Appealing to The Department**

If the procedure as noted in Section 1 has not been completed, the Department will not consider the Provider's appeal. Please complete Section 1 prior to the procedure described in Section 2.

1. The Provider must submit appeals to the Department in writing within 60 days of the date on GHCSCW's final decision notice, or in the case of no response, within 60 days from the 45 day timeline allotted for GHCSCW to respond.
2. A decision to uphold the HMO's original payment denial or to overturn the denial will be made based on the documentation submitted for review. Failure to submit the required documentation or submitting incomplete/insufficient documentation may lead to an upholding of the original denial. The decision to overturn GHCSCW's denial must be clearly supported by the documentation.
3. Providers may use the Department's form when submitting an appeal for State review. All elements of the form must be completed or listed in the letter if the form is not used. The form with instructions is available at the following website: <https://www.dhs.wisconsin.gov/library/F-12022.htm>
4. Providers are required to submit legible copies of all of the following documentation, regardless of whether the Managed Care Program Provider Appeal form or their own appeal letter is used. Incomplete appeals will not receive Departmental review and will be returned and the denial upheld. The appeal packet must contain:
  - a. A copy of the original claim submitted to GHCSCW. If applicable, include a copy of all corrected claims submitted to GHCSCW.
  - b. A copy of all of GHCSCW's payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial.
  - c. A copy of the provider's written appeal to GHCSCW.
  - d. A copy of the GHCSCW's response to the appeal.
  - e. A copy of the medical record for appeals regarding coding issues, medical necessity, or emergency determination. Providers should only send relevant medical documentation that supports the appeal. Large records submitted with no indication will not be reviewed. Large documents should be submitted on a CD.
  - f. A copy of any contract language that supports your appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial. Contract language submitted with no indication will not be reviewed.
  - g. Any other documentation that supports the appeal (e.g., commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort).
5. Providers should notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which they have submitted an appeal. Notification should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record.

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

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