WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 6/1/09	Reviewed: 11/3/10 By: JF Last Revision: 6/1/09	Section: PROVIDER NETWORK	Policy No: 065	Pages: 1 of 2 (2 Attachments)
☒ Wraparound ☒ Wraparound-REACH ☒ FISS ☒ Project O-Yeah	Effective Date: 6/1/09	Subject: PROVIDER PAPER CLAIMS PROCESSING and APPEAL SYSTEM			

I. POLICY

It is the policy of Wraparound Milwaukee, REACH and Family Intervention Support Services (FISS) to process claims, pay clean paper claims within 30 days of receipt and to have in place systems by which Providers may file an Appeal.

II. PROCEDURE

A. Paper Claims Received.

1. Fiscal support staff will check fax machine, interoffice mail and U.S. mail two times per day for claims.
2. Immediately upon receipt, fiscal staff will date and initial claims received and place in Fiscal Director's mailbox.
3. All claims are reviewed by the Fiscal Director, approved and paid or returned and denied within 30 days of receipt.
4. In the event the Fiscal Director is unavailable to receive, review and process claims, the following fiscal staff will provide coverage to ensure that claims are processed as outlined in this policy: 1) Administrative IT Assistant/Billing; 2) Fiscal Specialist.

B. Clean Paper Claims.

1. Claims are reviewed by fiscal staff for service provision, service code and date, member information, enrollment, authorization and provider information.
2. Claims are processed and paid within 30 days of receipt.
3. Fiscal staff assigned to processing payments enter claim information in the Synthesis IT system, enter the date the claim was received and indicate that it was a paper claim.
4. Fiscal staff assigned to claim processing mark "approved" on all claims to be paid.

C. Incompleted / Denied Claims.

1. Claims may be denied for one or more of the following reasons:
   - Service not authorized and/or requires prior authorization.
   - Provider not authorized to provide identified service.
   - Date of service – invoice received beyond 60 day invoicing limit.
   - Client not enrolled during the time service was delivered.
   - Service code missing/insufficient information to process claim.
   - Agency not authorized to provide identified service.
   - Service not authorized.
2. Incomplete/denied claims are returned to the Provider within 30 days of receipt with a PROVIDER DENIAL form (*see Attachment 1*) and a PROVIDER APPEAL PROCESS form (*see Attachment 2*).
3. Copies of all incomplete/denied claims are kept on file in the fiscal department.

D. Encounter Errors Over 60 Days.

1. All encounter errors are submitted to the Fiscal Director for review.
2. Within 30 days of receipt, the Fiscal Director will investigate and a determination will be made.
3. Providers will be notified in writing of final determination.

E. Adjudicating Provider Appeals – Wraparound Milwaukee (County) and State of Wisconsin – Medicaid (BadgerCare Plus).

1. Provider must initially appeal to Wraparound Milwaukee (County) – Program Director.
2. Provider must appeal **in writing within 60 days** of claim denial or payment notice to Wraparound Milwaukee (County) and include the following:
   a. Appeal must clearly be marked "Appeal".
   b. Appeal must include Provider's name, date of service, date of billing, date of payment or nonpayment, recipient/enrollee name, service code, and reason claim warrants reconsideration.
   c. Wraparound Milwaukee (County) may take up to 45 days to respond to Provider's request for reconsideration.
   d. Letters or forms must be addressed to:

      Bruce Kamradt, Director
      Wraparound Milwaukee
      9201 Watertown Plank Road
      Milwaukee, WI 53226

   e. Upon receipt of the appeal, the Program Director will review the appeal for completeness (as stated in section C, 2, b), reason for reconsideration, adjudicates the claim and then issues a written decision to the Provider within 45 days, and includes information on how to appeal to the State of Wisconsin – Medicaid (BadgerCare Plus).
3. Provider Appeal Process – Medicaid (BadgerCare Plus).
   Provider has the right to appeal to the State of Wisconsin – Medicaid (BadgerCare Plus) if the County fails to respond to the appeal within 45 days or if the Provider is not satisfied with the County's response to the request for reconsideration. Appeals to the State of Wisconsin – Medicaid (BadgerCare Plus) must be submitted **in writing within 60 days** of the County's final decision or, in the case of no response, **within 60 days from the 45-day timeline** allotted Wraparound Milwaukee (County) to respond. Appeals should be sent to:

   Medicaid Fiscal Agent
   Managed Health Care Unit
   P.O. Box 6470
   Madison, WI 53716-0470

Reviewed & Approved By: Bruce Kamradt
Bruce Kamradt, Director

MILWAUKEE BEHAVIORAL HEALTH DIVISION
WRAPAROUND MILWAUKEE

PHONE: (414)257-7611 9201 WATERTOWN PLANK ROAD, MILWAUKEE, WI 53226 FAX: (414)257-7575

Claim Denial

Date:

To:
From: Wraparound/REACH/FISS Milwaukee Finance Department
RE: Agency Invoice

Client:

Service Code(s):

Date(s) of Service:

Payment for the attached invoice has been denied as follows:

The reason for the denial is identified below:

- ☐ Client Not Enrolled in Wraparound/REACH/FISS at the time of service delivery
- ☐ Agency Not Authorized to Provide service at the time of service delivery
- ☐ Provider Not in Network /Not Authorized to Provide Identified Service
- ☐ Invoice Received beyond 60 day invoicing limit
  (See Fee-for-Service Agreement)
- ☐ Other

Action Required:

- ☐ None
- ☐ Contact Care Coordinator to obtain authorization and resubmit invoice
- ☐ See Provider Appeal Process
- ☐ Other

Signed: Janet Friedman, MSW
Administrative Coordinator – Finance
414-257-7597

COUNTY BEHAVIORAL HEALTH DIVISION

WRAPAROUND MILWAUKEE

Phone: (414) 257-7610 9201 Watertown Plank Road, Wauwatosa, WI 53226 Fax: (414) 257-7575

Provider Appeal Process
Medicaid Services

Statement:
Providers have the right to appeal claim denials by following the procedures outlined in this document.

Providers must initially appeal to Wraparound Milwaukee-Program Director and then to the State of Wisconsin-Medicaid Fiscal Agent, if they disagree with the County's payment or nonpayment of a claim.

1. **Initial Appeal**:
   Provider must appeal, in writing, within 60 days of the claim denial or payment notice to the County and include the following:
   - Include a separate letter or form clearly marked "Appeal".
   - Must include Provider's name, date of service, date of billing, date of payment or nonpayment, recipient name, enrollee name and date of birth, service code, and reason claim warrants reconsideration.
   - County may take up to 45 days to response to Provider's request for reconsideration.

   Letters or Forms must be addressed to:
   Bruce Kamradt-Director
   Wraparound Milwaukee
   9201 Watertown Plank Road
   Milwaukee, WI 53226

2. Provider has the right to appeal to the State of Wisconsin-Medicaid if the County fails to respond to the appeal within 45 days of if the provider is not satisfied with the County's response to the request for reconsideration. Appeals to the State of Wisconsin-Medicaid must be submitted in writing within 60 days of the County's final decision or, in the case of no response, within 60 days from the 45-day timeline allotted the County to respond.

   Appeals Should Be Sent To:
   Medicaid Fiscal Agent
   Managed Care Unit
   P.O. Box 6470
   Madison, WI 53716-0470

Medicaid has 45 days from the date of the receipt of all written comments to inform the provider and the County of the final decision. If Medicaid's decision is in favor of the provider, the County will pay provider with 45 days of receipt of Medicaid's final determination. The County must accept Medicaid's determinations regarding appeals of disputed claims.