INSTRUCTIONS FOR LOGGING HMO APPEALS

The HMO quarterly appeal log, F-03112, is the standard format health maintenance organizations (HMOs) must use to submit member appeal information to the Department of Health Services (DHS). Refer to the Contract for BadgerCare Plus and/or Medicaid SSI HMO Services for the report requirements, reporting periods, due dates, and submission email address.

Personal Information

Under Wis. Stat. § 49.45(4), personally identifiable information is kept confidential and is only used for the direct administration of the Badger Care Plus and Medicaid SSI programs.

General Instructions

1. This is an annual appeal log divided by quarters. The HMO is to enter each quarterly report on the corresponding quarter tab. **Only enter information on the 1st Quarter, 2nd Quarter, 3rd Quarter and 4th Quarter tabs.** The spreadsheet will automatically tabulate the data on the corresponding quarterly analysis and graphs tabs.

2. **Do not make any changes to the spreadsheet layout or formulas except to enter appeal information**. Do not reorder the columns, change column labels, or dropdown options. Please submit any suggestions for categories or corrections to the report format to the Bureau of Quality Oversight (BQO).

3. There are several drop-down menus included in the spreadsheet. Some of these menus contain "other" as an available selection. If the HMO needs to select "other," add additional detail in the *Comments* column. **Note**: The narrative sections are limited to a maximum of 350 characters.

4. **Log every appeal the HMO becomes aware of, including:**
   - Internal HMO appeals
   - Appeals that were not brought to the HMO Appeal and Grievance committee or that were resolved by mediation – log as Internal HMO appeal
   - Appeals to Third Party Administrators or Subcontractors (eg. Dental Benefit Administrator) – log as Internal HMO appeal
   - Division of Hearing and Appeals (DHA) request for state fair hearing
   - DHA request for rehearing

   Even if the hearing is regarding a decision made by an agency other than the HMO (for example, Income Maintenance), please include the appeal on the log and provide as much information as the HMO has available.

5. Select **"Pending/In Process"** from the drop-down menu ff a member filed an appeal (i.e., request for fair hearing, internal HMO appeal or request for rehearing) but a decision has not been issued by the end of the quarter being reported. The pending status should be removed and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 30 day period for the submission of the report, update the Appeal Log to reflect this.

Instructions for Header:

1. **HMO Name (cell B3)**
   Enter the name of the HMO.

2. **Program (cell B4)**
   Enter the program (BadgerCare Plus or Medicaid SSI). If the HMO serves both BadgerCare Plus and Medicaid SSI members, complete a separate Appeal Log for each program.

3. **HMO Census on Last Date of Quarter (cell G2)**
   Enter the total number of members enrolled on the last day of the previous quarter.

Instructions for Columns:

1. **Appeal # (column A):**
   Number individual appeals consecutively for ease of reference starting with number 1 for the first appeal of the calendar year.

2. **Member Name (column B):**
   Enter member's name using the following format: **Last name, First name, Middle initial**. If needed to distinguish members, you may need to add a full middle name.

3. **HMO ID (column C)**
   Enter the HMO's unique identifier. This column is optional for HMOs.

4. **Medicaid ID (column D):**
   Enter member's Medicaid ID.

5. **Appeal Type (column E):**
   Select an entry from drop-down menu. **If the member files more than one type of appeal regarding same issue, enter information about subsequent appeal or appeals on separate lines** and select appropriate appeal type on each line.
   - **HMO:** Internal/Local HMO or Third Party Administrator or Subcontractor appeal
   - **DHA:** Request for fair hearing with the Division of Hearings and Appeals
   - **DHA-Rehearing:** Request for rehearing with the Division of Hearings and Appeals

6. **Date Appeal Filed / Date of Appeal Notice (column F):**
   Enter the date using the following format: MM/DD/YYYY. Record the date according to appeal type:
   - **DHA**: Enter the date on the DHA Appeal Notice memo.
   - **DHA-Rehearing:** Enter the date of the scheduled rehearing.
   - **HMO:** Enter the date the member requests an internal HMO or Third Party Administrator appeal. If a member requests an internal HMO appeal both orally and in writing, enter the earlier of those two dates.

7. **Continuing Benefits (column G)**
   Select an entry from the drop-down menu:
   - Select "yes" if benefits were continued.
   - Select "no" if benefits were not continued.
   - Select "N/A" if the appeal does not involve the reduction, suspension or termination of a service.

8. If Benefits Not Continued, Why? (column H)

Select an entry from the drop-down menu:

- Member did not request continuation of benefits
- Member requested continuation of services but request was not timely
- Services to be continued were not ordered by an authorized provider
- The period covered by the original service authorization had expired
- Other - Explain briefly in *Comments* column.
- N/A - The appeal does not involve the reduction, suspension or termination of a service

9. If Benefits Continued But Have Now Stopped, Why? (column I)

Select an entry from the drop-down menu:

- Member withdrew appeal or subsequent request for fair hearing
- Member did not timely request a fair hearing after receiving an adverse resolution to the appeal
- DHA Hearing: Member continued services during HMO level appeal, but did not timely request continuation of services during Fair Hearing
- DHA issued a hearing decision adverse to the enrollee
- Other - Explain briefly in *Comments* column.
- N/A - Continued services have not stopped
- N/A - The appeal does not involve the reduction, suspension or termination of a service

10. Date HMO Appeal Acknowledged / Date DHA Summary Sent (column J):

Enter the date using the following format: MM/DD/YYYY. Record the date according to appeal type:

- **Date HMO Appeal Acknowledged:** Enter the **date the HMO sent written acknowledgment to the member** of therequest for an internal HMO appeal. (Each HMO must send a written acknowledgement of every request for internal HMO appeal to the member and/or member's representative within ten business days of receiving the request.)
- **Date DHA Summary Sent:** If the HMO is the named party of the state fair hearing, enter the **date the "Summary of Action Leading to Appeal" was sent** to DHA.
    - **Note:** The HMO should log every request for fair hearing it is aware of; however, the HMO will not return a Summary of Action to DHA for every fair hearing request (for example, a summary is not returned if the issue is loss of financial eligibility) In these instances, enter "None" in this line.

11. Assisting Representation (column K):

Select an entry from the drop-down menu. You do not need to indicate when a family member, friend, neighbor, or provider is present with the member in this column. **This column is optional for HMOs.**

- If the HMO would like to keep track of appeals in which a provider and/or the member's legal decision maker is present, select **"Other"** and add the information in the *Comments* column.
- Acronyms:
  DBS= Disability Benefit Specialist
  DRW= Disability Rights Wisconsin
  EBS= Elder Benefit Specialist (ages 60+)

12. Issue Type (column L):

Select an entry from the drop-down menu. Definitions for each Issue Type can be found in the table below:

Issue Type	Definition
Denial of Enrollee's right to request out of network care	The denial of a member's request to receive out of network care, for a resident of a rural area with only one health plan.
Denial of payment, in whole or part, for a service already rendered	The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Article IV of the DHS-HMO Contract.
Failure to resolve appeal/grievance timely	Failure of the HMO to act within the timeframes provided in the Contract for BadgerCare Plus and/or Medicaid SSI HMO Services regarding the standard resolution of grievances and appeals.
Failure to timely provide authorized service	The failure to provide services in a timely manner.
Financial liability	The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
Service denial or limited authorization	The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
Service reduction	The reduction of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.
Service suspension	The suspension of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.
Service termination	The termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.
State/Federal law change	The issue is related to a change in state or federal law (Not appealable).
Not appealable per DHS contract	The issue is not an appealable issue per the DHS-HMO contract or Contract for BadgerCare Plus and/or Medicaid SSI HMO Services.

13. Service Category, if applicable (column M)

Select an entry from the drop-down menu. Enter "N/A" if:

- The appeal does not involve a service; or
- The appeal involves a service but the service is not a general inpatient service, general outpatient service, inpatient behavioral health service or outpatient behavioral health service.

14. Service Type, if applicable (column N):

Select an entry from the drop-down menu.

- Select the option that best describes the service type requested.

- If the service type is not listed in the drop down, select **"Other"** and enter the service type into the *Summary of Issue* column. Service types of **"Other"** without a service type entered into the *Summary of Issue* column will result in a resubmission.
- Enter "N/A" if the appeal does not involve a service.

15. Summary of Issue (column O):

Briefly describe the adverse benefit determination the member is appealing. Include the service type (if not already selected in column N) and a narrative description of the issue. Entries are limited to 350 words.

16. Date of Resolution (column P):

Enter the date the appeal was resolved using the following format: MM/DD/YYYY. Record the date according to appeal type:

- Internal HMO Appeal: Use the date of the **decision**. Do not use the date of the HMO Grievance and Appeal Committee **meeting** unless that happens to be the same as the date of the written decision. If the appeal did not go to the Grievance and Appeal Committee or was resolved through mediation, enter the date that the HMO believes the appeal to be resolved.
- DHA Fair Hearings: Use the date the ALJ signs the hearing decision, which is located on the last page of the decision.

Note: Leave this column blank if the appeal is Pending/In Process.

17. Timely Resolution Provided by HMO (column Q)

Select an entry from the drop-down menu:

- Select **"yes - standard"** if written resolution of the member's appeal was provided to the member within the standard resolution timeframe.
- Select **"yes - standard-extended"** if written resolution of the member's appeal was provided to the member within the standard-extended resolution timeframe and the HMO followed all applicable extension requirements
- Select **"yes - expedited"** if written resolution of the member's appeal was provided to the member within the expedited resolution timeframe.
- Select **"yes - expedited-extended"** if written resolution of the member's appeal was provided to the member within the expedited-extended resolution timeframe and the HMO followed all applicable extension requirements.

- Select **"no - standard"** if written resolution of the member's appeal was not provided to the member within the standard resolution timeframe.
- Select **"no - standard-extended"** if written resolution of the member's appeal was not provided to the member within the standard-extended resolution timeframe and the HMO followed all applicable extension requirements.
- Select **"no - expedited"** if written resolution of the member's appeal was not provided to the member within the expedited resolution timeframe.
- Select **"no - expedited-extended"** if written resolution of the member' appeal was not provided to the member within the expedited-extended resolution timeframe and the HMO followed all applicable extension requirements.

For all "no" responses, provide a brief explanation of the reason for failing to meet the applicable deadline in the *Comments* column.

Note: If a member filed an internal HMO appeal but a decision has not been issued by the end of the quarter being reported, enter **"Pending/In Process."** The pending status should be removed and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 45 day period for the submission of the report, update the Appeal Log to reflect this.

18. Resolution Type (column R):

Select an entry from the drop-down menu.

- Select **"DHA - upheld HMO decision/dismissed"** if the ALJ dismissed the appeal or upheld the HMO's adverse benefit determination in its entirety.
- Select **"DHA - overturned HMO Decision/Remanded"** if the ALJ overturned the adverse benefit determination it its entirety.
- Select **"DHA - partially upheld HMO decision/remanded"** when the ALJ has partially upheld the adverse benefit determination.
- Select **"HMO Committee - upheld ABD"** if the HMO Committee upheld or maintained the adverse benefit determination in its entirety.
- Select **"HMO Committee - overturned ABD**" if the HMO Committee overturned the adverse benefit determination in its entirety.
- Select **"HMO Committee - partially upheld ABD"** HMO Committee has partially upheld the adverse benefit determination.
    - For example- A HMO Committee decides to partially uphold a service termination by allowing a limited amount or duration of a service, rather than the full amount or duration desired by the member.
- Select **"Member withdrew"** when a member chooses to withdraw or not participate in the appeal after requesting review of the appeal by the HMO Greivance and Appeal Committee or a DHA fair hearing, such as in the following types of situations:
    - The member formally requested a withdrawal of their DHA fair hearing request or HMO internal appeal.
    - The member was absent from a scheduled DHA fair hearing and therefore the hearing was dismissed.
    - The HMO was unable to contact the member to process a request for internal appeal (for example, unable to reach a member to schedule a time with the HMO Grievance and Appeal Committee meeting).
- Select **"Mediation - resolved"** if the issue was informally resolved through internal HMO review, negotiation, or mediation.
- Select **"Member Did Not Pursue"** if the member did not pursuethe appeal process, and the appeal was not otherwise resolved. Select this option when:
    - The member did not timely submit required documents, such as an appeal request form.
    - The member chooses not to bring the appeal to the HMO Grievance and Appeal Comittee after dissatisfaction with mediation.

      If known, include information in the *Comments* column to briefly explain why the member chose this option.
- Select **"Disenrolled"** if the member disenrolled during the course of the appeal. If known, include information in the *Reason for Disenrollment* column to briefly explain why the member disenrolled.

Note: Select **"Pending/In Process"** from the drop-down menu ff a member filed an appeal (i.e., request for fair hearing, internal HMO appeal or request for rehearing) but a decision has not been

issued by the end of the quarter being reported. The pending status should be removed and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 30 day period for the submission of the report, update the Appeal Log to reflect this.

19. Summary of Resolution / Reason for withdrawal (column S):

Briefly describe the resolution of the member's appeal. This should be brief but provide sufficient information to be meaningful.

- **When there is a written formal resolution** made by the HMO Grievance and Appeal Committee or the Administrative Law Judge renders a written decision, please include a brief synopsis of the decision maker's ruling and the reasoning.
- **When the member withdraws the appeal request**, and the HMO knows the reason why, indicate whether the HMO:
  - Changed its initial decision
  - Maintained its initial decision
- **Ifthe appeal is resolved by informal mediation or negotiation**, describe the terms of that compromise or solution rather than making a general statement like, "Member agreed with second assessment and withdrew."

Note: Select **"Pending/In Process**" from the drop-down menu if a member filed an appeal (i.e., request for fair hearing, internal HMO appeal or request for rehearing) but a decision has not been issued by the end of the quarter being reported. The pending status should be removed and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 45 day period for the submission of the report, update the Appeal Log to reflect this.

20. Did Member Disenroll? (column T)

Select an entry from the drop-down menu:

- Select **"yes"** if the member disenrolled during the course of the appeal or within fourteen calendar days of receipt of a decision from the HMO Grievance and Appeal Committee or DHA.
- Select **"no"** if the member did not disenroll during the course of the appeal or within fourteen calendar days of receipt of a decision from the HMO Grievance and Appeal Committee or DHA.
- Select **"unknown"** when the HMO does not know the member's enrollment status following the appeal.

21. Reason for Disenrollment, if applicable (column U):

If the answer to the previous column was "yes", briefly state, to the best of your knowledge, the reason the member disenrolled.

22. Comments (column V):

Comments are only mandatory when applicable to the situation, requested in the instruction form, or when requested after the HMO selects "other." Examples of information to include in the *Comments* column:

- Relevant notes for a pending/in process appeal.
- Explanation of why a member's appeal was not acknowledged within 5 business days of receipt.
- Explanation of why a member's standard or expedited appeal was not timely resolved.
- Explanation of why the HMO did not provide a summary to DHA within 10 days.
- The reason for a member not following through with the appeal process.
- Explanation of why benefits were not continued for appeals of adverse benefit determinations involving the reduction, suspension or termination of a service.

- Explanation of why, for benefits for that were continued for appeals of adverse benefit determinations involving the reduction, suspension or termination of a service, continued services were ended.
- Any other information the HMO would like to report to BQO or would like to track.