



WellCare of Georgia Policy and Procedure

Georgia Medicaid Provider Complaint Process - Claims

Background/Purpose:

The purpose of this policy is to ensure that WellCare Health Plans, Inc. (“Health Plan”) complies with all applicable contracts and State and federal laws relating to the handling of Georgia Medicaid Claims Provider Complaints. The Georgia Medicaid Claims Provider Complaint Process permits a Provider to dispute the Plans policies, procedures, or any aspect of the Health Plans claims functions, including proposed actions.

Definitions:

Provider Complaint

A written expression by a Provider, which indicates dissatisfaction or dispute with the Contractor’s policies, procedures, or any aspect of a Contractor’s administrative functions, including a Proposed Action.

Proposed Action

The proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the CMS to act within the time frames provided in 42 CFR 438.408(b).

Policy Statement:

- A. All Georgia Medicaid claims Provider Complaints are to be handled in accordance with all applicable rules and regulations for each line of business.
- B. The Claims Department will strictly adhere to the Georgia Medicaid Claims Provider Complaint Process requirements to ensure that all provider complaints are resolved accurately and timely.
- C. Georgia Medicaid Provider complaints can be identified as written correspondence, faxes, web inquiries, emails directly from the provider, and projects received directly from providers.
- D. The Georgia Medicaid Claims Provider Complaint Policies and Procedures will be published in the Provider Handbook that is distributed to all network providers.
- E. The Health Plan shall also distribute the Provider complaint system policies and procedures to out of network providers upon written or oral request.



- F. The Health Plan may distribute a summary of these policies and procedures, if the summary includes information about how the provider may access the full policies and procedures on the Health Plan's Web site.
- G. This summary shall also detail how the provider can request a hard-copy from the health plan at no charge to the provider.
- H. As part of the Provider Complaint System, the Health Plan shall:
- Allow Providers thirty (30) Calendar Days to file a written complaint;
 - Allow providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.
 - Allow a provider that has exhausted the care management's organization's internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal the option either to pursue the administrative review process described in subsection (e) of Code Section 49-4-153(e) or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the care management organization and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the care management organization and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees shall be shared equally by the parties.
 - For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.
 - All interest payments shall be accurately identified on the associated remittance advice submitted by the care management organization to the provider.
 - Require that the reason for the complaint is clearly documented;
 - Require that Providers exhaust the Contractor's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing);
 - Have dedicated staff for Providers to contact via telephone, electronic mail, or in person, to ask questions, file a Provider Complaint and resolve problems;
 - Identify a staff person specifically designed to receive and process Provider Complaints;



- Thoroughly investigate each GF Provider Complaint using applicable statutory, regulatory, and Contractual provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and
- Ensure the CMO plan executives with the authority to require corrective action are involved in the Provider Complaint process.
- In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Contractor shall provide a written Notice of Adverse Action to the Provider. The Notice of Adverse Action shall state that Providers may request an Administrative Law Hearing in accordance with OCGA 49-4-153, 50-13-13 and OCGA 50-13-15.
- The Contractor shall notify the Providers that a request for an Administrative Law Hearing must include the following information:
 - A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;
 - Identification of the Action being appealed and the issues that will be addressed at the hearing;
 - A specific statement of why the Provider believes the Contractor's Action is wrong; and
 - A statement of relief is sought
- DCH has delegated its statutory authority to receive hearing requests to the Contractor. The Contractor shall include with the Notice of Adverse Action the Contractor's address where a Provider's request for an Administrative Law Hearing should be sent in accordance with OCGA 49-4-153 (e).

WellCare Health Plans, Inc.
Administrative Law Hearing Request
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- I. In the event the outcome of the review of the provider complaint is adverse to the provider, the Health Plan shall provide a written Notice of Adverse Action to the Provider.
- J. When issuing a denial, a Notice of Proposed Action or Explanation of Payment (EOP) with complaint rights is mailed to the provider who requested the service or claim payment.
- K. To ensure that all Georgia Medicaid Provider Complaint policies are adhered to, the procedure outlined below will be followed:
 - The provider may file a claims denial complaint either orally or in writing. For oral filings, time frames for resolution begin the date the Health Plan receives the oral filing.
 - Standard complaints will be completed and a determination letter sent to the provider within 45 calendar days of receiving an oral or written request with an additional 14 calendar day extension if the Health Plan justifies the need.



Procedures:

A. **Oral Filing:**

1. The member and provider are notified in the denial letter (EOP) that to file an oral complaint, he/she may call the request into the toll free phone number designated in the denial letter/EOP.
2. The claims specialist/PRT specialist will open a ticket in the PRT database and document at minimum the following:
 - a. The date and time of the request; reason for the complaint (appealing); and the name of the person who issued the complaint; and
 - b. Why the caller feels the request should be approved
3. The Specialist will either adjust the claim accordingly or inform the complainant the reason why the denial stands. If the claim was adjusted for payment, no further action is needed. The EOP will provide documentation of the call outcome. If the claim denial was upheld, a letter will be sent to the provider indicating the reason for the denial decision and documenting the outcome of the call.

B. **Written Filing:**

1. Written complaints will be received in the mail room. Mail room associates will scan and batch the complaints and populate Correspondence Tracker within 48 hours of receipt. If the request is faxed, the printed fax will be batched with the complaints via the mail room.
2. The complaints will be assigned to the designated area staff for review.
3. The Specialist will either adjust the claim accordingly or send a letter to the complainant indicating the reason for the denial decision.