

CLAIM APPEAL PROCESS

Claims that are not “clean” will be denied. Provider will receive Explanation of Benefits (EOB) or a denial letter, indicating the reason for the denial. Provider may either re-submit the claim, or appeal.

- ❖ **RESUBMIT** if claim can be “cleaned up”
 - Correct the problem that caused the denial

- ❖ **APPEAL** if claim can not be “cleaned up,” or if time limit has passed
 - Appeals must be received at Lakeland office within **60 days** of the date of the EOB or denial letter
 - Clearly mark submission as an “APPEAL”
 - Include all elements of a clean claim that are possible
 - Copy of denial letter or EOB from original submission
 - Include a cover letter explaining the reason for the appeal and justification for payment despite missing claim elements
 - **Appeals are only considered one time**

- ❖ **APPEAL REVIEW PROCESS**
 - An appealed claim is reviewed by at least two of the following:
 - Fiscal supervisor
 - Case management supervisory staff and the appropriate Interdisciplinary Teams (IDT)
 - Provider Network Developer
 - Any other Lakeland staff with knowledge of the specific claim
 - Approved claims are paid
 - For denied claims, the fiscal supervisor sends a letter explaining the reason for final denial
 - Either payment or a denial letter will be sent out within 45 days of receipt of the appeal

- ❖ **FURTHER APPEAL**
 - Providers can dispute Lakeland’s determination by submitting an appeal to the Wisconsin Department of Health Services
 - Providers must submit written appeal to DHS within 60 days of Lakeland’s decision or failure to respond