Claim Administrative Review and Appeals Process

Indiana Health Coverage Programs (IHCP)

Gainwell Technologies

IHCP Works Annual Seminar October 2025

Agenda

- Differences Between Claim Inquiry, Administrative Review and Appeal
- Steps Taken Prior to the Claim Administrative Review and Appeals Process
- Submitting a Claim Administrative Review and Appeal
- Non-Emergency Medical Transportation (NEMT) Claim Administrative Reviews and Appeals
- Prior Authorization Administrative Review
- National Correct Coding Initiative (NCCI)
- Claim Appeals
- Ways We Can Assist You
- Helpful Tools
- Questions

Differences Between Claim Inquiry, Administrative Review and Appeal

The Basics

Definitions

- **Claim Inquiry:** Questions about the adjudication of a specific claim.
- **Claim Administrative Review:** If the provider has made reasonable attempts to correct a claim and still remains dissatisfied with the claim denial, the provider may submit a request for an administrative review stating why the provider disagrees with the denial ***within 60 calendar days*** of the denial receipt.
- **Claim Appeal:** When a provider has exhausted the formal administrative review process, as described in the *Filing an Administrative Review Request* section of the *Claim Administrative Review and Appeals* provider reference module, the provider may file a notice of appeal ***within 15 calendar days*** of the receipt of the administrative review response. Providers have 45 days to submit their full appeal.

Administrative Review and Appeals Basics

- If a provider disagrees with the Indiana Health Coverage Programs (IHCP) determination of claim payment, the provider's right of recourse is to file an administrative review and appeal, as provided in ***Indiana Administrative Code 405 IAC 1-1-3***.
- Requests for administrative review **must be filed within 60 calendar days of notification of claim payment or denial**.
- Requests *(notice of intent)* to appeal an adverse administrative review decision **must be filed within 15 calendar days of notification of the decision**. Providers have **45 calendar days to submit a full appeal** from the receipt of the adverse administrative review decision.

Steps Taken Prior to the Claim Administrative Review and Appeals Process

For Denied Claims

Step 1: Review the claim and the remittance advice (RA) denial reason codes.

Step 2: If the claim denial is due to a provider's incorrect or inaccurate claim information, the provider should make applicable corrections and resubmit the claim via routine claim-processing channels.

Step 3: If the provider has made reasonable attempts to correct a claim and remains dissatisfied with the claim denial, the provider may submit a request for an administrative review stating why the provider disagrees with the denial.

For Paid Claims

Step 1: Review the claim and the remittance advice (RA) information.

Step 2: If the claim was paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider should submit a claim adjustment or void/replacement.

Step 3: After the provider has made reasonable attempts to correct or adjust a claim, if the provider remains dissatisfied with the reimbursement, the provider may submit a request for an administrative review stating why the provider disagrees with the claim payment amount.

Things to Remember

1. Submitting a claim administrative review ***cannot*** correct a claim.
2. If there is no prior authorization (PA) on file, ***the service cannot be considered until an approved PA is on file***. Medical records cannot bypass this requirement.
3. Only ***one claim can be reviewed per submission***. If you have multiple claims with the same issue, please reach out to your Provider Relations consultant for assistance.
4. A claim administrative review ***cannot bypass timely filing requirements*** without supporting documentation***.***

Timely Filing

Each step of the process has a specific timely filing limit

Claim Administrative Review
The request must be submitted within **60 calendar days** of notification of claim payment or denial.

Claim Appeal
The request must be submitted Within **15 calendar days** after the upheld administrative review decision

Resources

- Professional Fee Schedule
- Outpatient Fee Schedule
- **Provider Reference Modules**
  - ❑ *Claim Submission and Processing*
  - ❑ *Member Eligibility and Benefit Coverage*
  - ❑ *Claim Adjustments*
  - ❑ *Claim Administrative Review and Appeals*
- Code Sets
- Bulletins

Submitting a Claim Administrative Review and Appeal

How to Submit a Claim
Administrative Review/Claim Appeal

Log in to the IHCP Provider Healthcare Portal (IHCP Portal)

Note: Please select ***Secure Correspondence*** to begin the submission process.

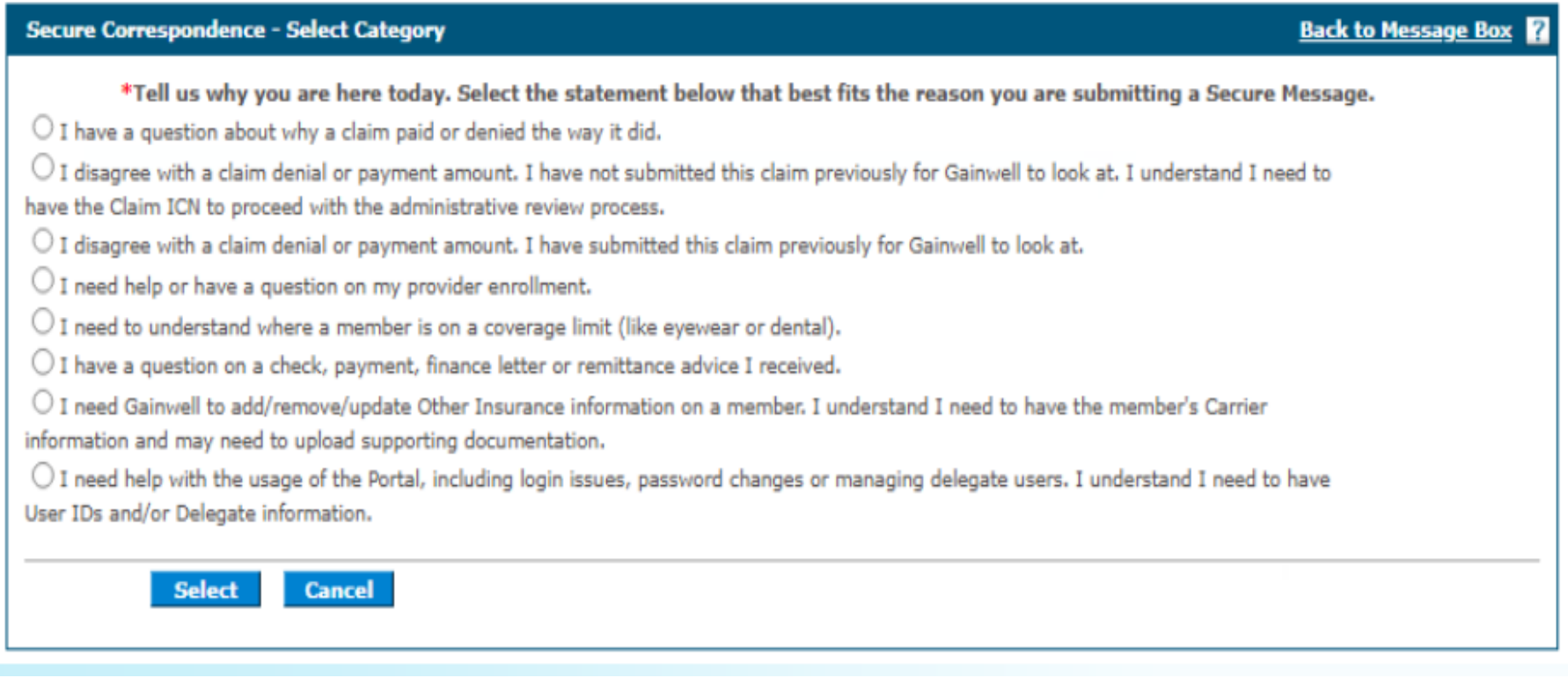
Secure Correspondence Submissions

IHCP Bulletin BT202588 provides detailed instruction on how to use the enhanced IHCP Portal features, such as additional options when submitting Secure Correspondence to Gainwell Technologies for review.

Category Selection Screen

- When selecting the category, submitters will see additional information.
- The following slides include new instructions on how to submit Secure Correspondence requests.

Category Selection Screen



Claim Inquiry Screen

Claim inquiries, administrative reviews and appeals: Providers have three options when submitting claim inquiries, administrative reviews and appeals:

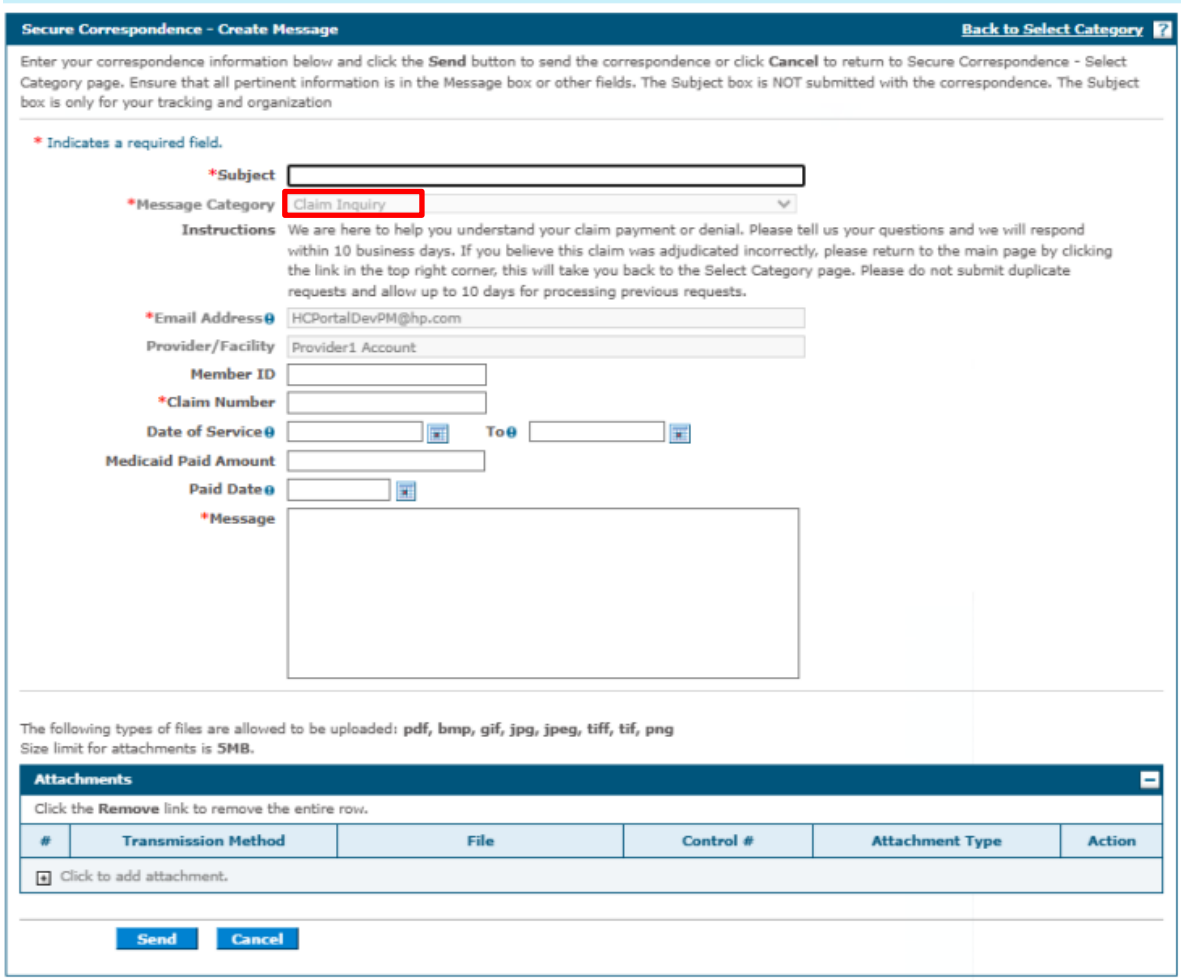
(1) I have a question about why a claim paid or denied the way it did.

Submitters will select this option if they have a *claim inquiry*. When this option is selected, the Secure Correspondence message on the following slide displays for the provider to complete.

Fields with a **red** asterisk (*) are ***required***.

- Providers will be asked for the claim number (ICN) and the RA date.
- If the system identifies that this claim ICN has been submitted for an inquiry in the last **60** days, the provider will receive an *error message* after selecting ***Send***, indicating this request has already been received, and the **submission cannot be duplicated.**

Claim Inquiry Screen Example



Claim Administrative Review Request Screen

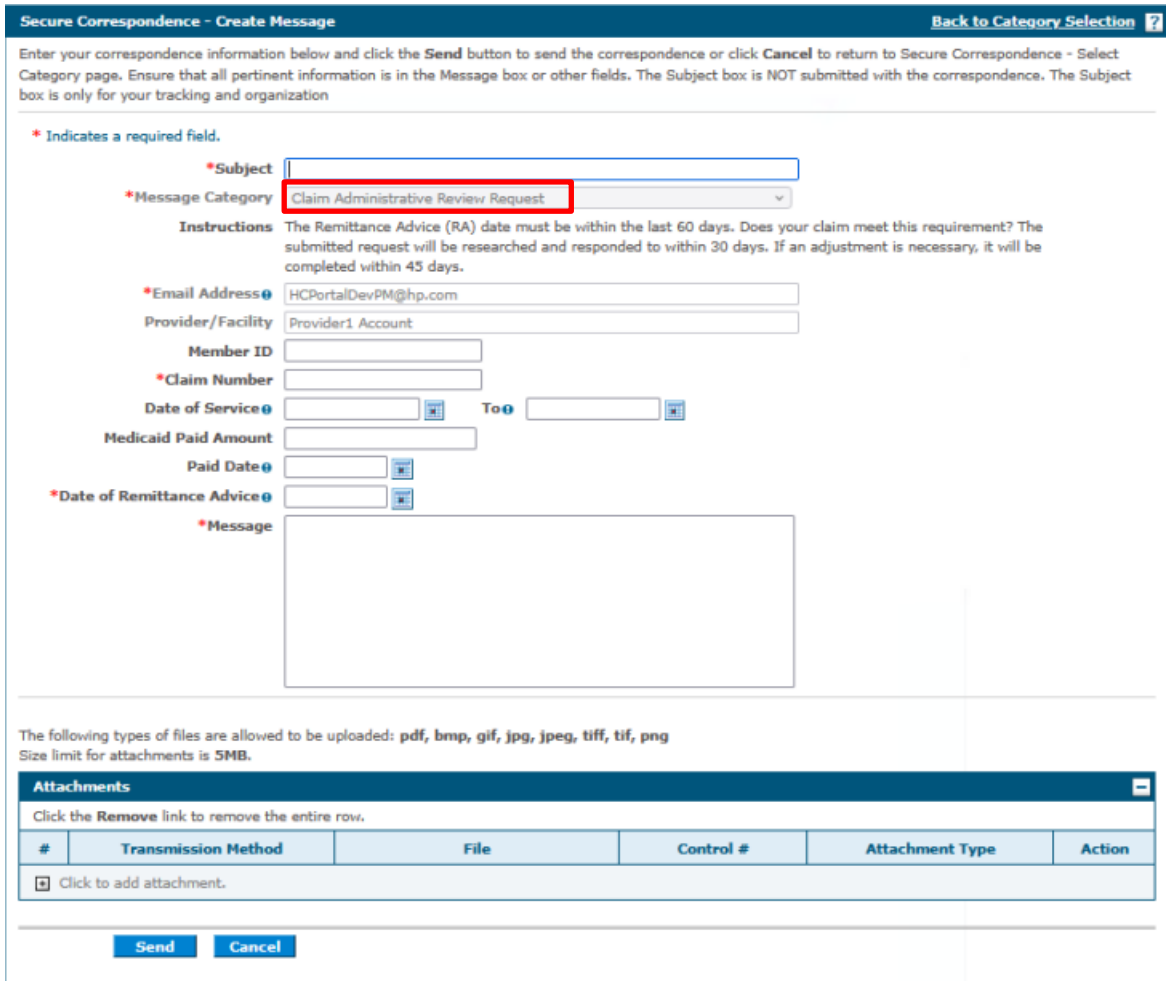
(2) I disagree with a claim denial or payment amount. I have not submitted this claim previously for Gainwell to look at. I understand I need to have the Claim ICN to proceed with the administrative review process.

Submitters may select this option if they wish to proceed with a *claim administrative review*. When selected, the Secure Correspondence message on the following slide displays for the provider to complete.

Fields with a **red** asterisk (*) are ***required***.

- Providers will be asked for the claim number (ICN) and the RA date.
- If the system identifies that this claim ICN has been submitted for an administrative review in the last **60** days, the provider will receive an *error message* after selecting ***Send***, indicating this request has already been received, and the **submission cannot be duplicated.**

Claim Administrative Review Screen Example



Claim Administrative Review and Appeal Requirement Reminders

- The process for disagreeing with a claim payment or denial requires providers to submit an administrative review ***within 60 days of the remittance advice (RA)***.

- If an administrative review decision is **upheld**, an appeal **must** be submitted **within 15 calendar days of the administrative review decision.** When submitting an administrative review request, providers must identify the ***claim number (ICN)*** from the RA.

- The provider should include the **contact tracking number (CTN)** of the **previously submitted administrative review** on the **appeal request**, as seen in *IHCP Bulletin* *BT20258*.

- For common billing errors and recommended corrections, see *IHCP Bulletin* *BT202590*.

Claim Appeal Screen

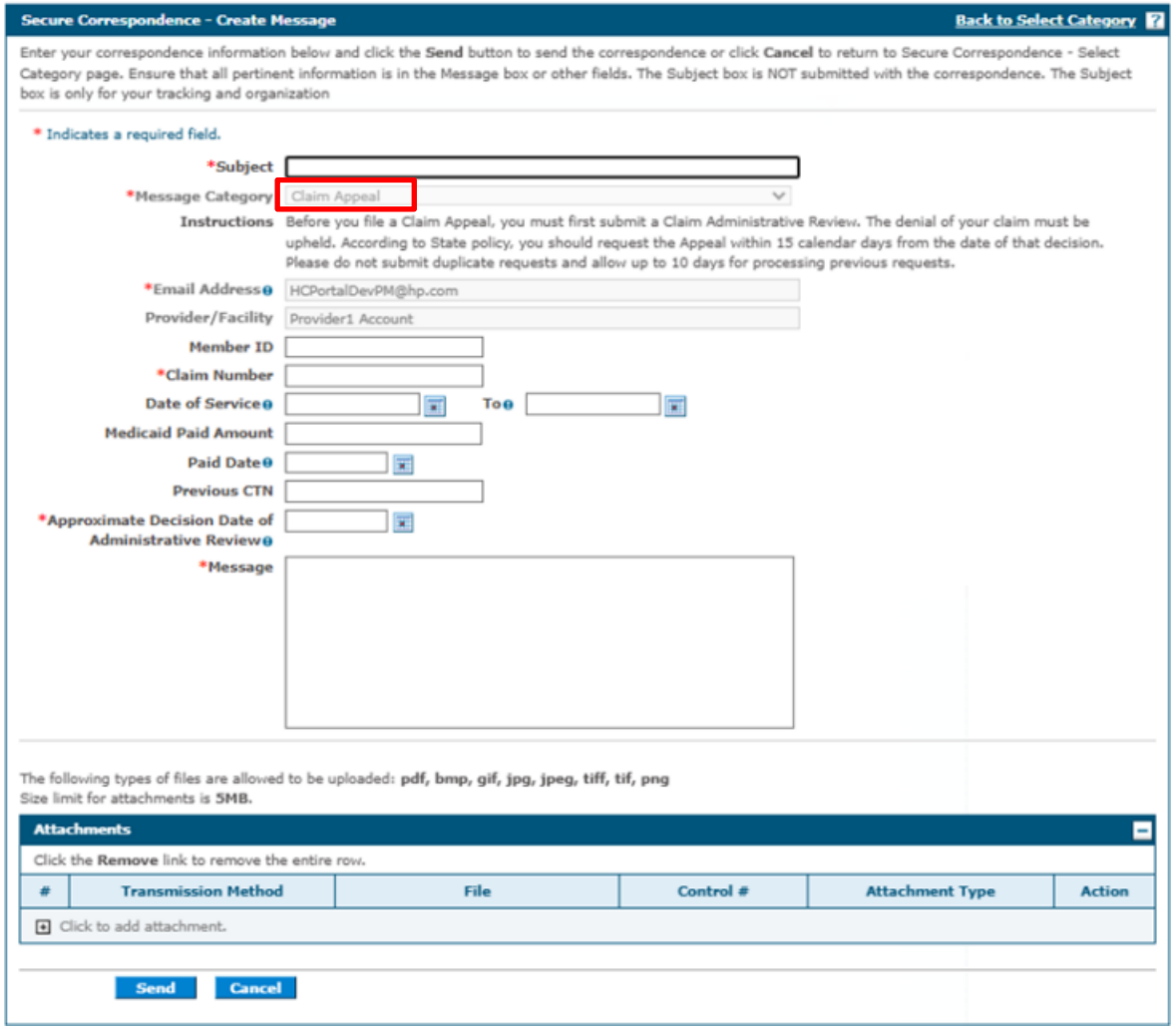
(3) I disagree with claim denial or payment amount. I have submitted this claim previously for Gainwell to look at.

Submitters may select this option if they wish to submit an *appeal* following an administrative review decision. When this option is selected, the Secure Correspondence message on the following slide displays for the provider to complete.

Fields with a **red** asterisk (*) are ***required***.

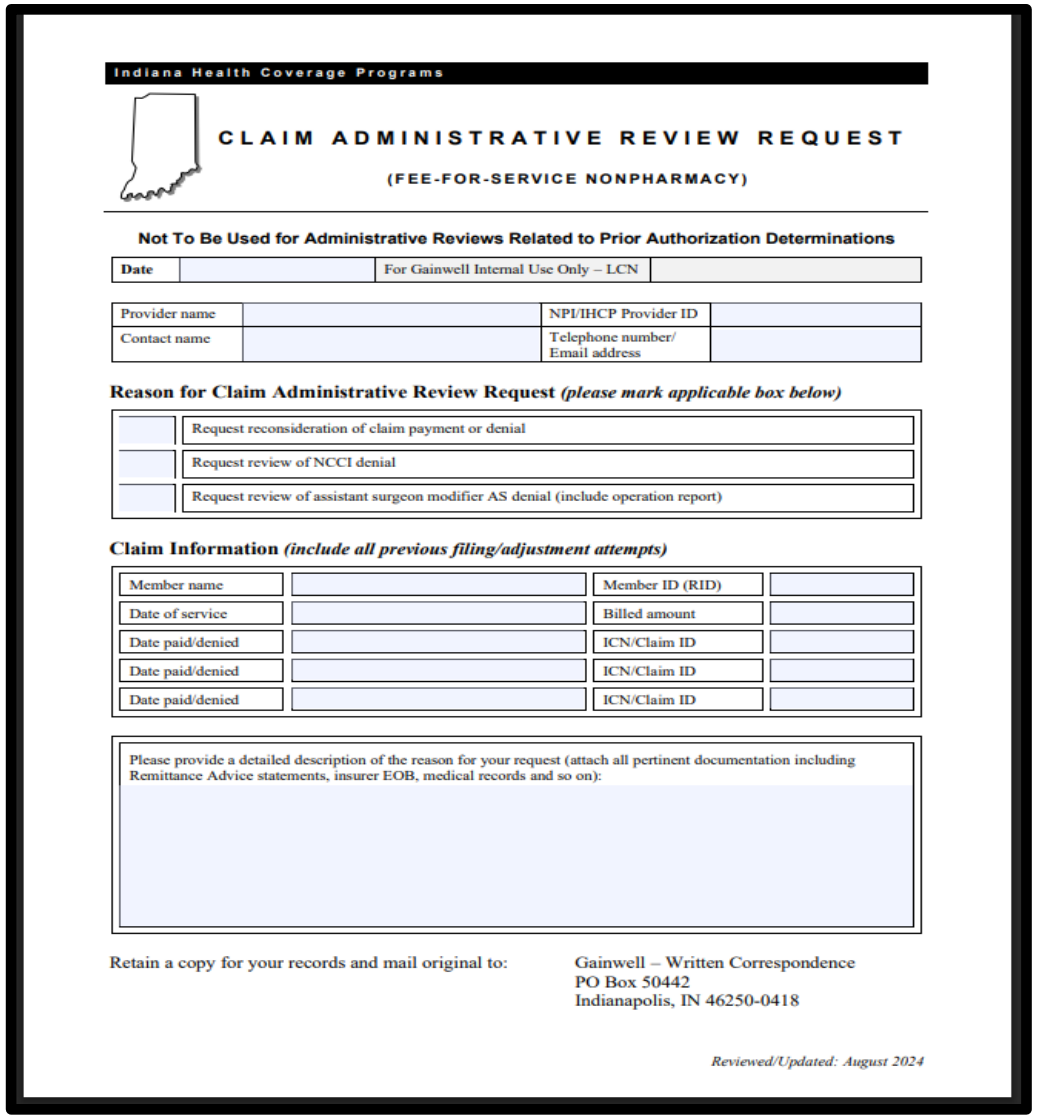
- When submitting an appeal, providers will be asked for the approximate date of the administrative review. This is a mandatory field.
- Valid appeals are forwarded to the ***Office of Medicaid Policy and Planning (OMPP)*** for review.
- Providers will be asked for the claim number (ICN) and the RA date.
- If the system identifies that this claim ICN has been submitted for an appeal in the last **60** days, the provider will receive an *error message* after selecting ***Send***, indicating this request has already been received, and the **submission cannot be duplicated.**

Claim Appeal Screen Example



Written Correspondence

[Claim Administrative Review Request Form]



Indiana Health Coverage Programs

CLAIM ADMINISTRATIVE REVIEW REQUEST

(FEE-FOR-SERVICE NONPHARMACY)

Not To Be Used for Administrative Reviews Related to Prior Authorization Determinations

Date		For Gainwell Internal Use Only – LCN	

Provider name		NPI/IHCP Provider ID	
Contact name		Telephone number/ Email address	

Reason for Claim Administrative Review Request ***(please mark applicable box below)***

	Request reconsideration of claim payment or denial
	Request review of NCCI denial
	Request review of assistant surgeon modifier AS denial (include operation report)

Claim Information ***(include all previous filing/adjustment attempts)***

Member name		Member ID (RID)	
Date of service		Billed amount	
Date paid/denied		ICN/Claim ID	
Date paid/denied		ICN/Claim ID	
Date paid/denied		ICN/Claim ID	

Please provide a detailed description of the reason for your request (attach all pertinent documentation including Remittance Advice statements, insurer EOB, medical records and so on):

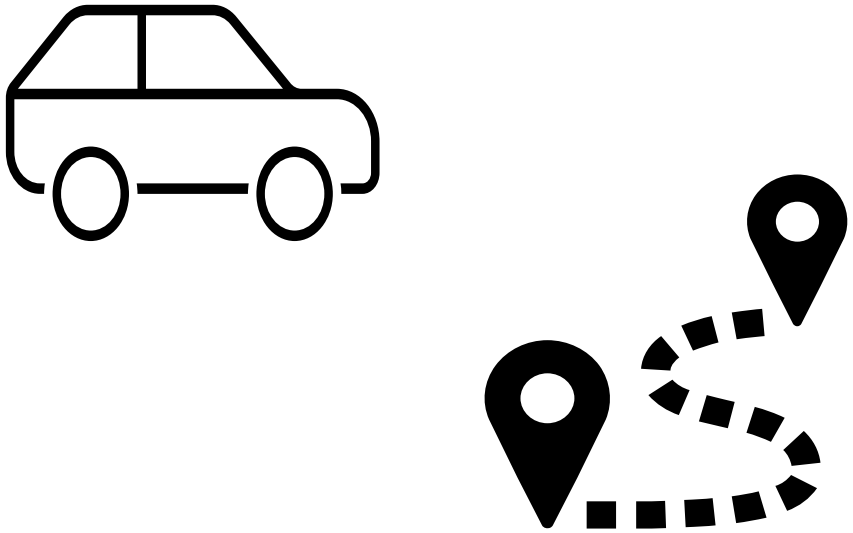
Retain a copy for your records and mail original to:

Gainwell – Written Correspondence
PO Box 50442
Indianapolis, IN 46250-0418

Reviewed/Updated: August 2024

Non-Emergency Medical Transportation (NEMT) Claim Administrative Reviews and Appeals

Non-Emergency Medical Transportation (NEMT) Claim Administrative Reviews and Appeals



Request Administrative Review
INClaims@verida.com

Claim Processing
Verida
4751 Best Rd., Suite 300
Atlanta, GA 30337

Claim Appeals
Verida Claims
843 Dallas Highway
Villa Rica, GA 30180

Prior Authorization Administrative Review

Prior Authorization Administrative Review

Acentra Health

- Prior authorization administrative reviews are handled by Acentra Health.
- See the *Prior Authorization* provider reference module for additional details.

Prior Authorization Administrative Review Contact Information

Submit via:

- The Atrezzo Portal
- **Fax:** 800-261-2774
- **Mail:**
  Acentra Health – Prior Authorization
  6802 Paragon Place, Suite 440
  Richmond, VA 23230

National Correct Coding Initiative (NCCI)

NCCI – National Correct Coding Initiative

Procedure-to-Procedure (PTP) Edits:

- ***PTP*** edits prevent inappropriate payment of services that should not be reported together.
- Each edit has a **column I** and **column II** Healthcare Common Procedure Coding System (HCPCS)/CPT code.
- If the same provider reports the two codes of an edit pair for the same member on the same date of service, the ***column I code*** is eligible for payment but the ***column II code*** is denied.

Medically Unlikely Edits (MUEs):

- ***MUEs*** prevent payment for an inappropriate number or quantity of the same service on a single day.
- An MUE for a HCPCS/CPT code is the **maximum number of units of service (UOS)**, under most circumstances, reportable by the same provider for the *same beneficiary* on the *same date of service.*

For Claims With NCCI Edits

Access the Medicaid NCCI Edit Files webpage at cms.gov for the Procedure-to-Procedure (PTP) and Medically Unlikely Edit (MUE) files.

For additional information regarding National Correct Coding Initiative, please see the NCCI provider reference module.

If you confirm that a claim was coded correctly and would like reconsideration, submit an Administrative Review Request on the IHCP Portal or via Written Correspondence.

Submitting an NCCI Claim Administrative Review

Write NCCI at the beginning of the ***secure correspondence*** message or on the face of the letter *(**written correspondence**)*.

If using the *IHCP Claim Administrative Review Request* form, select the box marked "Request review of NCCI denial."

The request should document any unusual circumstances in which the provider believes the claim was coded correctly.

Claim Appeals

Claim Appeal Process

- An unfavorable outcome to the administrative review allows you the right to appeal that decision.
- **The appeal request must be complete and include**: **1.** Pertinent facts **2.** Proof of actions taken to resolve the payment/denial and any associated documentation.
- Per *Indiana Code IC 4-21.5-3-7*, the IHCP must receive the appeal request **within 15 calendar days** after the provider receives the adverse administrative review decision notification.
- The appeal request must be submitted as an IHCP Portal **secure correspondence message** (using the Appeal category, see slides 21 and 22) or delivered in writing by mail, email or fax.

After Submission: What Happens Next

Providers will receive **written response** for a claim administrative review ***within 30 calendar days***.

All claim appeal requests will receive response ***within 45 calendar days*** of receipt of the request, regardless of the decision to pay or deny the claim.

What If

What if I submit my request in the wrong order?

If you submit an appeal prior to filing a claim administrative review, your appeal will be processed as a claim administrative review.

What if I want to know the status of my claim administrative review?

You may always reach out to your Provider Relations consultant to obtain the status of your claim inquiry/claim administrative review.

What if I want the status of my appeal?

Appeals submitted via **Written Correspondence/Secure Correspondence** are forwarded to **Office of Administrative Law Proceedings (OALP)** at the state upon receipt. After the state makes a determination on the submitted information, a notification of that decision is sent directly to the mail-to address on file for the provider location. Gainwell does **NOT** receive copies of the determination letters. You may always reach out to OALP at fssa.appeals@oalp.in.gov for additional information.

Important Notes

Timely Filing Limits must be observed throughout this process.

Claim Administrative Review: *60 Calendar Days* from receipt of the RA.

Claim Appeal: *15 Calendar Days* from receipt of administrative review decision.

It is also important to note that Provider Relations consultants, Customer Assistance and/or Written/Secure Correspondence **CANNOT** expedite the processing of your appeal. Appeals are processed at the state level.

While Gainwell and the OMPP strive to process appeals within the time frames previously stated, completion is subject to many variables that may affect finalization.

Claim Appeal Determinations

Any inquiry regarding appeals sent to the state must be inquired upon using the following contact information:

MS07
Secretary
Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
402 W. Washington St., Room W374
Indianapolis, IN 46204-2739

Fax: 317-232-4412

Email: fssa.appeals@oalp.in.gov

Ways We Can Assist You

Ways Gainwell Can Assist

- Claim research
- Claim reprocessing
- Shadow claim voids
- Completing documents on the IHCP Portal
- Education on correcting claims

Important Links

Bulk Administrative Review and Appeal Submission:

See *IHCP Bulletin BT202591*

Timely Filing Limits:

See *IHCP Bulletin BT201829 and the Claim Submission and Processing provider reference module*

Claim Adjustments:

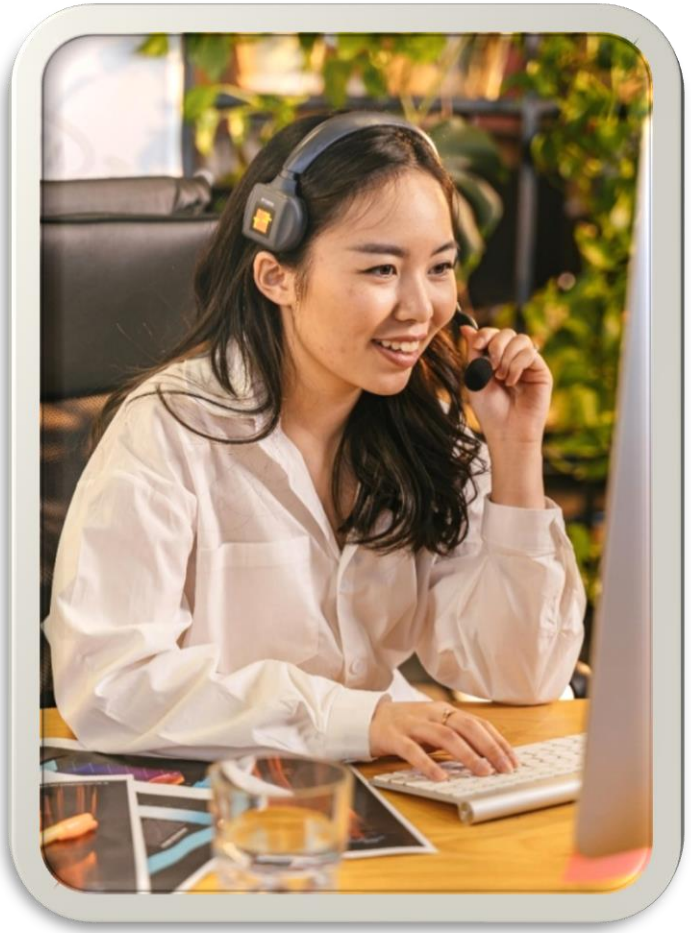
See the *Claim Adjustments* provider reference module

Gainwell Mail Changes:

See *IHCP Bulletin BT2025107*

Helpful Tools

Useful Information



Indiana Medicaid for Providers website

IHCP Provider Reference Modules

IHCP Bulletins

Sign up for email notifications to receive weekly summaries of new and updated bulletins, modules and other publications.

Customer Assistance

800-457-4584

8 a.m. - 6 p.m. Eastern Time Monday – Friday

Provider Relations Consultants by region

Secure Correspondence via the IHCP Provider Healthcare Portal

*(After logging in to the IHCP Portal, click the **Secure Correspondence** link to submit a request.)*

Provider Relations Consultants

Areas Covered	Consultant	Email	Telephone
Region 1 plus Chicago/Watseka, IL, and Sturgis, MI	Michelle Walls	INXIXRegion1@gainwelltechnologies.com	317-488-5071
Region 2 plus Danville, IL	Jill Harris	INXIXRegion2@gainwelltechnologies.com	317-488-5080
Region 3	Gabrielle Anderson	INXIXRegion3@gainwelltechnologies.com	317-488-5324
Region 4 plus Cincinnati/Harrison and Hamilton/Oxford, OH	Kassandra Johnson	INXIXRegion4@gainwelltechnologies.com	317-488-5153
Region 5	Jeannette Moore	INXIXRegion5@gainwelltechnologies.com	317-488-5186
Region 6	Emily Redman	INXIXRegion6@gainwelltechnologies.com	317-210-2618
Region 7 plus Louisville and Owensboro, KY	Tami Lott	INXIXRegion7@gainwelltechnologies.com	317-286-6894
All out-of-state providers except those in the previously listed cities	Judy Green	INXIX_OOS@gainwelltechnologies.com	317-488-5026

Questions

Thank you for attending!

By taking a few moments to complete the event and session evaluations, you help us understand your experience and shape the future of our programs.

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