Indiana Health Coverage Programs Portal Claim Tips

Indiana Health Coverage Programs (IHCP)
Gainwell Technologies
IHCP Works Annual Seminar October 2025

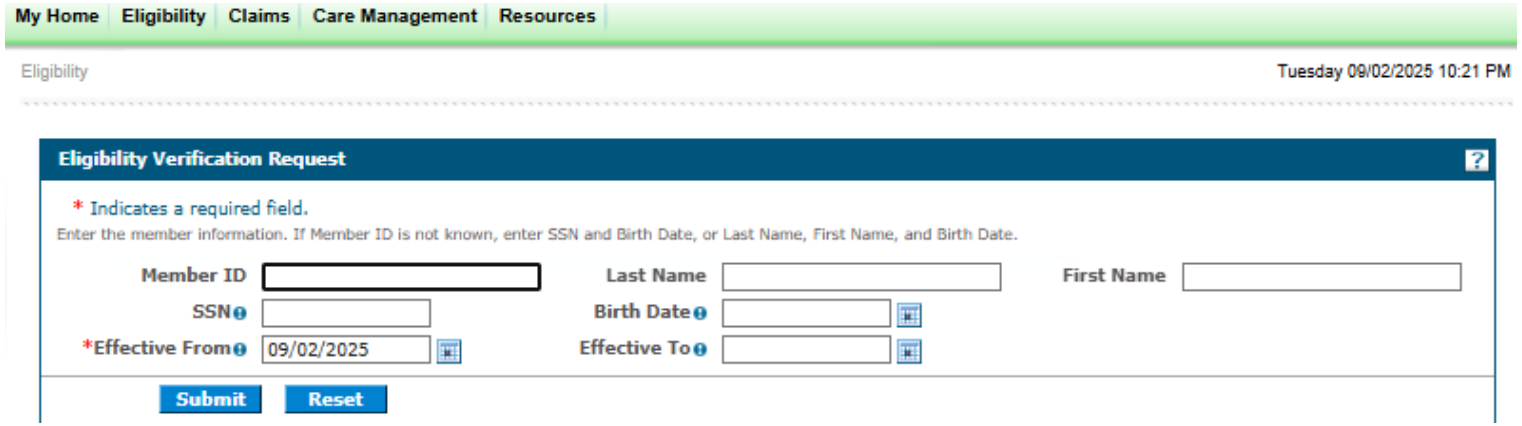
Agenda

- Eligibility
- Common Claim Denials
- IHCP Portal Claim Submission Tips for Secondary Claims
- Claim Adjustments On the IHCP Portal
- Remittance Advice Basics
- Submitting Medicare Exhaust Inpatient Claims on the IHCP Portal
- Helpful Tools
- Questions

Eligibility

Verifying Eligibility

- Members may have periods of inactive coverage due to varying circumstances; therefore, always check eligibility **prior** to rendering services for **every** date of service
- You can check online on the **IHCP Portal**, with the virtual assistant (GABBY) at 800-457-4584, option 2, or through an approved vendor software for the 270/271 batch or interactive eligibility benefit transactions
- Eligibility **cannot** be verified for future dates
- Use one of the following: the Member's ID; Social Security Number (SSN) and Birth Date; or Last Name, First Name, and Birth Date



Member is Eligible

Continue to Review the Following:

- **Benefit Details** lists the member's coverage, including benefit plan name and description, and copayment requirements if applicable.

Benefit Details

Coverage	Description	Effective Date	End Date
Aged and Disabled HCBS Pathways	Aged and Disabled HCBS Pathways	09/03/2025	09/03/2025
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	09/03/2025	09/03/2025
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	09/03/2025	09/03/2025

Coverage	Description and Copayment Message	Copay Amount
Full Medicaid	Chiropractic - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Medical Care - Copay is not applicable to this type of service.	$0.00

Some searches may have more than one coverage type listed.

Eligibility Limits, Managed Care Assignment and Other Insurance Details

Limit Details lists many member benefit limits.

Managed Care Assignment Details lists any Managed Care Program such as Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise or Indiana PathWays for Aging.

Review for the Managed Care Entity (MCE) name such as United Healthcare, CareSource, MDwise, Humana, etc.

Other Insurance Details lists any other insurance on file.

Limit Details

The Dollar Limits and Service Limits may not reflect recent claims.

Dollar Limits	Limit	Remaining
6085 INCONTINENCE SUPPLIES LIMITED $1950/ROLLING Y	$1,950.00	$1,859.00
Service Limits	**Limit**	**Remaining**
6195 FRAMES INITIAL OR REPAIR/REPLACEMENT 21 YRS O	1	-
6223 PERIODONTAL ROOT PLAN 21 YR OR > 4/LIFE NON-I	4	1
6272 LENSES INITIAL REPAIR/REPLACEMENT MEMBER 21 Y	2	1

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Indiana Pathways for Aging			
Effective Date	**End Date**	**MCO / CMO Name**	**MCO / CMO Phone**
09/03/2025	09/03/2025	UNITEDHEALTHCARE COMMUNITY PLAN	1-877-610-9785

Other Insurance Details

Carrier Name (Carrier ID)	Address	Phone Number	Policy ID	Group ID	Policy Holder	Coverage Type
Medicare						MEDICARE A
Medicare						MEDICARE B

Common Claim Denials

Denial Example #1

Denial EOB Code 2017 and Claim Adjustment Reason Code 24:

Claim EOB Information

Claim / Service #	Disposition	EOB Code	Description
Svc # 1	Deny	2017	THE MEMBER IS ENROLLED IN RISK BASED MANAGED CARE. PLEASE SUBMIT TO APPROPRIATE RISK BASED MANAGED CARE PROCESSOR..

Claim Adjustment Reason Code Information

Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	24	$90.00	System	Charges are covered under a capitation agreement/managed care plan.

When you receive a denial like this, check eligibility and review the Managed Care Assignment Details section on the IHCP Portal.

Managed Care Assignment Details

Denial Reason Example #1:

The claim denied because the member is enrolled with Anthem Blue Cross and Blue Shield Indiana PathWays for Aging.

Always check the Managed Care Assignment Details and submit your claims to the correct payer.

Benefit Details

Coverage	Description	Effective Date	End Date
Aged and Disabled HCBS Pathways	Aged and Disabled HCBS Pathways	07/19/2025	07/19/2025
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	07/19/2025	07/19/2025

Coverage	Description and Copayment Message	Copay Amount
Full Medicaid	Chiropractic - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Medical Care - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Urgent Care - Copay is not applicable to this type of service.	$0.00
Full Medicaid	Mental Health - Copay is not applicable to this type of service.	$0.00

Limit Details

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Indiana Pathways for Aging			
Effective Date	**End Date**	**MCO / CMO Name**	**MCO / CMO Phone**
07/19/2025	07/19/2025	ANTHEM BLUE CROSS AND BLUE SHIELD	1-844-533-1995

Denial Example #2

Denial EOB Code 2505 and Claim Adjustment Reason Code 22:

Claim EOB Information

Claim / Service #	Disposition	EOB Code	Description
Svc # 1	Deny	2505	THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.
Svc # 1	Pay	2505	THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.
Svc # 2	Pay	2505	THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.
Svc # 2	Deny	2505	THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.

Claim Adjustment Reason Code Information

Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	22	$352.00	System	This care may be covered by another payer per coordination of benefits.
Svc # 1	22		System	This care may be covered by another payer per coordination of benefits.
Svc # 2	22		System	This care may be covered by another payer per coordination of benefits.
Svc # 2	22	$150.00	System	This care may be covered by another payer per coordination of benefits.

When you receive a denial like this, check eligibility and review the Other Insurance Details section on the IHCP Portal.

Other Insurance Details – Third-Party Liability (TPL)

Denial Reason Example #2:

The claim denied because the member has other insurance primary to IHCP Medicaid Fee-For-Service (FFS).

Other Insurance Details

Carrier Name (Carrier ID)	Address	Phone Number	Policy ID	Group ID	Policy Holder	Coverage Type
US ABLE ADMINISTRATORS	P.O. BOX 1460 TPL LITTLE ROCK, AR 72203	1-855-279-2398				MENTAL HEALTH
ANTHEM BC/BS	PO BOX 105187 N/A ATLANTA, GA 30348	1-800-676-2583				HOSPITALIZATION, MEDICAL AND MAJOR MEDICAL

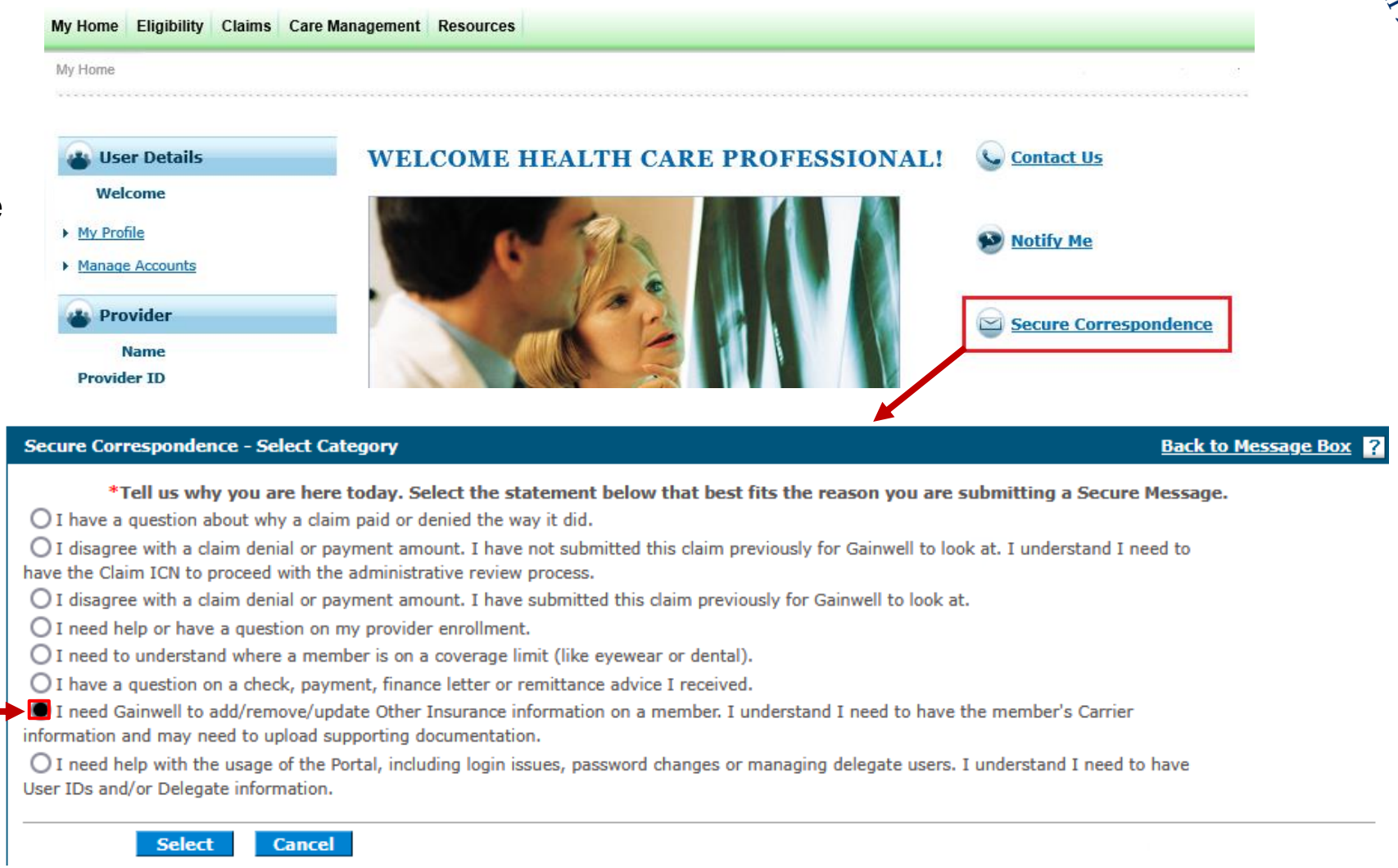
The IHCP requires members and providers to follow the rules of their primary insurance carrier.

If the member goes out of network OR the provider does not get authorization and the TPL denies, Medicaid Fee-For-Service will NOT cover the services.

For more information, see the Third-Party Liability provider reference module.

Secure Correspondence – Other Insurance

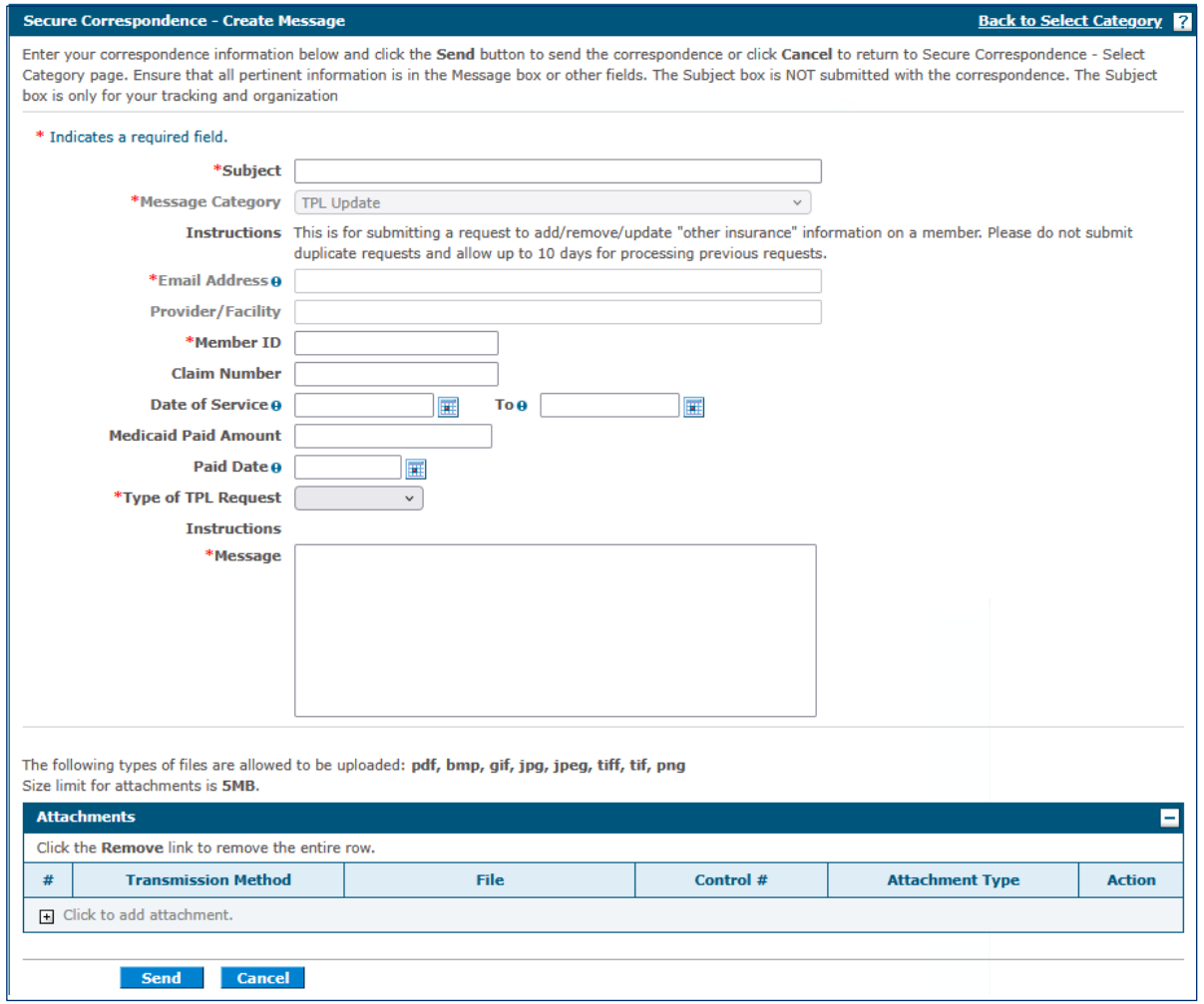
If your TPL-Other Insurance details differ from those in the IHCP Portal or Electronic Verification System, you can submit a TPL Update through Secure Correspondence while logged in to the IHCP Portal.



Create Message to Update TPL

Providers should forward copies of any documentation, including:

- Explanation of benefits (EOB)
- Remittance advice (RA)
- Member's third-party insurance card
- Letter from the carrier
- Start and Termination dates, if applicable
- Claim Date of Service



Please allow up to <u>10 business days</u> for the TPL to be updated.

Once it is updated, <u>you will need to resubmit your claim</u>.

Denial Reason Example #3

Denial EOB Codes 2006, 2033 and Claim Adjustment Reason Code 40:

Claim EOB Information

Claim / Service #	Disposition	EOB Code	Description
Svc # 1	Deny	2006	DIAGNOSIS CODE BILLED IS NOT COVERED FOR THE MEMBER'S BENEFIT PLAN.
Svc # 1	Deny	2033	INVALID CLAIM TYPE FOR THE PROGRAM BILLED

Claim Adjustment Reason Code Information

Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	40	$1,621.00	System	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

When you receive a denial like this, check eligibility and review the Coverage Details section on the IHCP Portal.

Package E – Emergency Services Only

Denial Reason Example #3:

The claim denied because this member has Package E – Emergency Services Only and the claim was not billed as emergent.

Benefit Details

Coverage	Description	Effective Date	End Date
Package E - Emergency Services Only	Package E - Emergency Services Only	07/21/2025	07/21/2025

Coverage	Description and Copayment Message	Copay Amount
Package E - Emergency Services Only	Hospital - Inpatient - Copay is not applicable to an emergency services only member.	$0.00

Review the next 2 slides to show how you might bill for claims that are emergent and see the Emergency Services and Claim Submission and Processing provider reference modules for additional information.

Emergency Services Only – Package E Billing Instructions for Professional and Dental Claims on the IHCP Portal

Package E Billing Instructions for your claim type IF Emergent:

Professional Claim Type on the IHCP Portal:
• In the Service Details panel in Step 3, select the EMG box for each applicable detail to indicate that it was an emergency service.

Dental Claim Type on the IHCP Portal:
• In the Claim Information panel in Step 1, select the Emergency box to indicate that the claim is for an emergency situation, and if the treatment is a result of an occupational illness or injury, auto accident, or other accident, select the appropriate option from the drop-down menu in the Accident Related field.
• In the Service Details panel in Step 3, enter only appropriate procedure codes that have been designated by the IHCP as emergency dental services in the Procedure Code field.

See Dental Services Codes for Dental Procedure Codes Allowed for Emergency Services Only.

Emergency Services Only – Package E Billing Instructions Outpatient and Inpatient Claims on the IHCP Portal

Package E Billing Instructions for your claim type IF Emergent:

Outpatient Claim Type on the IHCP Portal:
• In the Diagnosis Codes panel in Step 2, enter the appropriate emergency diagnosis code in the first (primary) position.

Inpatient Claim Type on the IHCP Portal:
• In the Claim Information panel in Step 1, enter 1 – Emergency in the Admission Type field.

See the Emergency Services provider reference module for more details, including billing for emergency department screenings.

Denial Example #4
Prior Authorization Units Exceeded

Denial EOB Code 3006 - Units Exceed PA Master
Claim Adjustment Reason Code 198

Claim EOB Information

Claim / Service #	Disposition	EOB Code	Description
Svc # 1	Deny	3006	PAYMENT FOR THIS SERVICE HAS BEEN DENIED OR CUTBACK DUE TO DOLLARS BILLED EXCEEDING THE DOLLARS PRIOR AUTHORIZED.

Claim Adjustment Reason Code Information

Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	198		System	Precertification/notification/authorization/pre-treatment exceeded.

The claim denied due to the number of units billed for an authorized service/procedure code exceeds the unused number of units authorized for the date of service.

OR

The claim cuts back and pays up to the remaining number of units.

Denial Example #4 Resolution
Prior Authorization Units Exceed PA Master

Denal EOB Code 3006 - Units Exceed PA Master
Claim Adjustment Reason Code 198

Resolution: For a non-waiver claim, please review your prior authorization (PA) via Acentra Health's **Atrezzo** system. Verify what you were approved for versus what you billed, including dates, units, and modifiers.

For waiver claims, please review your Notice of Action (NOA) / Service Authorization. If the member needs additional authorization, please reach out to the member's care manager.

See the **Prior Authorization** provider reference module for additional details.

Denial Example #5
Prior Authorization Not Found

Denial EOB Code 3001 – Date of Service Not on PA Master File/
Claim Adjustment Reason Code 197

Claim EOB Information

Claim / Service #	Disposition	EOB Code	Description
Svc # 1	Deny	3001	DATES OF SERVICE NOT ON THE P.A. MASTER FILE.

Claim Adjustment Reason Code Information

Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	197	$300.00	System	Precertification/authorization/notification/pre-treatment absent.

When you receive a denial like this, the code billed requires prior authorization (PA) for that program, and the date(s) of service indicated on the claim do not fall within the start/stop dates prior authorized for the service rendered.

OR

If the modifier usage on the claim does not match the usage on the PA.

Denial Example #5 Resolution
Prior Authorization Not Found

Denial EOB Code 3001 – Date of Service Not on PA Master File/
Claim Adjustment Reason Code 197

Resolution: For a non-waiver claim, contact the PA vendor Acentra Health via their **Atrezzo** system to follow up on the status of the request and review your claim dates and modifier usage versus authorization approved. If there is no prior authorization (PA) on file, the claim will remain denied unless you are able to obtain retro authorization. Medical records cannot bypass this requirement.

For waiver claims, please review your NOA and make sure that you billed with the correct service and modifiers. If you did, please reach out to the member's care manager for assistance.

IHCP Portal Claim Submission Tips for Secondary Claims

Electronic Claim Submission

Submitting claims electronically through a Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 transaction or through the IHCP Portal reduces paperwork, increases accuracy, and claims are processed more quickly, resulting in faster payment.

Resources available on the Indiana Medicaid for Providers website include:

Provider Reference Modules:

- Claim Submission and Processing
- Electronic Data Interchange
- Provider Healthcare Portal
- Third-Party Liability

Electronic Data Interchange (EDI) Solutions

IHCP Provider Healthcare Portal Training

For assistance and training, providers should contact their Provider Relations Consultant.

IHCP Portal Claim Submission

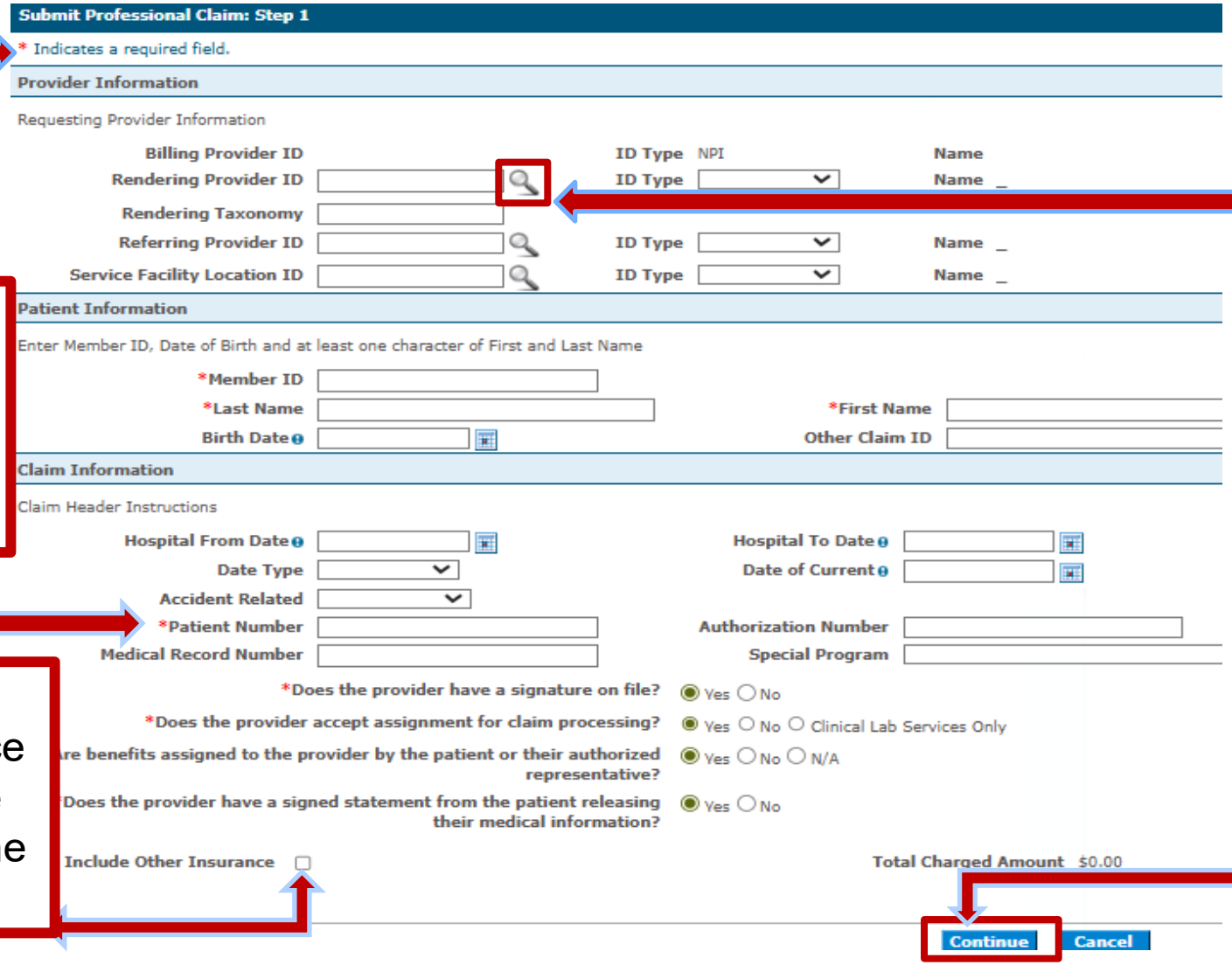
While logged into the [IHCP Portal] under the correct Service Location, you will click on the **Claims** Menu and select the appropriate Submit Claim type for your specialty

Secondary Professional Claim Submission on the IHCP Portal When Primary Paid

Everything with an * needs to be completed

Patient Number is your identification number for this claim - not specific to the IHCP

If there is a primary insurance that **covers** the service, check the box

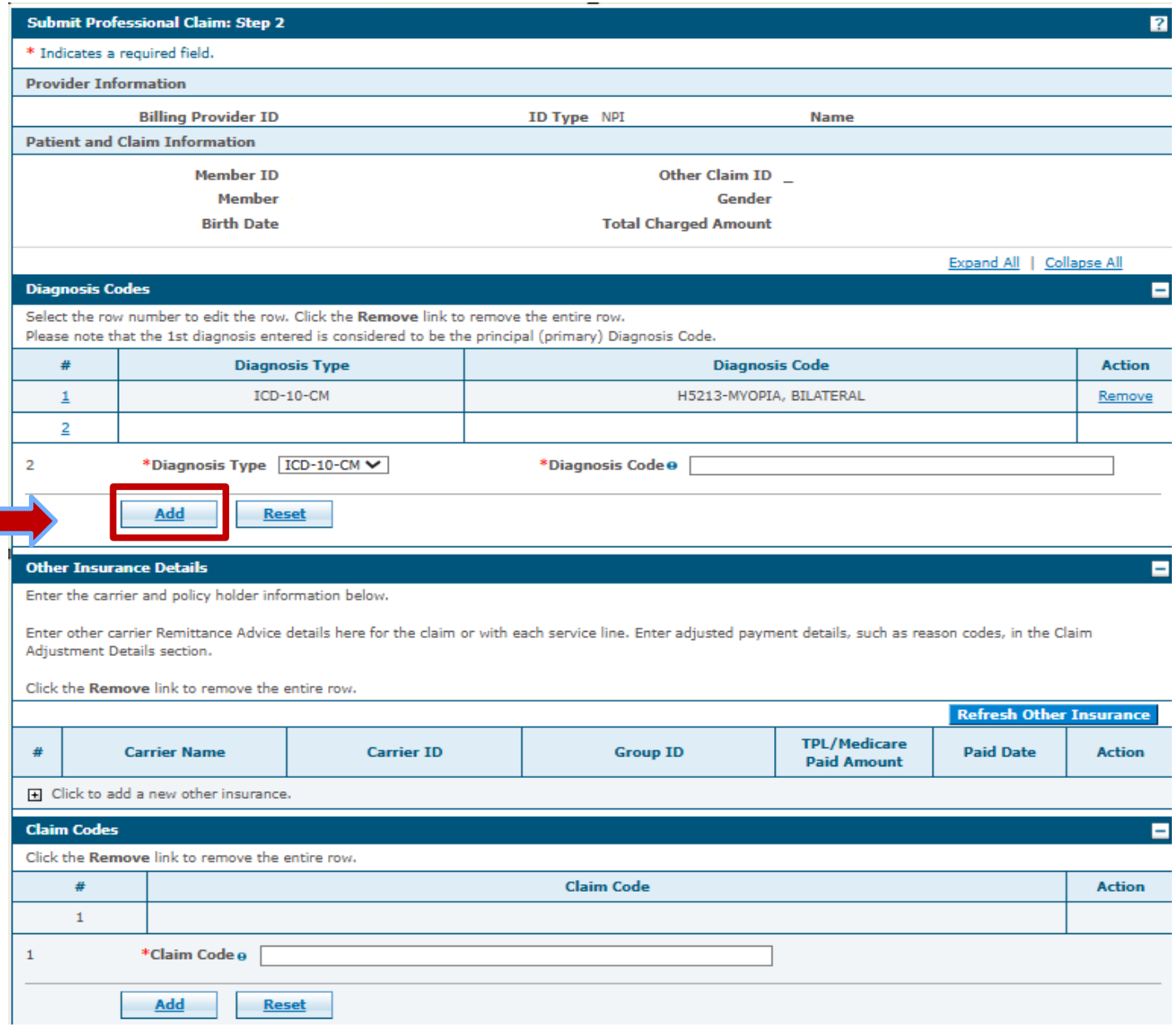


Click on the Magnifying Glass Icon – use NPI or Medicaid Provider ID to choose and add **Rendering Provider ID or Referring ID** (If Needed)

Click continue to go to Step 2

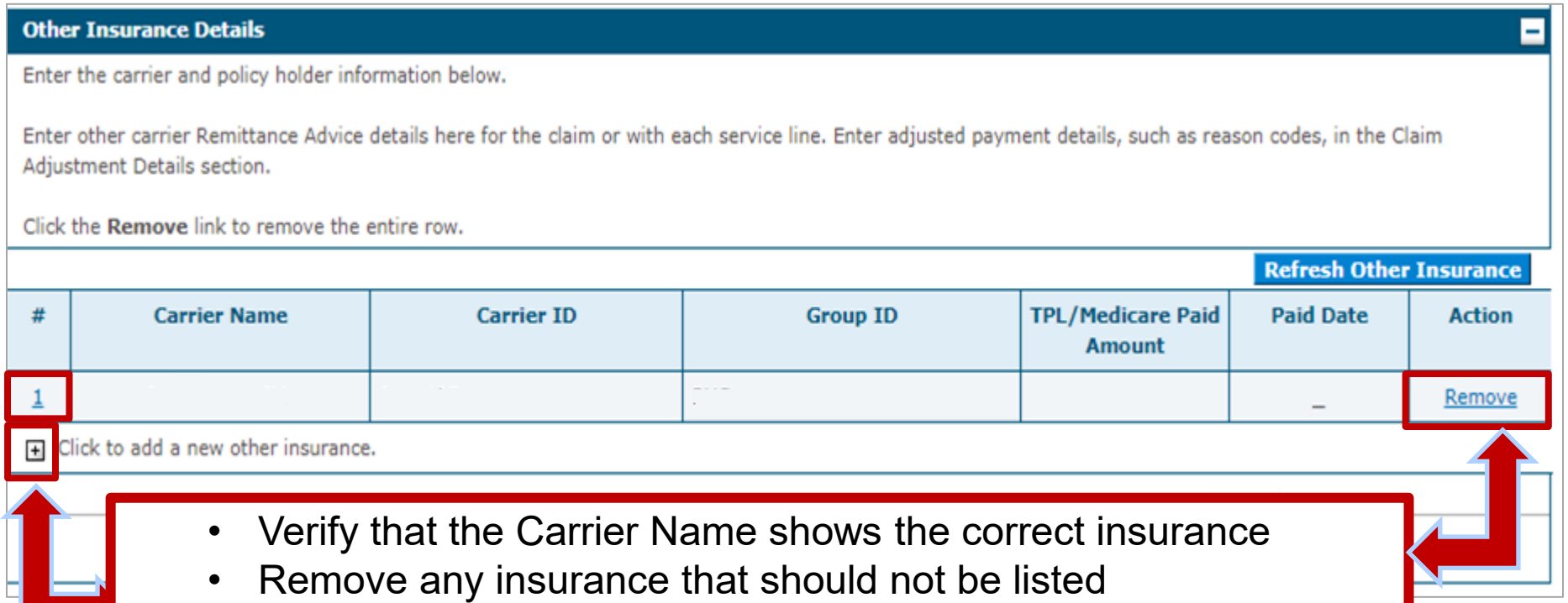
Diagnosis Codes Section

Add each diagnosis by entering the description or diagnosis code without any punctuation and selecting the add button.



Other Insurance Details

Review the primary insurance information under
Other Insurance Details – the **Header** Level – which is Step 2 of the claim



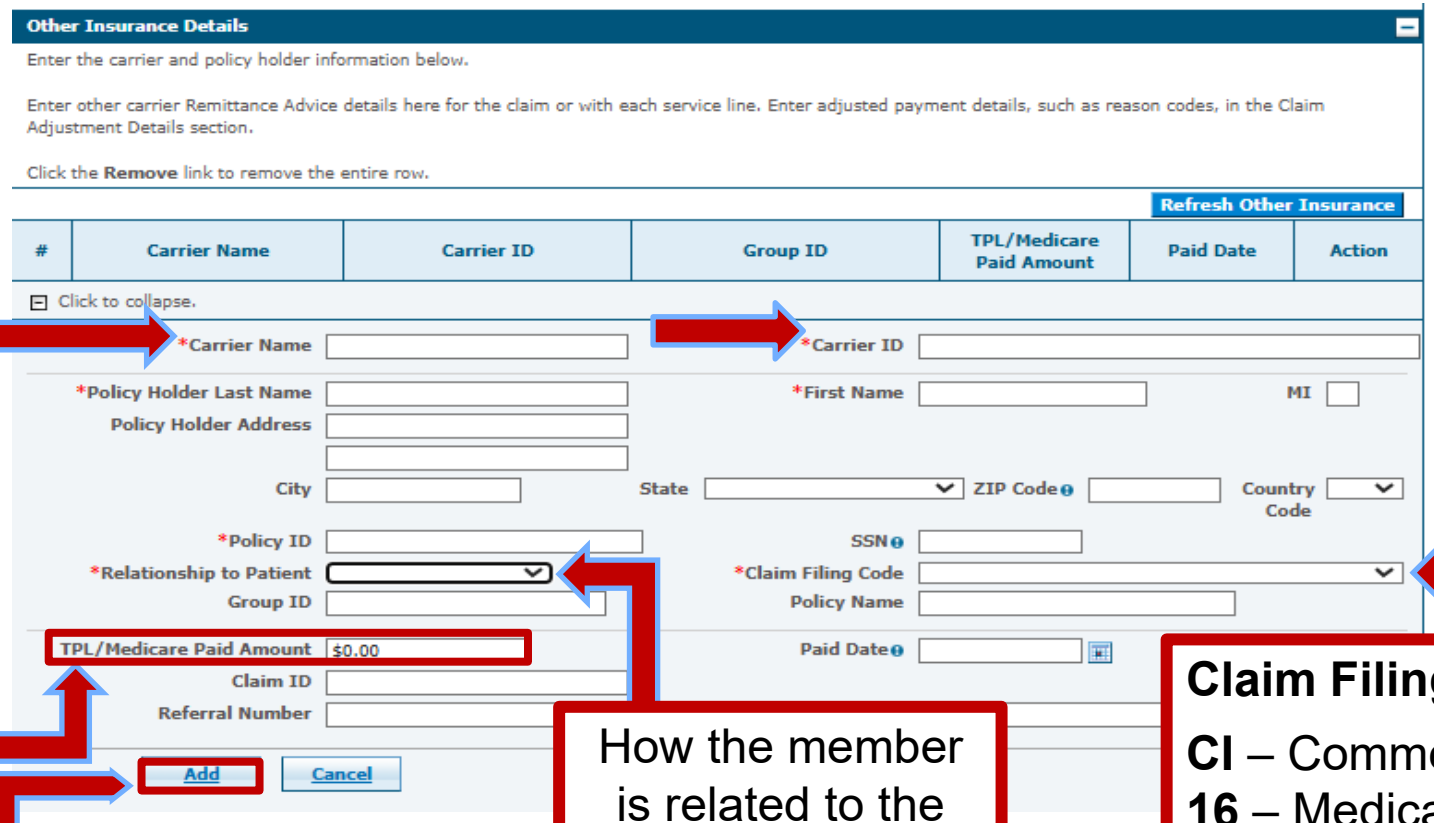
- Verify that the Carrier Name shows the correct insurance
- Remove any insurance that should not be listed
- Click the 1 **by the Carrier Name to complete the information**
- **Click** the + to add the correct primary/secondary insurances if not listed

Completing Other Insurance Details

Enter Primary Insurance Information/TPL at the **Header** Level in Step 2

Enter name of the Primary Insurance in both **Carrier Name** and **Carrier ID** boxes

Everything with an * needs to be completed



Paid amount for the **ENTIRE** claim goes here. It does not have an * but is required for processing.

Final Step - Select Add

How the member is related to the person who holds the insurance

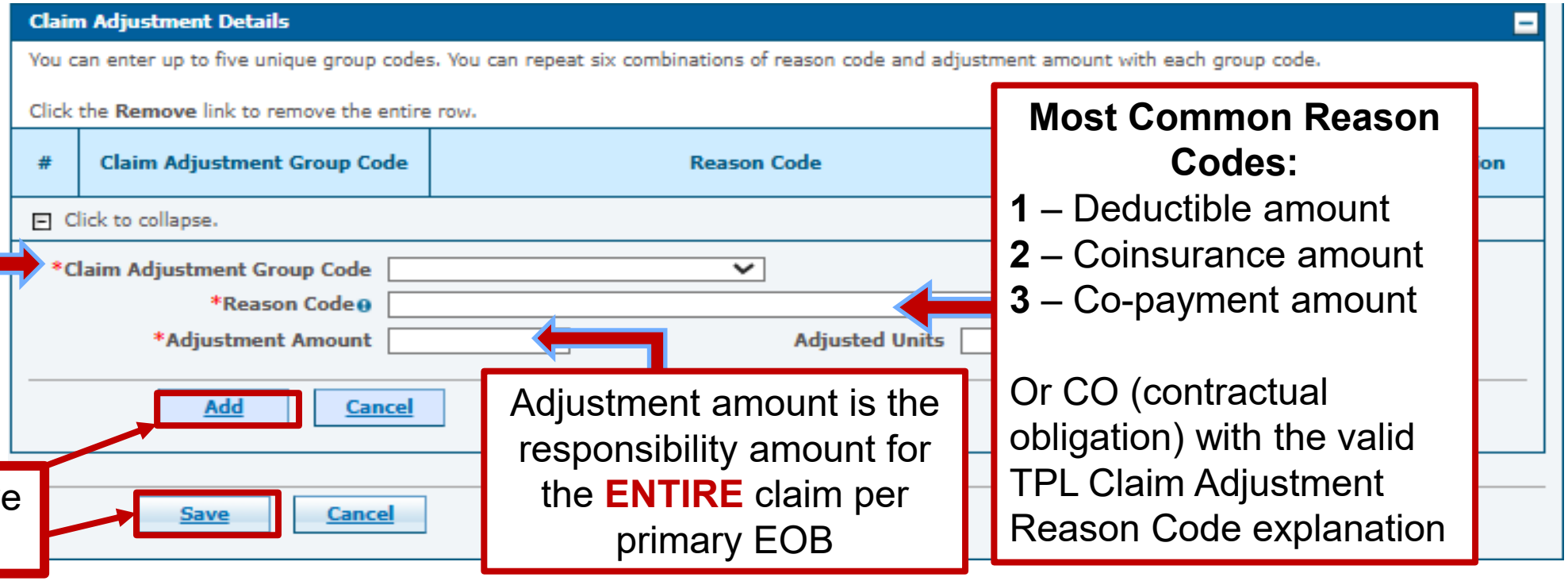
Claim Filing Codes:

CI – Commercial Insurance
16 – Medicare Replacement Plan
MB – Medicare B

Claim Adjustment Details

Enter Patient Responsibility (PR) Information at the **Header** Level in Step 2

Most Common Claim Adjustment Group Code:
PR - patient responsibility



Most Common Reason Codes:
1 – Deductible amount
2 – Coinsurance amount
3 – Co-payment amount

Or CO (contractual obligation) with the valid TPL Claim Adjustment Reason Code explanation

Adjustment amount is the responsibility amount for the **ENTIRE** claim per primary EOB

Add and Save each time

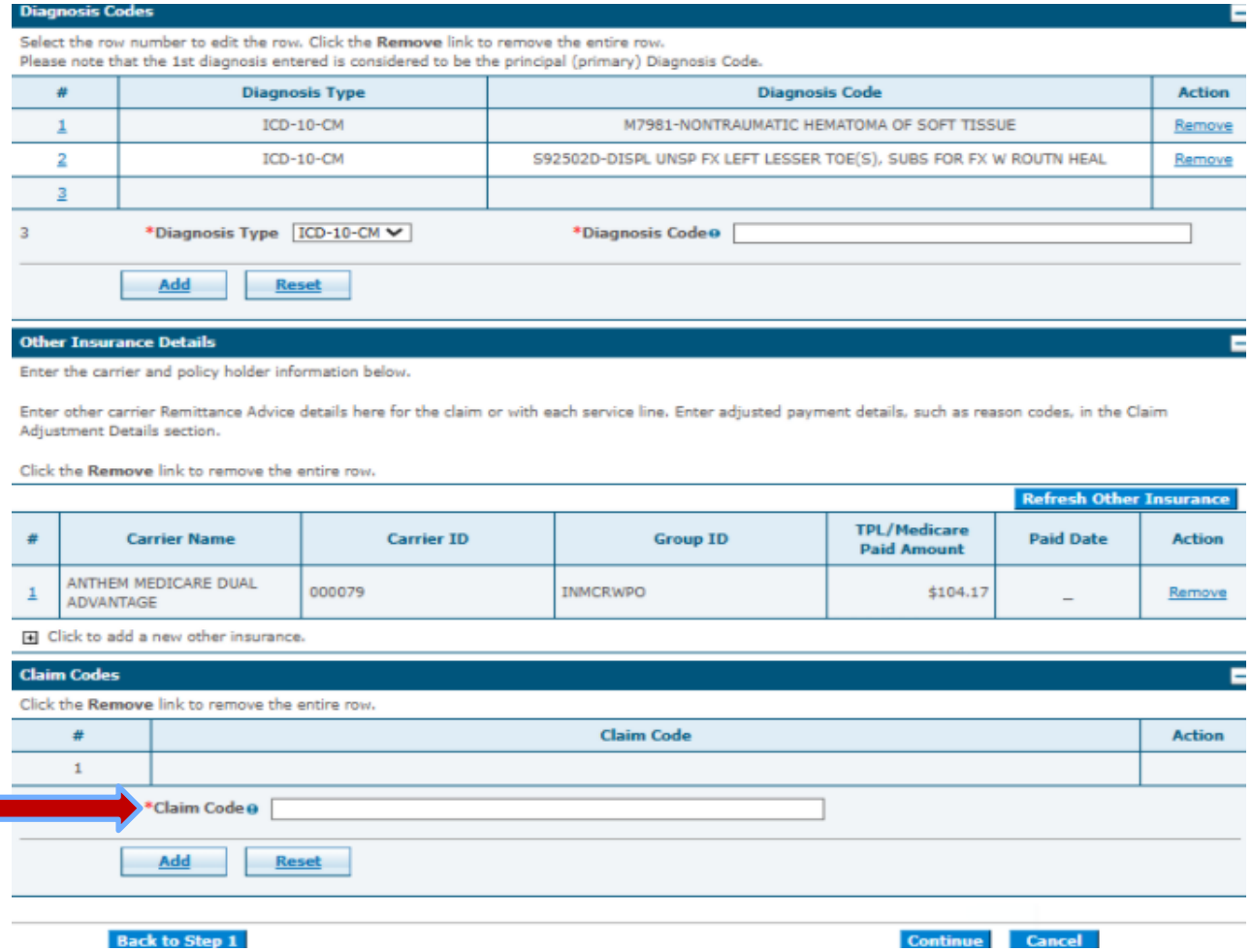
- The claim adjustment details are **NOT** completed for TPL, unless there is an acceptable denial adjustment reason code (ARC).
- The claim adjustment details **ARE** completed for Medicare and Medicare Replacement Plans.

Claim Codes Section

IMPORTANT

No claim code is needed on most claims.

Leave blank!



Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1	ICD-10-CM	M7981-NONTRAUMATIC HEMATOMA OF SOFT TISSUE	Remove
2	ICD-10-CM	S92502D-DISPL UNSP FX LEFT LESSER TOE(S), SUBS FOR FX W ROUTN HEAL	Remove
3			

3 *Diagnosis Type ICD-10-CM *Diagnosis Code

Add Reset

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

Refresh Other Insurance

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	ANTHEM MEDICARE DUAL ADVANTAGE	000079	INMCRWPO	$104.17	_	Remove

Click to add a new other insurance.

Claim Codes

Click the **Remove** link to remove the entire row.

#	Claim Code	Action
1		

*Claim Code

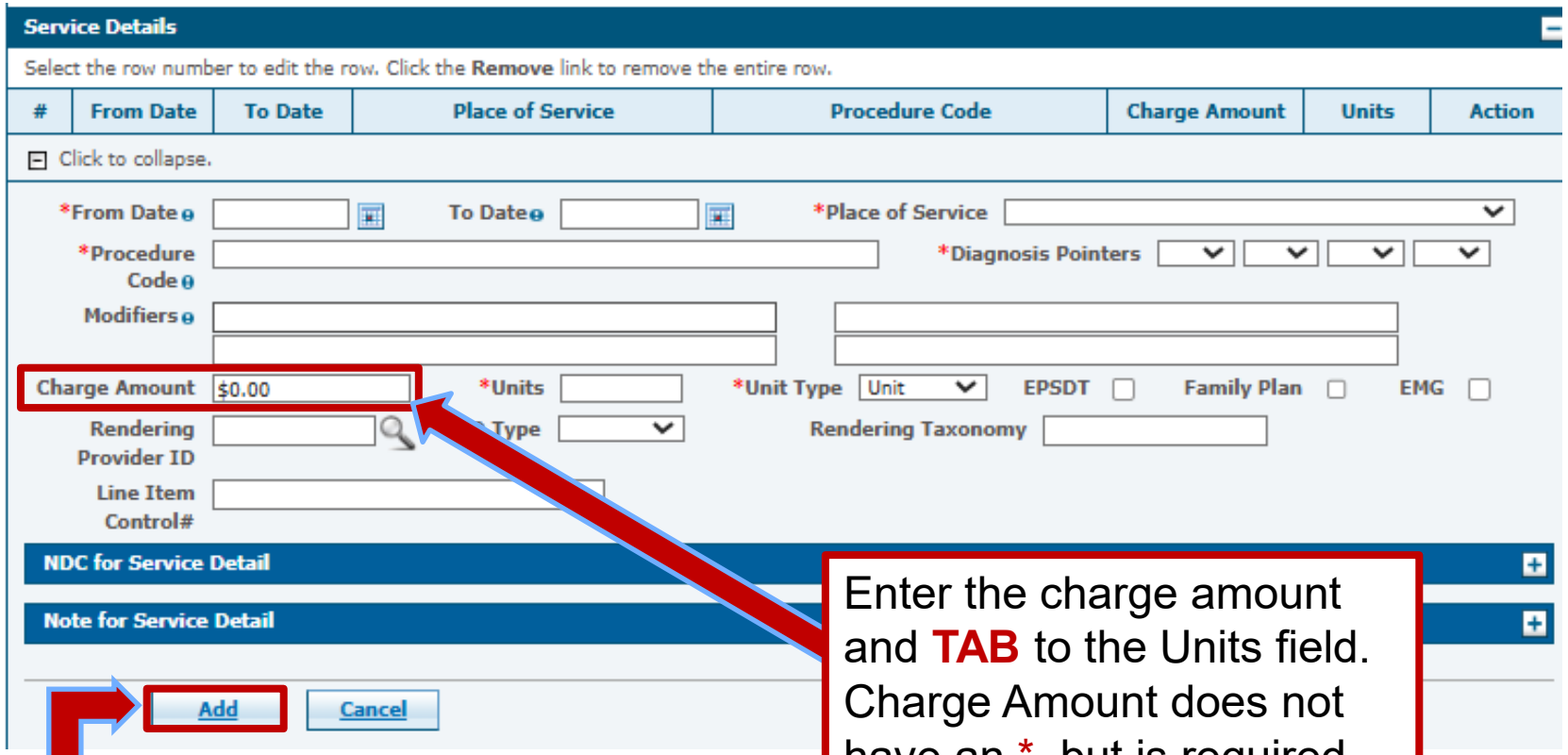
Add Reset

Back to Step 1 Continue Cancel

Service Detail Level

Adding Secondary Insurance Information at the **Service Detail** Level of the claim in Step 3

All * need to be completed



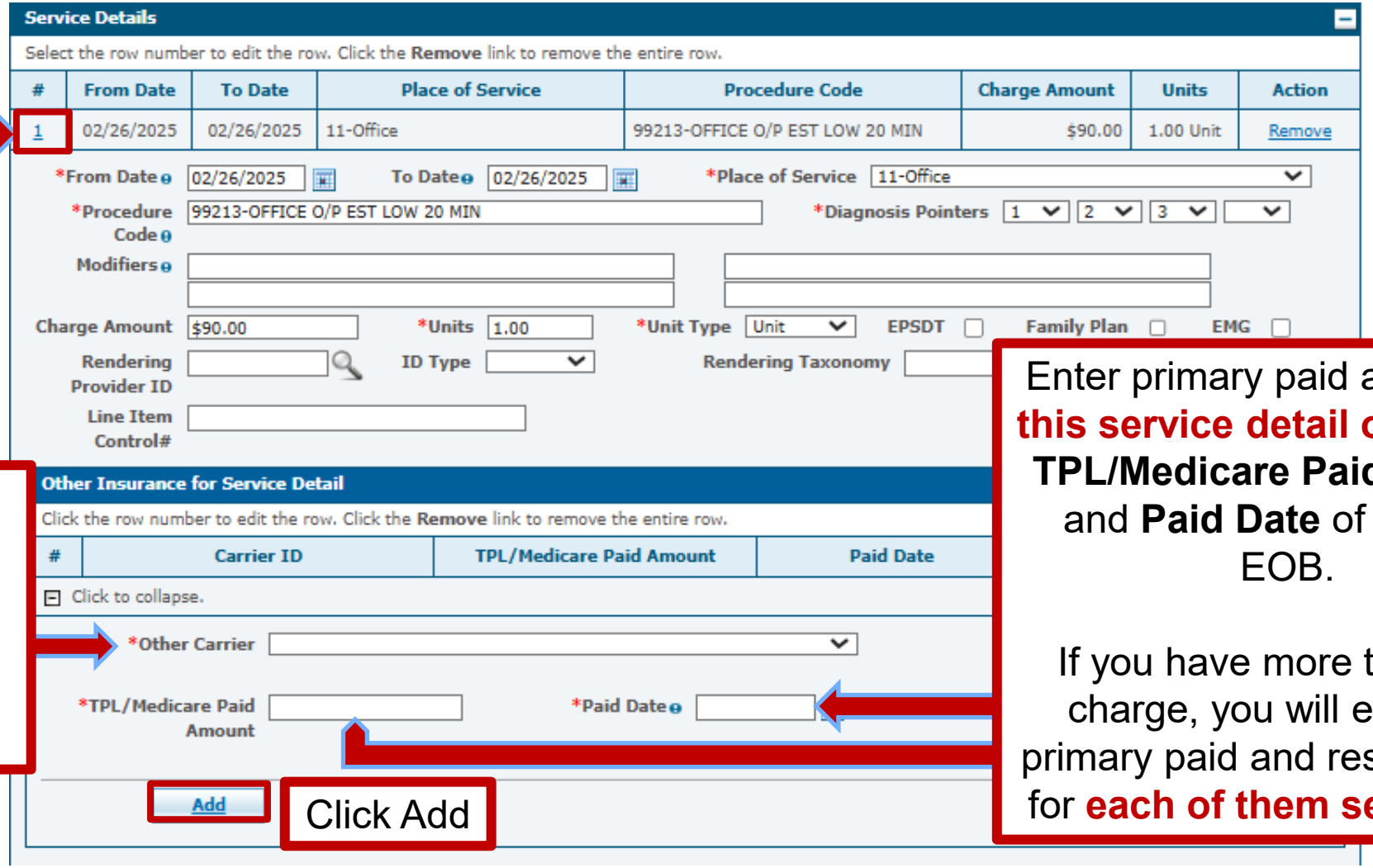
Enter the charge amount and **TAB** to the Units field. Charge Amount does not have an *, but is required for processing.

Add and Save each time

Other Insurance at the Service Detail

Adding information at the **Service Detail** Level of the claim in Step 3

Once you input your service detail/each charge and hit add button, click on the **# 1** to open the **Other Insurance for Service Detail** row.



Other Carrier
Choose the Primary /TPL Insurance you added on Step 2 (header level) of the Claim.

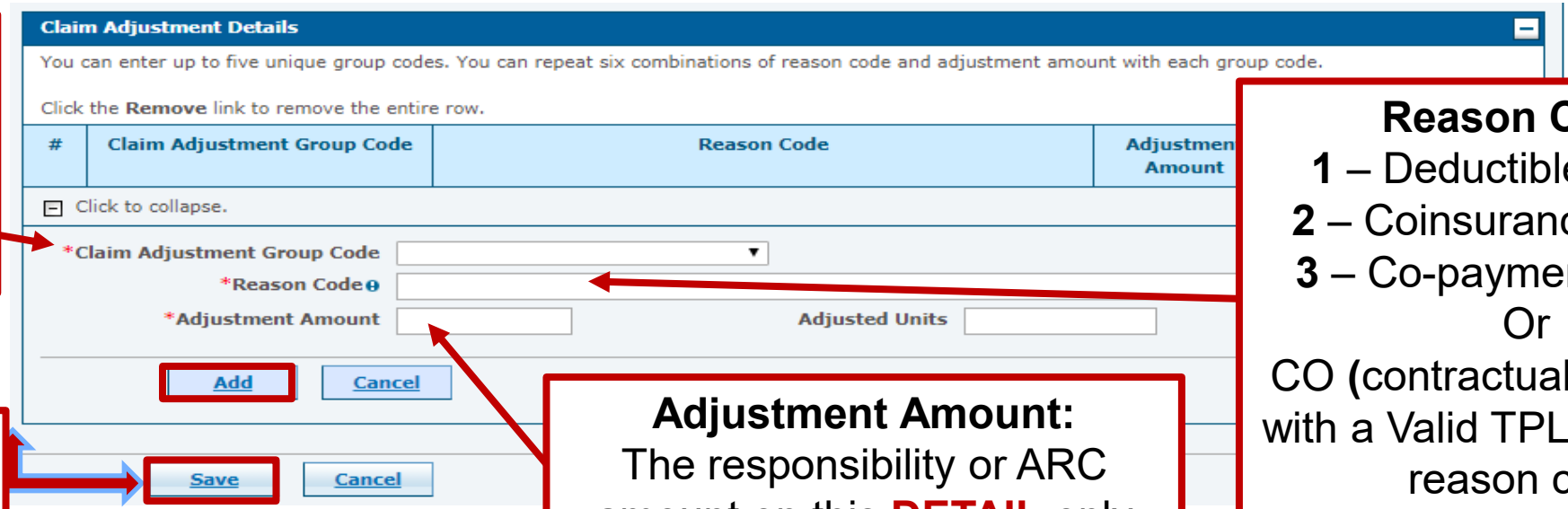
Enter primary paid amount for **this service detail only in the TPL/Medicare Paid Amount** and **Paid Date** of Primary EOB.

If you have more than one charge, you will enter the primary paid and responsibility for **each of them separately**.

Claim Adjustment Details at the Service

Adding information at the **Service Detail** Level of the claim in Step 3

Claim Adjustment Group Code:
PR - Patient Responsibility



Reason Code:
1 – Deductible amount
2 – Coinsurance amount
3 – Co-payment amount
Or
CO (contractual obligation) with a Valid TPL adjustment reason code

Add and Save each time

Adjustment Amount:
The responsibility or ARC amount on this **DETAIL** only

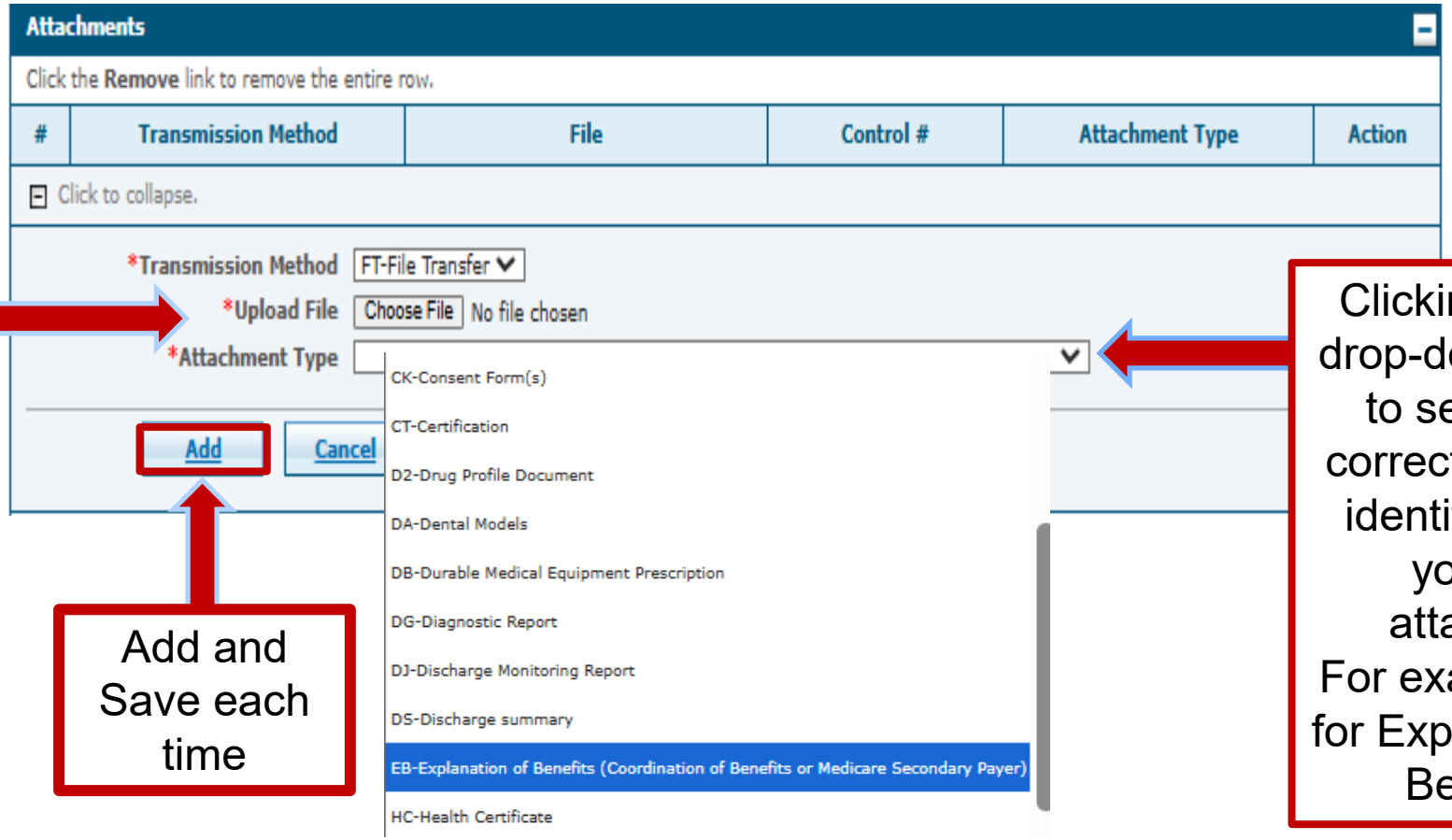
- Claim adjustment details are **NOT** completed for TPL, unless there is an acceptable denial adjustment reason code (ARC)
- Claim adjustment details **ARE** completed for Medicare and Medicare Replacement Plans

Submitting Attachments

When a primary EOB or other documentation to support your claim is needed, use the Attachments feature on Step 3

Click on **Choose File** to find your document on your system to upload

Your file must be one of the following types: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif and .tiff **PDF files work best!**



Add and Save each time

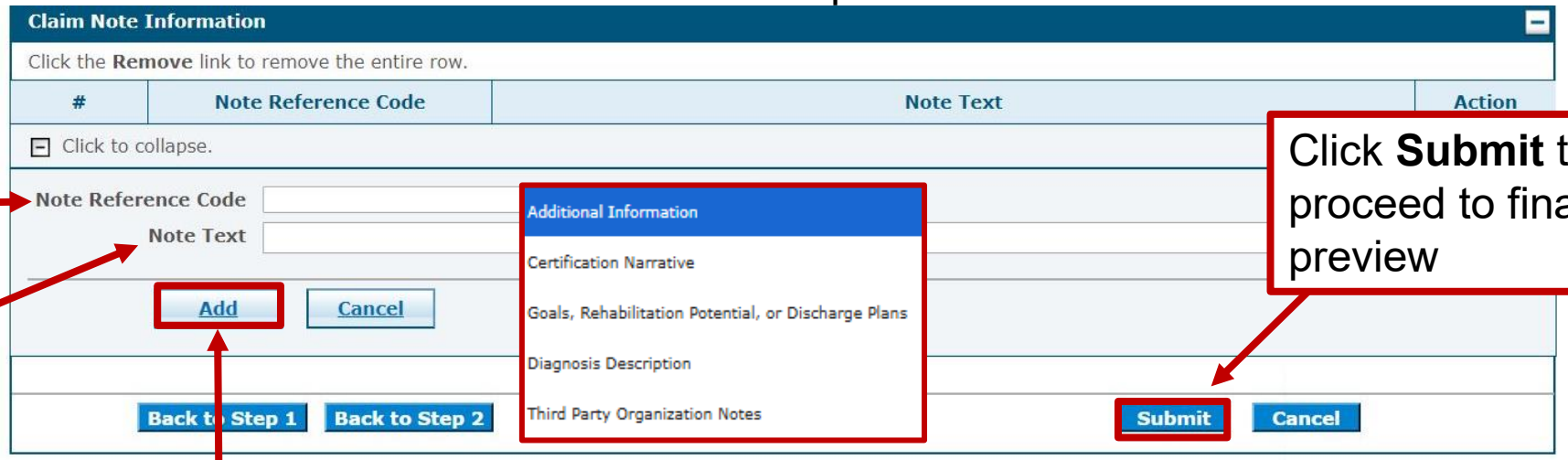
Clicking on the drop-down arrow to select the correct item that identifies what you are attaching. For example: EB for Explanation of Benefits

Claim Note Information

The Indiana Health Coverage Programs accepts claim notes as documentation for certain situations, and Claim Note Information is entered in Step 3

Note Reference Code: select the drop-down menu to identify the functional area or purpose to which the note applies.

Note Text: type your claim note here.



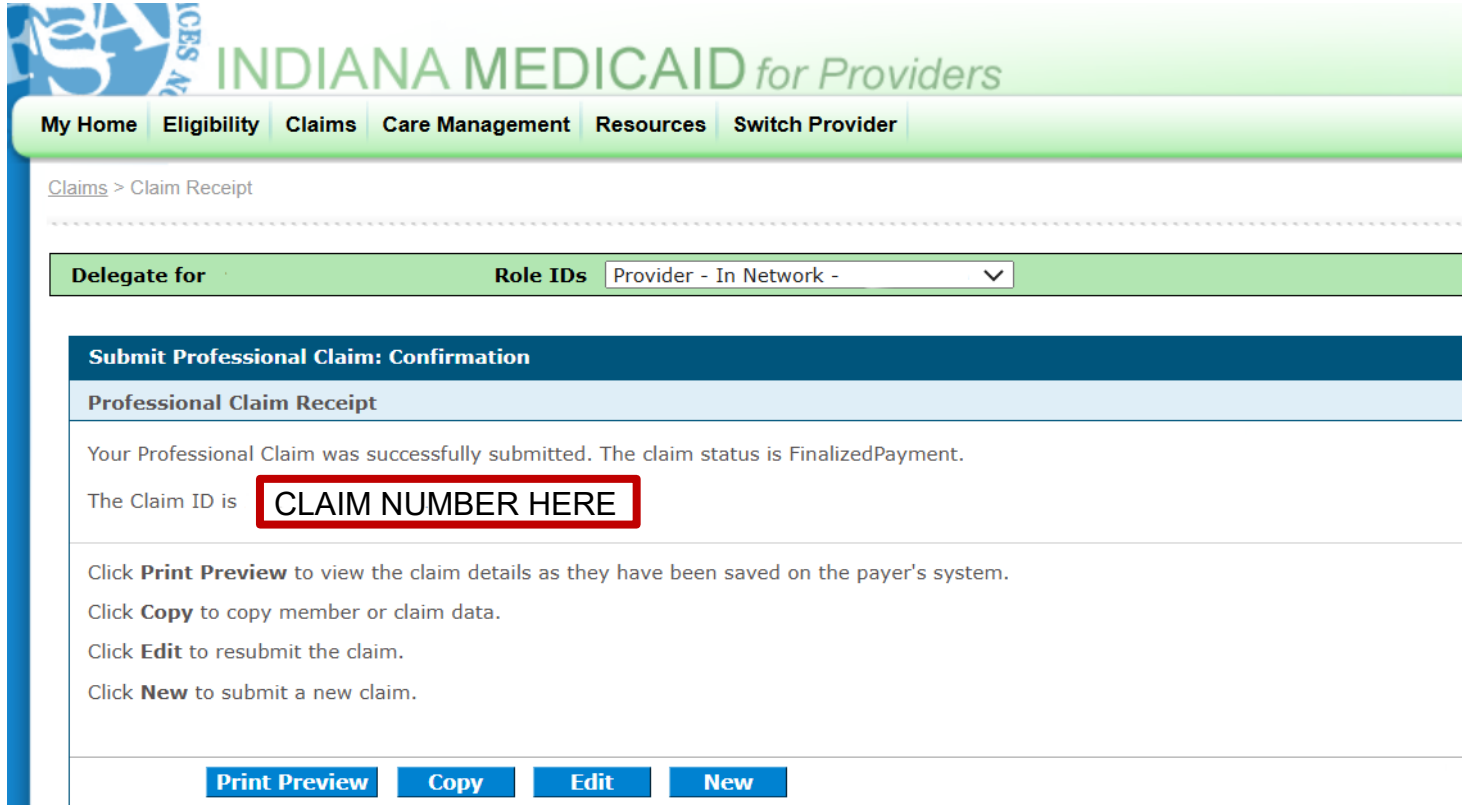
Click **Add** to add the claim note

Click **Submit** to proceed to final preview

Please refer to the **Claim Submission and Processing** provider reference module for acceptable claim notes, or your **Provider Relations Consultant.**

Claim notes cause the claim to go in pending status to allow a claim analyst time to review.

Claim Status



- If a claim denies, you can make corrections and rebill the claim again. There is no need to wait.

- Submitting claims online via the IHCP Portal provides immediate status- Paid, Denied or Pending in Process.

An attachment or Claim Note may cause the claim to go into Pending in Process status for a claim analyst to review.

Claim Adjustments on the IHCP Portal

Claim Adjustments on the IHCP Portal

Edit, Copy and Void Functions

- **Edit** a **paid** claim that needs to be adjusted.
- Leave the correct information on the claim that was previously paid, correct what is wrong.
- **Never** edit a paid claim if the date of service is past timely filing, unless it meets specific guidelines.
- **Copy** a **denied** claim - you **cannot** adjust a denied claim.
- Do not use **Void** unless the **entire** paid amount on the claim needs to be refunded.

Editing Claims

1. Search claims by the Member ID and date of service.
2. Choose the most recent ***paid*** claim for your date of service and select the Edit button.

A claim adjustment must be done within **180** calendar days from the **date of service or the date on a primary EOB** to file on the **IHCP Portal**.

For questions regarding the filing limit, or if you need claim adjustment help, please refer to your **Provider Relations Consultant**.

Claim Adjustments
Additional Information

Exceptions for the 180-calendar day filing limit examples for claim adjustment:

- Crossover claims *
- Retro eligibility *
- Retro prior authorization or Notice of Action *
- Retro provider enrollment *
- Change in policy/coverage *
- Primary payment (adjustment must be within 180 days of the date on the primary EOB)
- Overpayment*

*Claim Note may be required to bypass timely filing

For additional information on claim adjustments, please see the **Claim Adjustments** provider reference module.

Remittance Advice Basics

Remittance Advice Overview

Financial cycle runs each Friday

Electronic funds transfer (EFT) deposited each Wednesday

Check payments are dated each Wednesday following the financial cycle

Payments are calculated based on paid claims, less payments for outstanding accounts receivable and liens

Sections of the Remittance Advice include Claims Paid, Claims Denied, Claims In Process, Claim Adjustments, Payment Holds, Financial Transactions and Refunds

Remittance Advice statements are available via the IHCP secure website weekly

Locating Your Remittance Advice on the IHCP Portal

Once logged into the [IHCP Portal] under the specific service location, click on the Claims menu, then choose **Search Payment History.**

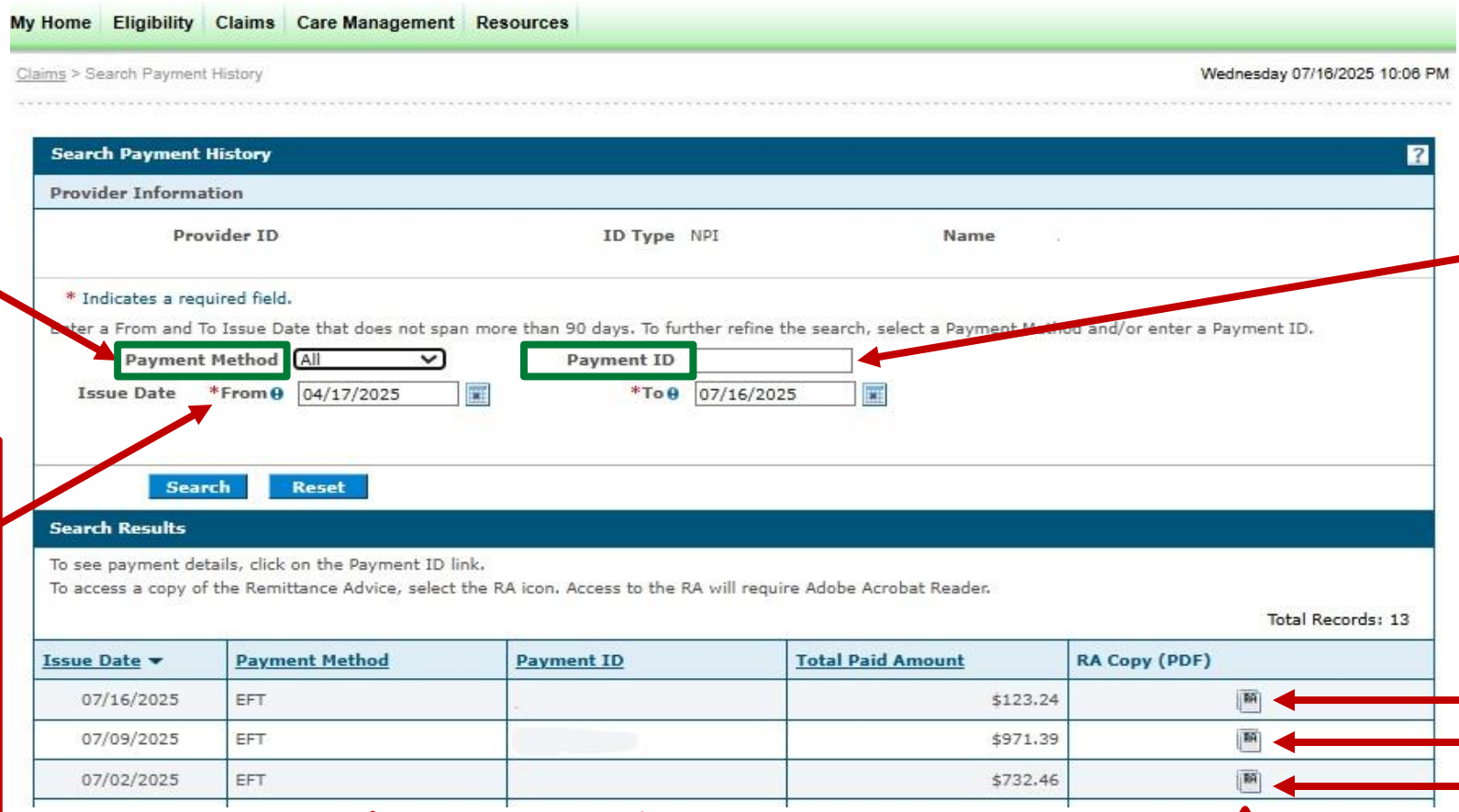
Search Payment History

The **Payment Method** will default to All - leave as is.

To search for previous dates, change the date range.
Can be no greater than a 90 calendar-day span.

Payment ID will be blank. Leave blank to search for all RAs in that time frame. If searching for a specific RA, enter the **Payment ID**.

Click on the RA icon to download the PDF to see the complete RA information.



RA Date

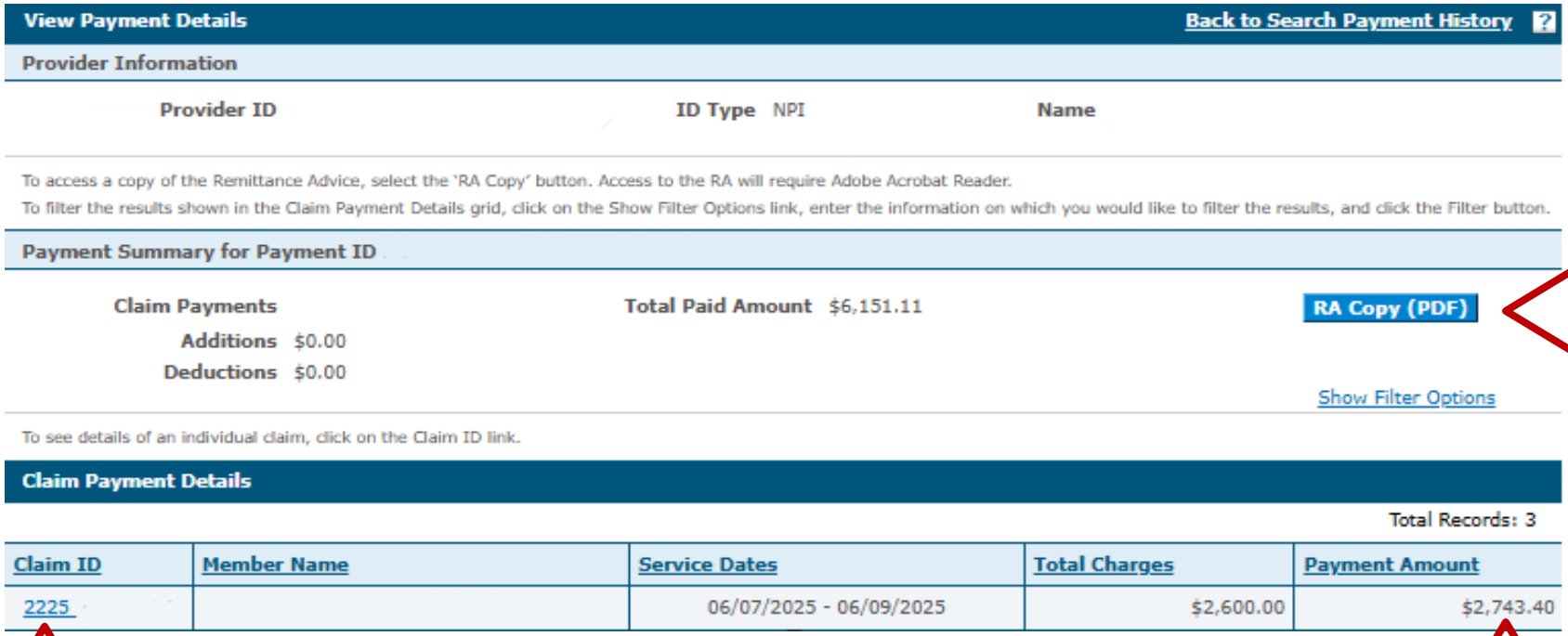
Payment Method

Payment ID

Payment Amount

Remittance Advice Copy

View Payment Details



Click on **RA Copy (PDF)** to open a full copy of your Remittance Advice

Claim ID-can click on hyperlink to open claim and review.

Payment Amount of claim

Provider Remittance Advice
Claim Paid Example

REPORT:
RA#:
PAYER:

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
PROFESSIONAL SERVICES CLAIMS PAID

DATE: 05/16/2025
PAGE: 1

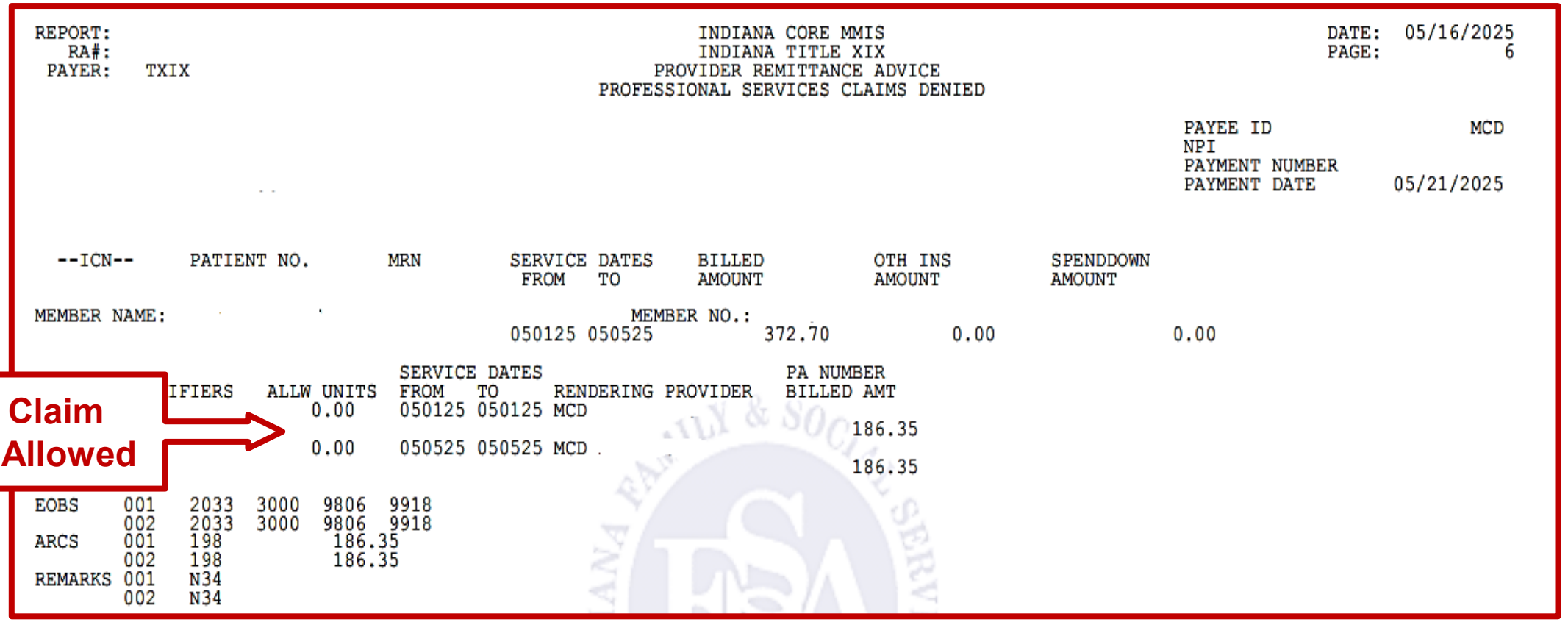
PAYEE ID
NPI
PAYMENT NUMBER
PAYMENT DATE 05/21/2025

--ICN--	PATIENT NUMBER	MRN	SERVICE DATES FROM	TO	BILLED AMT / ALLOWED AMT	OTH INS AMT / SPENDDOWN AMT	COPAY AMT / CO-INS CB	PAID AMT / OUTPAT DED
MEMBER NAME:				MEMBER NO.:				
			031325	031325	186.35	0.00	0.00	141.44
					141.44	0.00	0.00	0.00

PROC CD	MODIFIERS	SERVICE DATES FROM	TO	ALLW UNITS / COPAY AMT	RENDERING PROVIDER / BILLED AMT	ALLOWED AMT	PA NUMBER / PAID AMT
H0015		031325	031325	1.00	MCD		
				0.00	186.35	141.44	141.44

Allowed Amount $141.44
Claim Paid $141.44

Provider Remittance Advice
Claim Denied Example



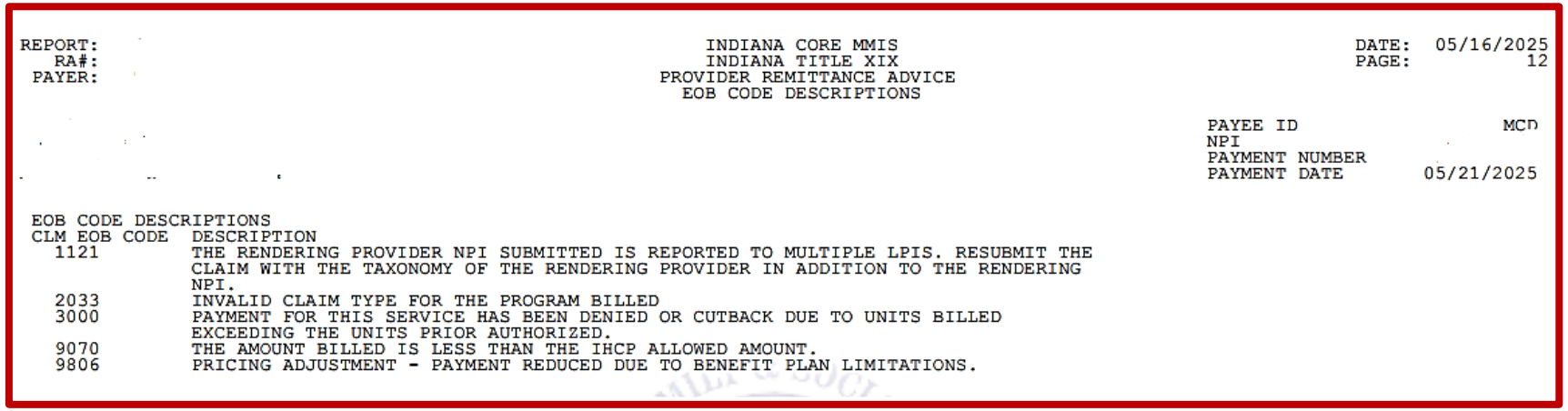
```
REPORT:                                                                    DATE:  05/16/2025
  RA#:                                                                     PAGE:         6
 PAYER:   TXIX
                                                INDIANA CORE MMIS
                                                INDIANA TITLE XIX
                                          PROVIDER REMITTANCE ADVICE
                                      PROFESSIONAL SERVICES CLAIMS DENIED

                                                                    PAYEE ID                MCD
                                                                    NPI
                                                                    PAYMENT NUMBER
                                                                    PAYMENT DATE      05/21/2025

  --ICN--      PATIENT NO.        MRN        SERVICE DATES    BILLED          OTH INS         SPENDDOWN
                                              FROM    TO       AMOUNT          AMOUNT          AMOUNT

MEMBER NAME:                                                MEMBER NO.:
                                           050125 050525        372.70          0.00            0.00

                                  SERVICE DATES                          PA NUMBER
          IFIERS   ALLW UNITS     FROM    TO      RENDERING PROVIDER     BILLED AMT
                        0.00      050125 050125 MCD                      186.35
                        0.00      050525 050525 MCD                      186.35

EOBS      001   2033  3000  9806  9918
          002   2033  3000  9806  9918
ARCS      001   198          186.35
          002   198          186.35
REMARKS   001   N34
          002   N34
```

Denied Claim
No Units Allowed

EOB Code, ADJ Reason Code and Remark Code Descriptions

Each claim listed on your Remittance Advice lists EOB, ARCS and Remarks Codes.

Find these descriptions near the end of the RA to see the description of how a claim processed.



REPORT:
RA#:
PAYER:

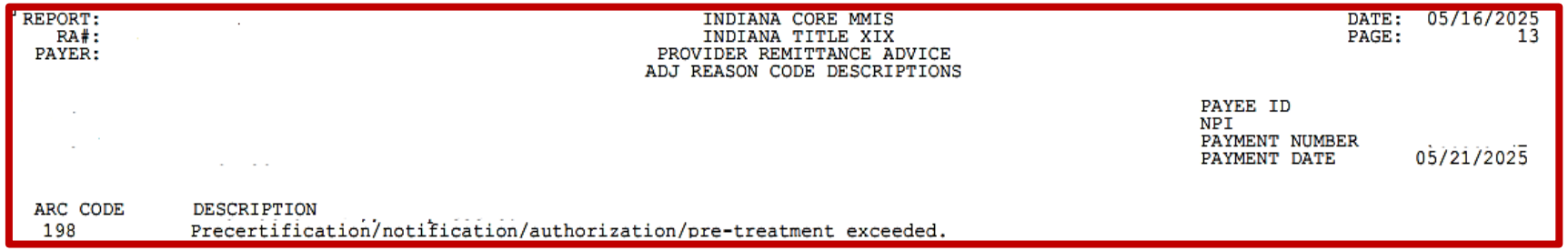
INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

DATE: 05/16/2025
PAGE: 12

PAYEE ID MCD
NPI
PAYMENT NUMBER
PAYMENT DATE 05/21/2025

EOB CODE DESCRIPTIONS

CLM EOB CODE	DESCRIPTION
1121	THE RENDERING PROVIDER NPI SUBMITTED IS REPORTED TO MULTIPLE LPIS. RESUBMIT THE CLAIM WITH THE TAXONOMY OF THE RENDERING PROVIDER IN ADDITION TO THE RENDERING NPI.
2033	INVALID CLAIM TYPE FOR THE PROGRAM BILLED
3000	PAYMENT FOR THIS SERVICE HAS BEEN DENIED OR CUTBACK DUE TO UNITS BILLED EXCEEDING THE UNITS PRIOR AUTHORIZED.
9070	THE AMOUNT BILLED IS LESS THAN THE IHCP ALLOWED AMOUNT.
9806	PRICING ADJUSTMENT - PAYMENT REDUCED DUE TO BENEFIT PLAN LIMITATIONS.



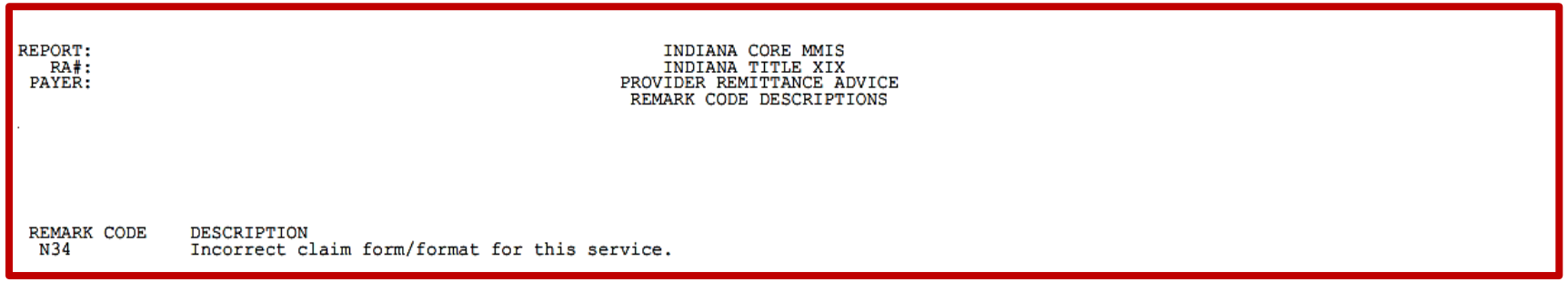
REPORT:
RA#:
PAYER:

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
ADJ REASON CODE DESCRIPTIONS

DATE: 05/16/2025
PAGE: 13

PAYEE ID
NPI
PAYMENT NUMBER
PAYMENT DATE 05/21/2025

ARC CODE	DESCRIPTION
198	Precertification/notification/authorization/pre-treatment exceeded.



REPORT:
RA#:
PAYER:

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
REMARK CODE DESCRIPTIONS

REMARK CODE	DESCRIPTION
N34	Incorrect claim form/format for this service.

RA Summary

REPORT: CRA-SUMM-R
RA#:
PAYER: TXIX

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
SUMMARY

DATE: 06/13/2025
PAGE: 7

PAYEE ID MCD
NPI
PAYMENT NUMBER
PAYMENT DATE 06/18/2025

CLAIMS DATA

	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TO-DATE NUMBER	MONTH-TO-DATE AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
CLAIMS PAID	2	161.58	4	206.62	47	3,672.02
CLAIM ADJUSTMENTS	0	0.00	0	0.00	0	0.00
CLAIM INTEREST		0.00		0.00		0.00
TOTAL CLAIMS PAYMENTS	2	161.58	4	206.62	47	3,672.02
CLAIMS DENIED	4		9		84	
CLAIMS IN PROCESS	0	0.00				

EARNINGS DATA

PAYMENTS:			
CLAIMS PAYMENTS	161.58	206.62	3,672.02
MANAGED CARE ADMINISTRATIVE PAYMENT*	0.00	0.00	0.00
HOOSIER HEALTHWISE CAPITATION PAYMENT*	0.00	0.00	0.00
PATHWAYS CAPITATION PAYMENT*	0.00	0.00	0.00
HEALTHY INDIANA PLAN POWER ACCOUNT*	0.00	0.00	0.00
HEALTHY INDIANA PLAN CAPITATION PAYMENT*	0.00	0.00	0.00
NON EMERG MED TRANSP CAPITATION PAYMENT*	0.00	0.00	0.00
PAYOUTS	0.00	0.00	0.00
ACCOUNTS RECEIVABLE:			
CLAIM SPECIFIC:			
CURRENT CYCLE	(0.00)	(0.00)	(0.00)
OUTSTANDING FROM PREVIOUS CYCLES	(0.00)	(0.00)	(0.00)
NON-CLAIM SPECIFIC	(0.00)	(0.00)	(0.00)
REFUNDS:			
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)	(0.00)	(0.00)
NON CLAIM SPECIFIC REFUNDS	(0.00)	(0.00)	(0.00)
OTHER FINANCIAL:			
MANUAL PAYOUTS	(0.00)	(0.00)	(0.00)
VOIDS	(0.00)	(0.00)	(0.00)
MEMBER CONTRIBUTION (POWER)	(0.00)	(0.00)	(0.00)
NET PAYMENT	161.58	206.62	3,672.02
NET EARNINGS	161.58	206.62	3,672.02

Financial Transactions

REPORT: CRA-TRAN-R
RA#:
PAYER: TXIX

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

DATE: 06/13/2025
PAGE: 6

Name of Provider and Address

PAYEE ID MCD
NPI
PAYMENT NUMBER
PAYMENT DATE 06/18/2025

----------NON-CLAIM SPECIFIC PAYOUTS TO PAYEE----------

TRANSACTION NUMBER	PAYOUT AMOUNT	REASON CODE	FIN ARC	SERVICE DATE FROM	SERVICE DATE THRU	RELATED PROVIDER ID

NO NON-CLAIM SPECIFIC PAYOUTS TO PAYEE

----------NON-CLAIM SPECIFIC REFUNDS FROM PAYEE----------

TRANSACTION NUMBER	REFUND AMOUNT	REASON CODE	FIN ARC	PAYMENT NUMBER	RECEIPT DATE	MEMBER NAME	MEMBER NO.

NO NON-CLAIM SPECIFIC REFUNDS FROM PAYEE

----------ACCOUNTS RECEIVABLE----------

A/R NUMBER	SETUP DATE	ORIGINAL AMOUNT	RECOUPMENT AMOUNT TO DATE	BALANCE	REASON CODE	FIN ARC	MEMBER NAME	MEMBER NO.	ADJUSTMENT --ICN--	PREVIOUS --ICN--	AMOUNT RECOUPEI CURRENT CYCLE

NO OUTSTANDING ACCOUNTS RECEIVABLE

- Accounts receivables are set up when claims are adjusted.
- Adjusted ICN, new ICN, and AR numbers are displayed.
- Accounts Receivables may be recouped in current cycle or future cycles.

Remittance Advice and Financial Transaction Resources

The **Financial Transactions and Remittance Advice** provider reference module

Call the Customer Assistance Unit toll-free line at 800-457-4584 for requests such as asking Finance to reissue a lost check. Live assistance is available 8 a.m. to 6 p.m. Eastern Time, Monday through Friday, excluding holidays. Providers should allow two weeks (14 calendar days) before submitting a reissue request to allow for delivery delays from the U.S. Postal Service.

Your **Provider Relations Consultant** if needing instructions on updating your address to report correct information on your W-9 and service location, need help with EFT enrollment or updates, questions on claim denials, remittance advice, accounts receivables and much more.

Send a Secure Correspondence message while logged on through the **IHCP Portal** if you have questions on a finance letter, check, payment or remittance advice.

Submitting Medicare Exhaust Inpatient Claims on the IHCP Portal

Medicare Part A Benefits Exhaust IHCP Portal Instructions Without Medicare Part B Benefits

IHCP Portal claim transactions for inpatient acute services must be submitted with the following information, as applicable:

Medicare Part A benefits exhausted without Medicare Part B benefits:

- Adjustment reason code (ARC) 119 – Benefit maximum for this time period or occurrence has been reached
- Claim filing code indicator of MA
- Medicare Part A paid amount = $0

Please see BT2025125 for more information, including the (837I) electronic claim transactions.

Medicare Part A Benefits Exhaust IHCP Portal Step 2 Example Without Medicare Part B Benefits

Add Medicare Part A to **Carrier Name/ Carrier ID**

Claim Filing Code MA – Medicare Part A

TPL/Medicare Paid Amount enter $0 or amount paid

Claim Adjustment Group and Reason Codes PR 119 and amount

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

Refresh Other Insurance

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	MEDICARE PART A	MEDICARE PART A		$0.00	10/01/2025	Remove

*Relationship to Patient: 18-Self
Group ID:
*Claim Filing Code: MA-Medicare Part A
Policy Name: MEDICARE
TPL/Medicare Paid Amount: $0.00
Paid Date: 10/01/2025
Claim ID:
Referral Number:
Authorization Number:

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	Action
1	PR-Patient Responsibility	119-Benefit maximum for this time period or occurrence has been reached.	$31,625.27		Remove

Medicare Part A Benefits Exhaust With Medicare Part B Benefits IHCP Portal Instructions

IHCP Portal claim transactions for inpatient acute services must be submitted with the following information, as applicable:

Medicare Part A benefits exhausted with Medicare Part B benefits:

- Adjustment Reason Code (ARC) 119
- Claim filing code indicator of MA
- Medicare Part A paid amount = $0

AND

- Claim filing indicator of MB
- Medicare Part B paid amount

Please see BT2025125 for more information, including the (837I) electronic claim transactions.

Medicare Part A Benefits Exhaust With Medicare Part B Benefits IHCP Portal Step 2 Example Part 1

Add Medicare Part A to **Carrier Name/ Carrier ID**

Claim Filing Code
MA – Medicare Part A

TPL/Medicare Paid Amount
enter $0 or amount paid

Claim Adjustment Group and Reason Codes
PR 119 and amount

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

Refresh Other Insu

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	A
1	MEDICARE PART A	MEDICARE PART A		$0.00	10/01/2025	Re
2	MEDICARE PART B	MEDICARE PART B		$1,086.66	10/01/2025	Remove

*Relationship to Patient: 18-Self
Group ID:
*Claim Filing Code: MA-Medicare Part A
Policy Name: MEDICARE
TPL/Medicare Paid Amount: $0.00
Paid Date: 10/01/2025
Claim ID:
Referral Number:
Authorization Number:

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	
1	PR-Patient Responsibility	119-Benefit maximum for this time period or occurrence has been reached.	$31,625.27		Remove

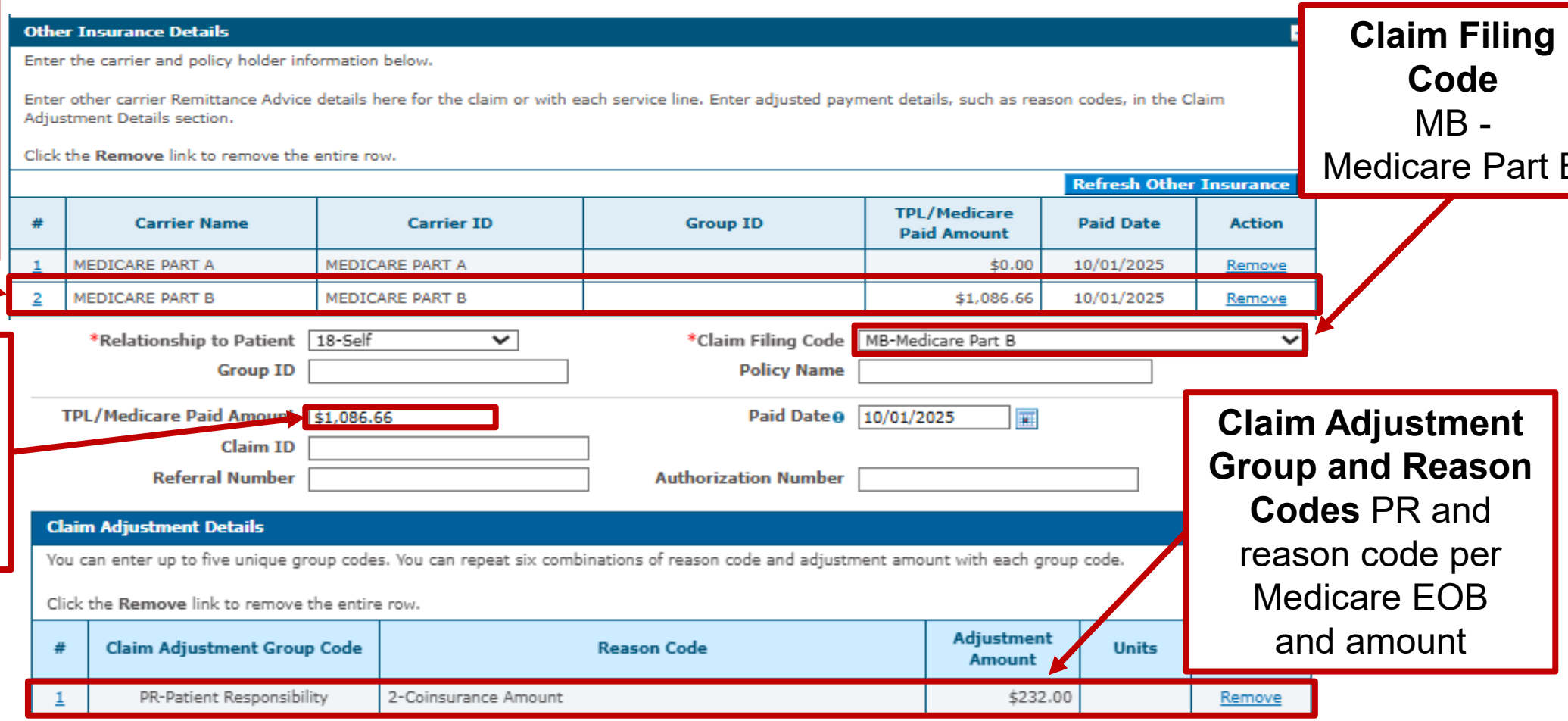
Medicare Part A Benefits Exhaust With Medicare Part B Benefits
IHCP Portal Step 2 Example Part 2

Add Medicare Part B to **Carrier Name/Carrier ID** below Medicare Part A

TPL/Medicare Paid Amount enter Medicare Part B paid Amount

Claim Filing Code MB - Medicare Part B

Claim Adjustment Group and Reason Codes PR and reason code per Medicare EOB and amount



Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

Refresh Other Insurance

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	MEDICARE PART A	MEDICARE PART A		$0.00	10/01/2025	Remove
2	MEDICARE PART B	MEDICARE PART B		$1,086.66	10/01/2025	Remove

*Relationship to Patient: 18-Self

*Claim Filing Code: MB-Medicare Part B

Group ID:

Policy Name:

TPL/Medicare Paid Amount: $1,086.66

Paid Date: 10/01/2025

Claim ID:

Referral Number:

Authorization Number:

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	
1	PR-Patient Responsibility	2-Coinsurance Amount	$232.00		Remove

No Medicare Part A Benefits
IHCP Portal Instructions

IHCP Portal claim transactions for inpatient acute services must be submitted with the following information, as applicable:

No Medicare Part A benefits with Medicare Part B benefits:

- Claim filing code indicator of MB
- Medicare Part B paid amount

Please see BT2025125 for more information, including the (837I) electronic claim transactions.

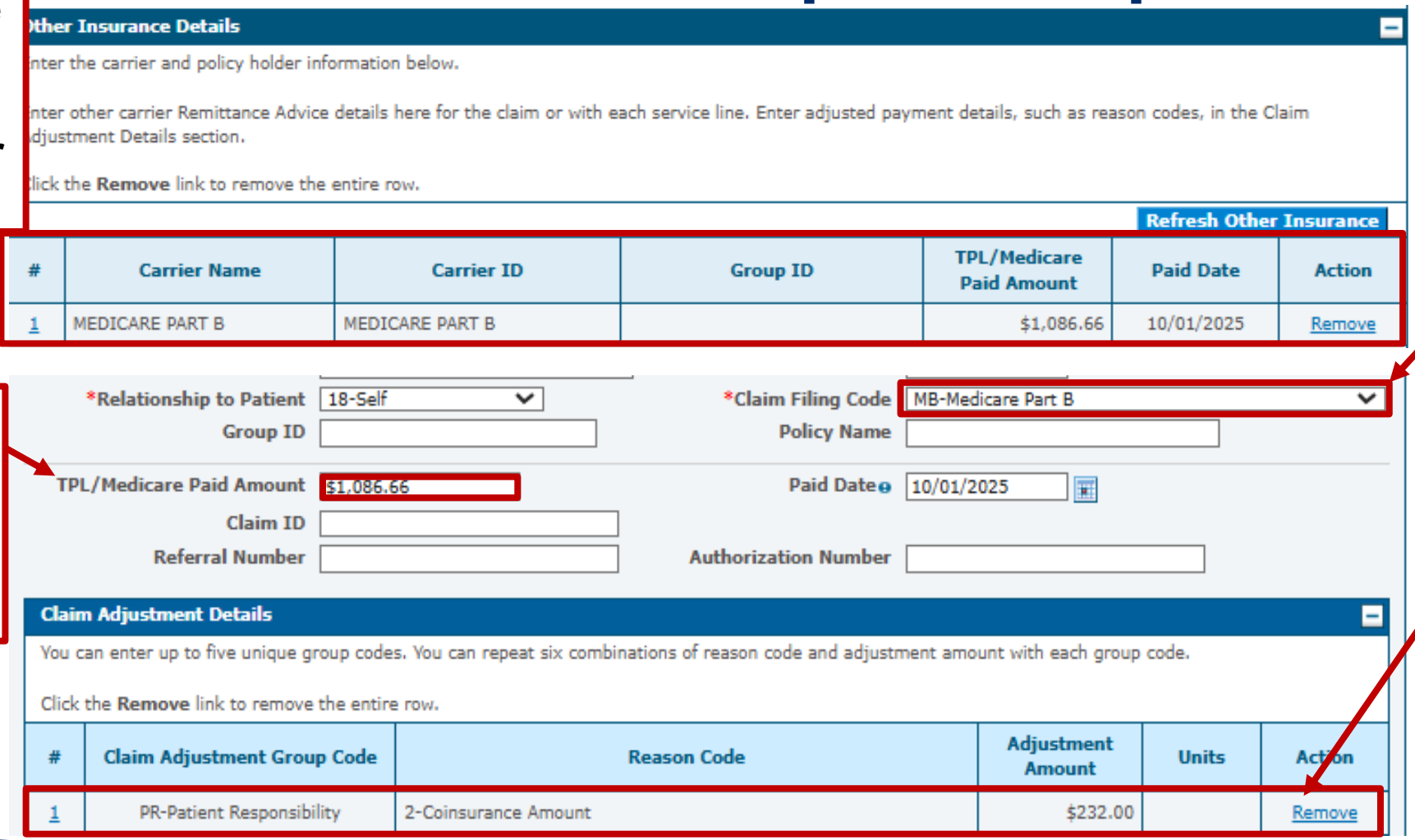
No Medicare Part A Benefits
IHCP Portal Step 2 Example

Add Medicare Part B to **Carrier Name/Carrier ID**

TPL/Medicare Paid Amount enter Medicare Part B paid amount

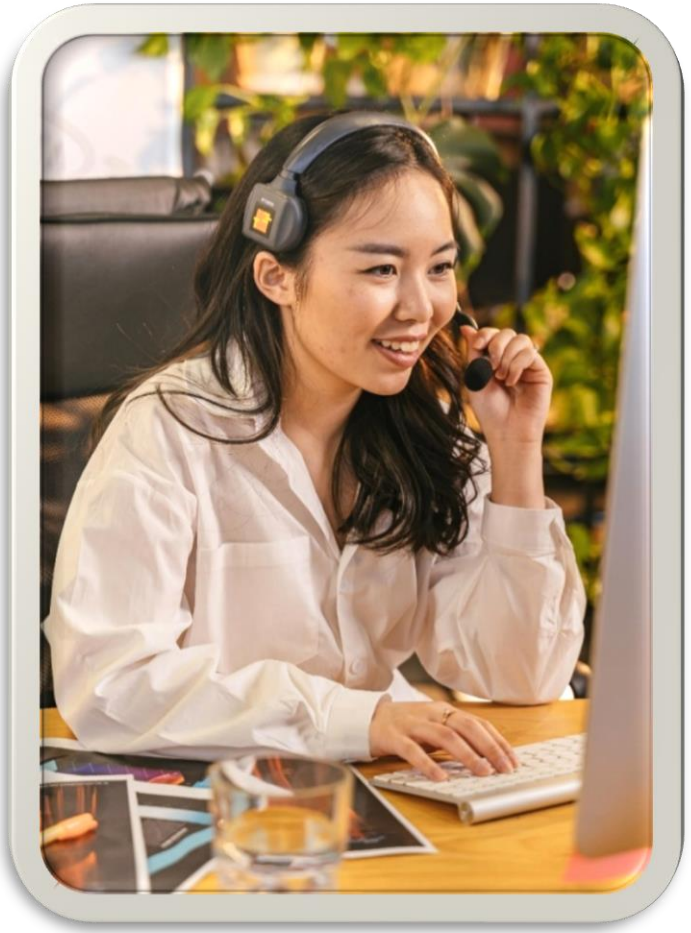
Claim Filing Code MB-Medicare Part B

Claim Adjustment Group and Reason Codes PR and reason code per Medicare EOB and amount



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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