



Understanding Claims Processes

IHCP Works Annual Seminar
Fall 2026

Agenda

- Clean Claims Fundamentals
- Filing Limits and Corrections
- EDI (Electronic Data Interchange) and Availability
- Coordination of Benefits, Payment, and Recovery
- Important Information

Course Overview



Anthem Indiana
Medicaid claims lifecycle



Provider billing
responsibilities



Clean claim expectations

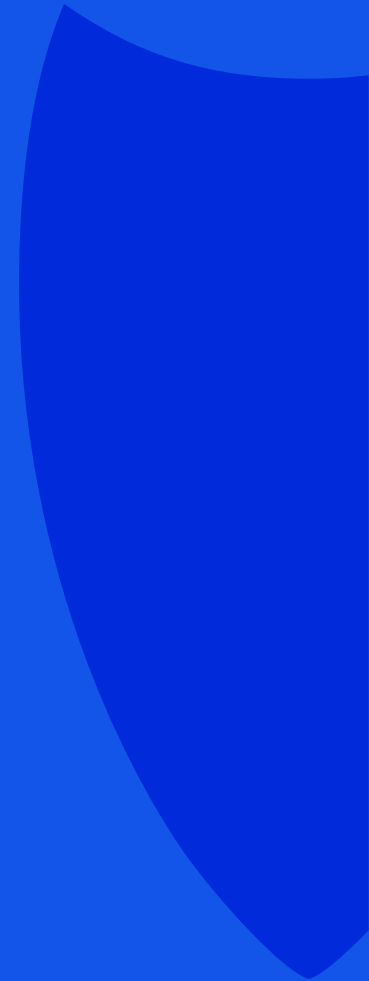
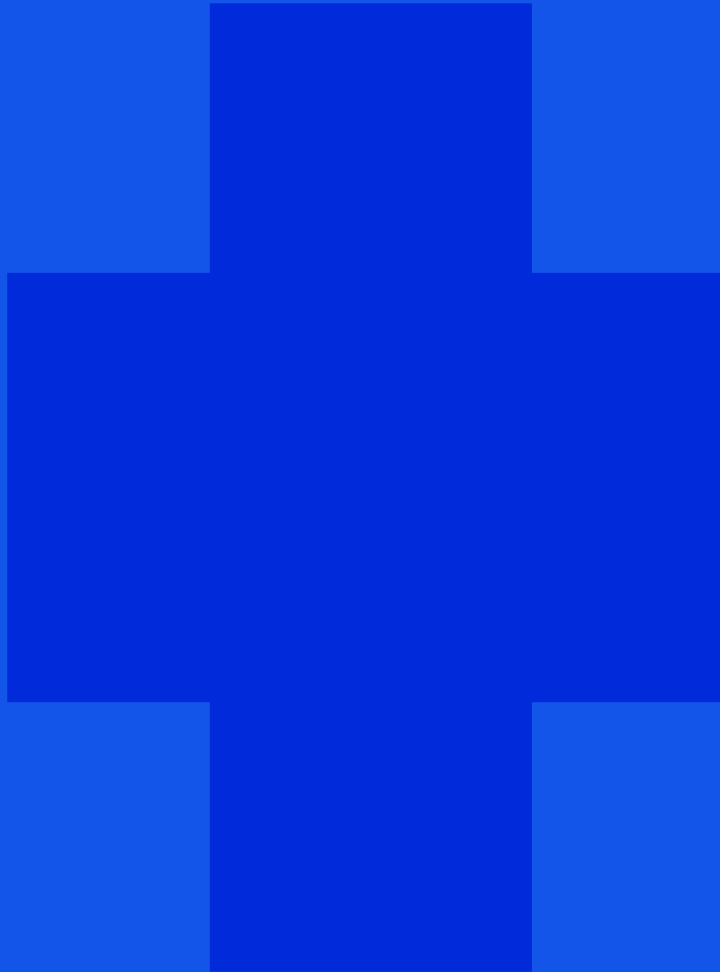


Training goals and
outcomes

Why Claims Accuracy Matters

- Reduces denials and rework, less administrative burden
- Accelerates payment
 - Submit right the first time, every time
- Supports compliance
 - Ensures you're meeting state and payer submission guidelines
- Improves member experience
 - Claim processes the first time and reduces member frustration

Clean Claim Fundamentals



What is a Clean Claim?

Complete member information

- Required Member ID and prefix

Valid provider information

- Billing and rendering provider data

Accurate coding

- Diagnosis and Procedure Codes

No additional documentation required

[Indiana Medicaid: Providers: Best Practices for Claim Submission](#)

Coding Requirements

- HIPAA (Health Insurance Portability and Accountability Act) compliant code sets
- National Correct Coding Initiatives (NCCI) edits apply
 - Procedure-to-Procedure (PTP) edits
 - Inappropriate payment of services that should not be reported together
- Medically Unlikely Edits (MUE)
 - The maximum units of service for a single beneficiary on a single date of service

Common Rejection Reasons

- Invalid National Provider Identifier (NPI)
- Missing demographics
- Invalid codes
- Formatting issues



Denied vs. Rejected Claims

- A rejected claim occurs before processing, due to errors
 - Rejected before adjudication
- A denied claim occurs after processing when the payer refuses payment
 - Denied after adjudication
- Different correction paths for resolution
- Different timelines for resolution

Electronic Processing Standards

- Availability response files
- Clearinghouse review
- Error correction workflow
- Resubmission expectations

Claims Adjudication Workflow

- Submission
- Eligibility validation
- Provider validation
- Coding edits
- Pricing and payment



Filing Limits and Corrections

Filing Limits

Primary

- 90 calendar days from last date of service
- Must pass front-end edits
- Late claims deny
- Track submissions

Secondary

- 90 calendar days from primary remittance advice (RA)
- Retain EOB documentation
- Coordination of Benefits (COB) requirements
- Timely follow-up

Corrected Claims Overview

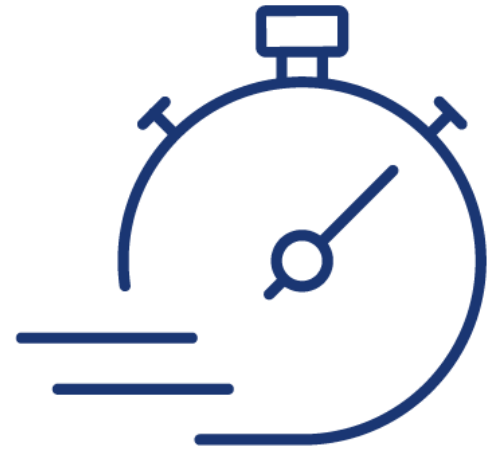
- Provider error corrections
 - Identify the error
- Underpayments
- Data corrections
 - Include all service lines
- Replacement claims
 - Use frequency code 7

Void Process

- Use frequency code 8
- Full recovery occurs
- Must be submitted within 60 calendar days
- Submit new claim if needed

Timely Filing Exceptions

- Anthem will waive timely filing for:
 - Retro eligibility
 - Authorization updates
 - COB errors
 - Anthem processing issues
 - Other conditions established by FSSA in rule or policy
- Use documentation to support exceptions



Wrong Payer Scenario

- Document timely filing
- Obtain denial
- Resubmit within 90 calendar days
- Include proof

Claim Disputes

- Reconsideration and Appeals process
 - Utilize Availity [Providers | Availity](#)
 - Within 60 calendar days of receipt of the RA
- Supporting documentation
 - Explain why you believe it should be reconsidered
- Follow-up expectations
 - Provide details for what you want to happen with the claim
- Escalation steps
 - Understand Anthem's processes and follow accordingly
- Anthem Provider Manual, Chapter 13
 - [2026 Indiana BCBS Medicaid Provider Manual](#)



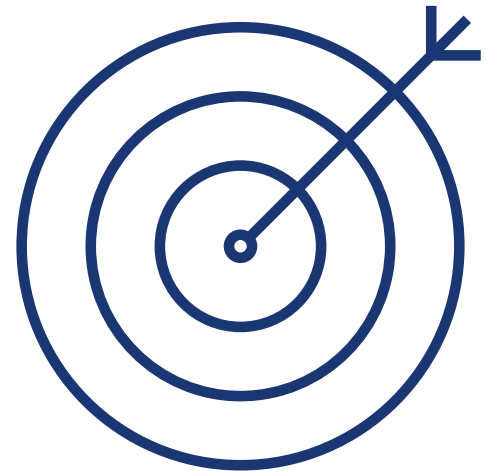
EDI and Availability

Availability Overview

- Exclusive EDI partner
- Claim submission
- Eligibility tools
- Status inquiry

EDI Benefits

- Faster processing
- Reduced costs
- Improved accuracy
- Electronic notifications
- Supported Transactions
 - 837P professional EOB
 - 837I institutional EOB
 - 835 claim submission
 - 270/271 eligibility
 - 276/277 claim status requests
 - 275 medical attachments
 - 278 prior authorizations



EDI Gateway Options

- Direct submission
- Clearinghouse option
- Vendor integration
- Response reporting

ERA (Electronic Remittance Advice) and EFT (Electronic Funds Transfer) Enrollment

Electronic Remittance Advice

- Electronic remittance
- Enrollment Center
- Payment reconciliation
- Reduced paper

Electronic Funds Transfer

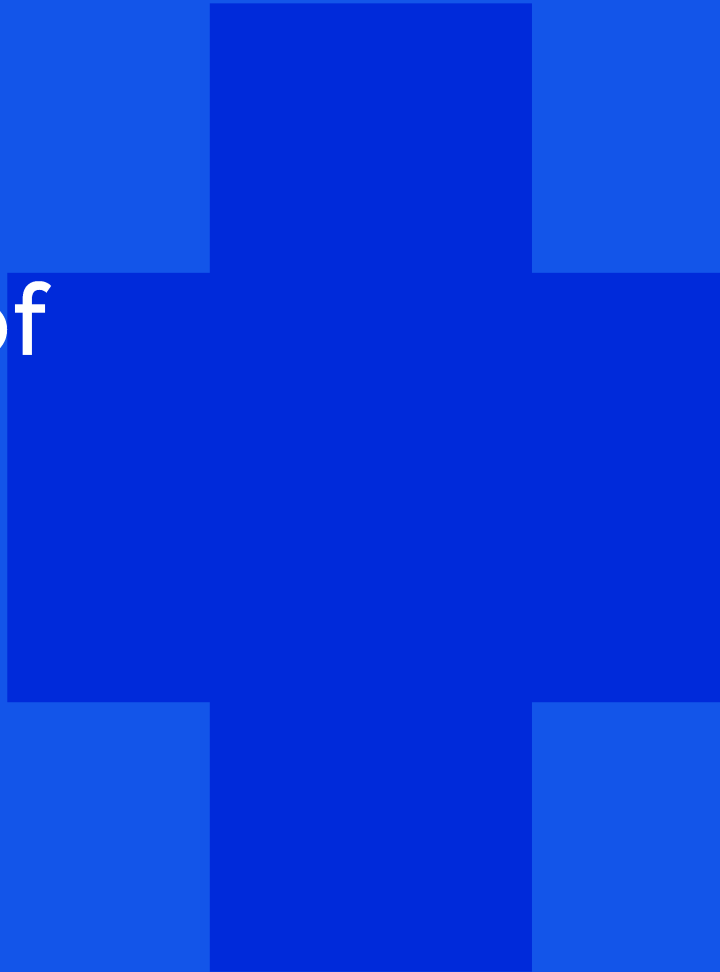
- EnrollSafe process
- Secure Payments
- Trace Numbers
- Bank Management

Claims Monitoring Tools

- Availability
- Interactive Voice Response (IVR)
- Digital RFAI (request for additional information)
- Weekly RA review



Coordination of Benefits, Payment, and Recovery



Member Medicaid Copayments

- Hoosier Healthwise copays
 - \$10 ambulance transport
 - \$3 generic drugs, \$10 brand name drugs
- Eligibility review
 - Recommended to verify eligibility prior to each visit
- Collection standards
 - Copays should be collected at time of service
 - Providers are not allowed to deny services if the Medicaid copay cannot be collected at the time of service



Balance Billing Rules

- No balance billing, unless a copay or waiver has been signed
- Covered services protected
- Waiver requirements
 - Must be signed prior to rendering services and then can bill member
- Member protections

Coordination of Benefits Overview

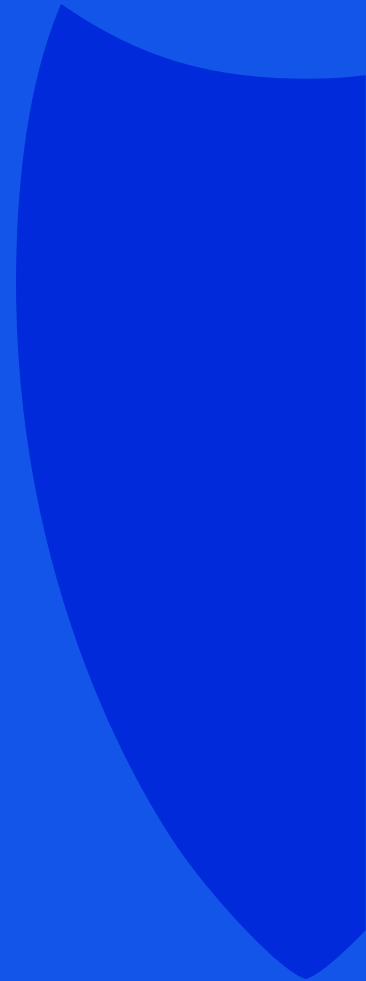
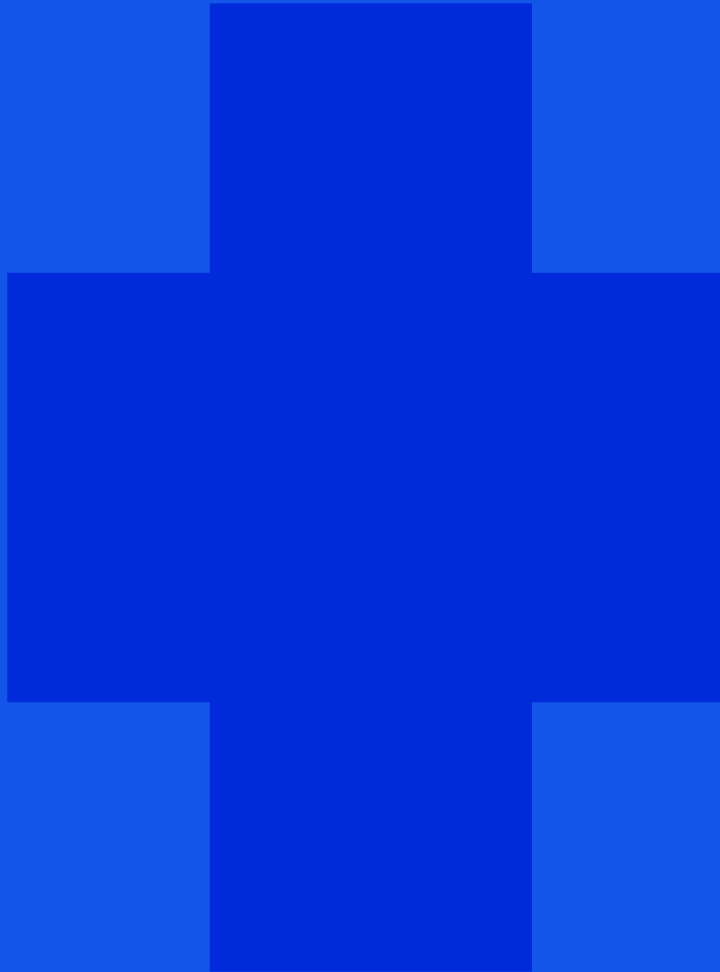
- Payer of last resort
- Primary insurance first
- COB documentation
- Secondary processing
- Decision Tree
- Other coverage
- Primary adjudication
- Submit EOB
- Anthem secondary claim
- Anthem Medicaid Provider Manual, chapter 13
- IHCP Third Party Liability Module
 - [Third-Party Liability](#)

Overpayment Recovery

- Refund form
 - [IN_CAID_RefundForm](#)
- Recoupment form
 - [IN_CAID_PU_RecoupmentForm.pdf](#)
- Dispute rights
- Recovery process



Important Information



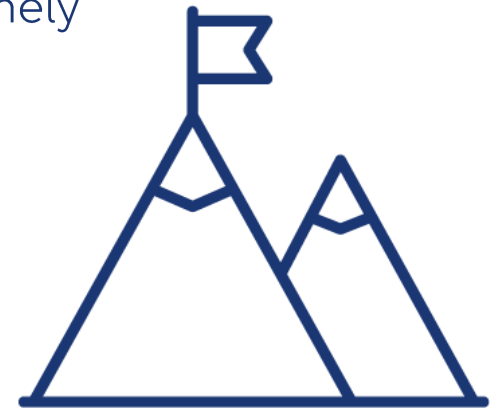
Resources

- Availity [Availity Essentials - Sign In](#)
- Provider Services [Contact Us](#)
- Webform [Webform](#)
- Provider Relationship Account Manager



Key Takeaways

- Submit clean claims
 - Ensure all claims are scrubbed prior to submission
- Meet filing deadlines
 - Know file limits to ensure claims are submitted timely
- Monitor claims
 - Check transmission and denial reports
- Utilize resources
 - Know who to contact when problems arise



THANK YOU!

We'd like to know how this presentation helped you and if there is any additional information or clarification we could offer.

Please take a moment to complete the survey by scanning the QR code or following [this link](#).





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