



Clean Claims, Fast Payments

Unlocking Efficient Claim Resolution

Indiana Health Coverage Programs (IHCP)

Gainwell Technologies

IHCP Works Annual Seminar October 2026



Agenda

- Efficient Claim Resolution Tips and Tools
- Common Causes of Claim Denials and Delays
- Denial Resolution Options
- Putting the Pieces Together
- Helpful Tools
- Questions



Efficient Claim Resolution Tips and Tools



What is a Clean Claim?

- A clean claim is one that can be processed without the payer needing additional information from the provider or a third party.
- A clean claim is one focusing on key details before that claim is submitted in an effort to prevent most denials.

Clean Claims = Fast Payments

The Keys to Clean Claim Submission



Verify the member's eligibility and managed care assignment before every date of service.

- Confirm active coverage on the [IHCP Provider Healthcare Portal](#) (IHCP Portal).
- Verify the member's managed care organization (MCO) assignment.
- Check benefit limitations and service eligibility for the services being billed.
- Verify if there is a primary payer (third-party liability [TPL]) that must be billed and confirm that coverage.





Confirm Authorization Requirements

- Prior Authorization requests for fee-for-service (FFS) members can be submitted to [Acentra Health](#) via their [Atrezzo](#) provider portal.
- Ensure authorization dates, units, procedure codes and modifiers exactly match the services that will be rendered.
- See the [Prior Authorization](#) provider reference module for additional details.



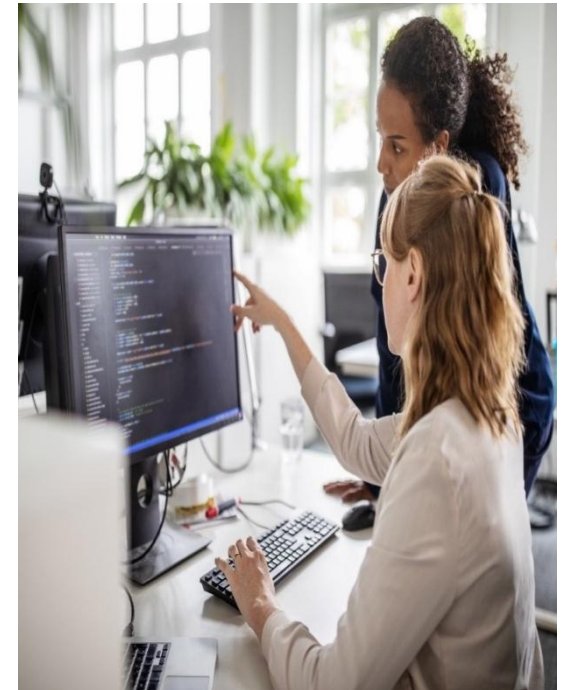
Use Correct Coding

Bill using current guidelines for the following (See [IHCP Provider Code Sets](#) webpage for additional information):

- Common Procedural Terminology (**CPT**)/ Current Dental Terminology (**CDT**)
- Healthcare Common Procedure Coding System (**HCPCS**)
- International Classification of Diseases 10th Revision, Clinical Modification (**ICD-10-CM**)
- Modifier
- Place of service (**POS**)
- Revenue codes

Follow billing guidance as per the [provider reference module](#) specific to your service type and [fee schedules](#).

Avoid unbundling and incorrect modifier use. See the [Medicaid NCCI Edit Files](#) webpage as well as the [National Correct Coding Initiative](#) provider reference module.





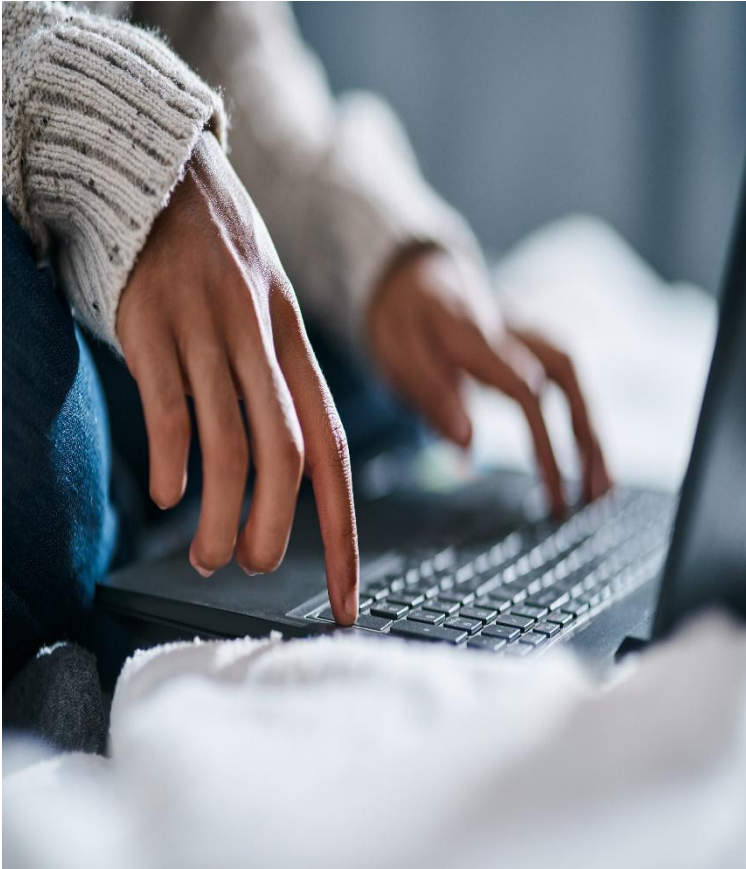
Ensure Documentation Fully and Clearly Supports the Claim in the Event the Information Is Needed

- Medical necessity, if required.
- Provider signature and credentials.
- Date and time of service.
- Complete treatment documentation.
- Documentation should support every billed code.

NOTE: In most cases, a provider should not submit documentation of medical necessity with a claim unless the information is required.



Submit Claims Electronically Whenever Possible



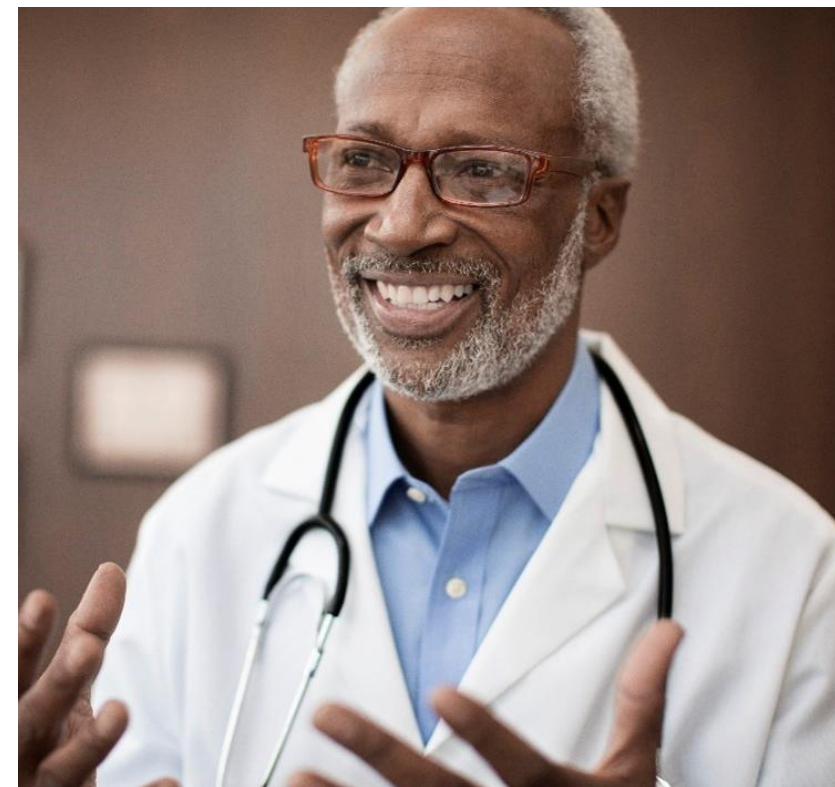
- Electronic claims submitted via the [IHCP Portal](#) or via 837 file submission pay faster
- Electronic edits for claims submitted on the IHCP Portal identify missing or invalid information before submission
- The IHCP Portal and [electronic data interchange](#) (EDI) are the preferred method of claim submission
- Avoid the **\$5.00** per claim fee assessed for paper claim submission



Validate Provider Enrollment

Make sure of the following:

- Billing provider is enrolled
- Rendering provider is enrolled and linked to the group
- Ordering/Prescribing/Referring provider is enrolled if required
- National Provider Identifier (NPI)/Legacy Provider Identifier (LPI) and taxonomy must be correct



Review Claims For the Following Before Submission:



- Invalid diagnosis/procedure code combinations
- Age and gender edits
- Duplicate claims
- Modifier conflicts
- Missing/invalid NPI
- Missing units
- Invalid POS

Coordinate Benefits Correctly

- Bill commercial insurance and Medicare.
- Report TPL payments and adjustments accurately per the [Claim Submission and Processing](#) provider reference module.
- Attach required TPL information if necessary. See the [Third-Party Liability](#) provider reference module for more information.



Complete Every Required Field On All Claim Forms



Common omissions include the following:

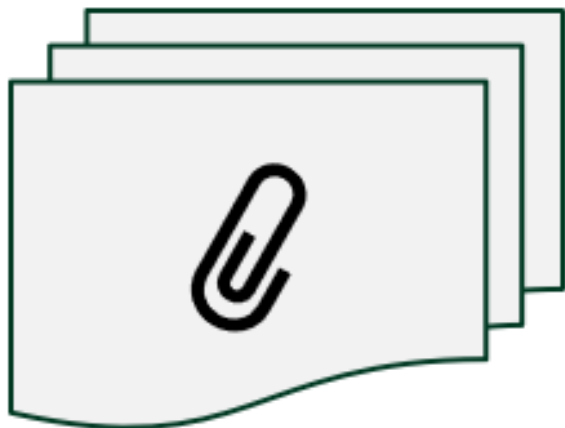
- Rendering provider for professional claims
- Referring provider (when necessary)
- Diagnosis pointers
- Units
- Dates of service (DOS)
- POS for professional claims
- [National drug code](#) (NDC) when required



Submit All Required Attachments When Necessary

Including documentation, such as:

- Medical records
- Operative reports
- PA documentation
- [Sterilization](#) or other consent [forms](#)
- Other payers' Explanation of Benefits (EOB)/Explanation of Payment (EOP) if Medicaid is the secondary or tertiary payer



Submit Within Timely Filing Limitations



Original FFS Claim Filing

Within 180 calendar days from the date of service

Administrative Review Request

Within 60 calendar days from claim payment/denial

Notice of Appeal of an Upheld Administrative Review

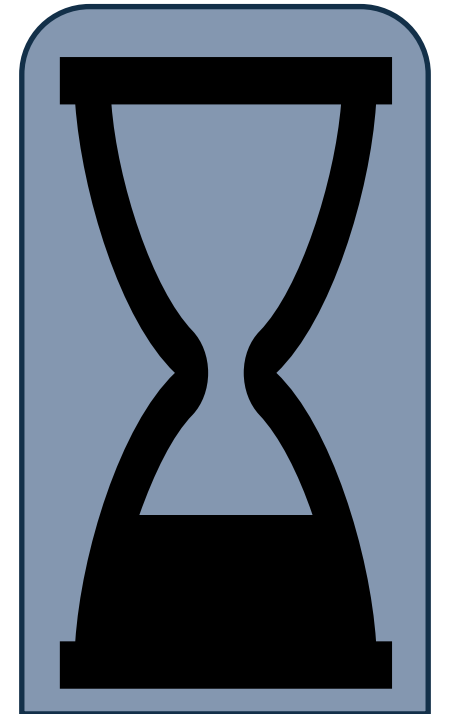
Within 15 calendar days from the upheld response to an administrative review

Statement of issues: Full Appeal

Within 45 calendar days from the upheld response to an administrative review

Submit a new claim (if required)

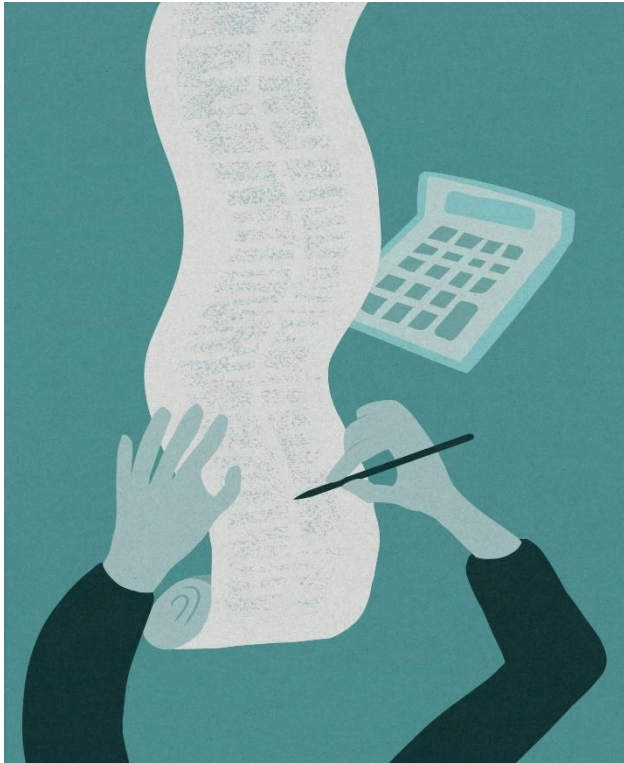
Within 30 calendar days from the notification of an overturned decision that requires a new claim



Review Remittance Advice Upon Receipt



- Correct claims when required
- Submit claim inquiries to clarify denials either via the [IHCP Portal](#) or through your [Provider Relations Consultant](#) should you need further clarification.
- Follow the Administrative Review and Appeals process as outlined in the [Claim Administrative Review and Appeals](#) provider reference module.
- Identify denial/rejection trends for impact on multiple claims. Please submit those identified issues via a spreadsheet to your Provider Relations Consultant.





Lightning Round 1: Clean Claims



1. What is the first step to submitting a clean IHCP claim?

- a. Submit the claim immediately
- b. Verify member eligibility and payer assignment
- c. Print the claim before submitting
- d. Call the member

Answer:

b.



Lightning Round 1: Clean Claims, Question 2



2. True or False:

Prior authorization should match the procedure code, modifiers, dates of service, and units/dollars billed when required.

Answer:

True



Lightning Round 1: Clean Claims, Question 3



- 3. Which submission method is usually the fastest AND helps catch errors before a claim is submitted?**
- a. Faxed claim
 - b. Paper claim
 - c. Electronic/837 file claim
 - d. Emailed claim

Answer:

c.



Common Causes of Claim Denials and Delays



Frequent Medicaid Denial Reasons

- Timely Filing Limits
- Missing or Invalid PA
- Eligibility and Coverage Issues
- Primary Insurance (Coordination of Benefits [COB]) not billed
- Provider Enrollment Errors
- Coding and Modifier Errors



Denial Reason 1

Denial Reason	Description	Common Causes	Prevention Tips
Timely Filing Limits	Claims submitted after the allowable filing deadline are automatically denied. The IHCP generally requires FFS claims to be submitted within 180 days from the date of service.	• Delayed claim submission • Untimely corrections or resubmissions • Administrative backlog	• Submit claims promptly after services are rendered. • Monitor aging claims consistently, tracking timely filing deadlines for original and corrected claims. • When the claim qualifies for a waiver of timely filing, make certain to add the correct claim note.



Denial Reason 2

Denial Reason	Description	Common Causes	Prevention Tips
Missing or Invalid PA	Many services require authorization before they are performed. Claims submitted without approved PA, or with incorrect authorization information, are frequently denied.	• No PA obtained. • Incorrect procedure codes on the authorization. • Authorization expired. • Units exceed approved authorization.	• Verify PA requirements before scheduling service. • Ensure CPT/HCPCS codes on the claim exactly match the approved authorization. • Confirm approved units and service dates.



Denial Reason 3

Denial Reason	Description	Common Causes	Prevention Tips
Eligibility and Coverage Issues	Claims are denied when a member is not eligible for Medicaid coverage on the date of service OR when the claim is submitted to the wrong payer.	• Coverage is inactive on the date of service. • The member is enrolled in an MCO and the claim was submitted to Traditional Medicaid in error. • Incorrect member information, such as incorrect IHCP Member ID, member name or other identifiers (date of birth, etc.).	• Verify eligibility before each visit. • Confirm the member's MCO assignment. • Confirm that benefit plan the member is enrolled in. • Update any TPL information and submit claims to the correct primary payer.



Denial Reason 4

Denial Reason	Description	Common Causes	Prevention Tips
Primary Insurance (COB not billed)	A COB denial happens when an identified primary payer is not billed before submitting a claim to Indiana Medicaid.	• Current eligibility not updated. • Billing FFS Medicaid instead of the assigned MCO. • TPL update not completed.	• Verify eligibility for each date of service. • Make certain to obtain all insurance information from the member and update TPL on the IHCP Portal via secure correspondence when necessary. • Make certain electronic claims are keyed to reflect all EOB/EOP information in the correct fields.



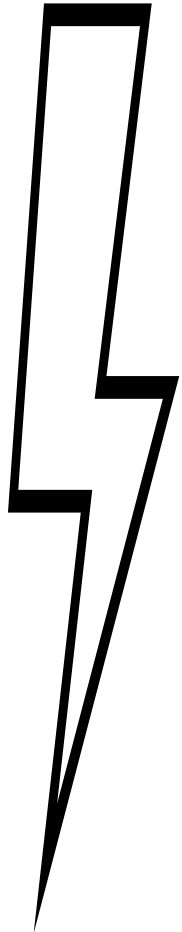
Denial Reason 5

Denial Reason	Description	Common Causes	Prevention Tips
Provider Enrollment Errors	Claims are rejected when the provider enrollment records do not match the billing information submitted.	• Rendering provider not linked to the billing group. • Incorrect NPI/LPI • The provider's enrollment is inactive or incomplete.	• Verify your provider's enrollment status. • Ensure that rendering providers are properly linked to the group enrollment. • Confirm the provider's NPI before claim submission.



Denial Reason 6

Denial Reason	Description	Common Causes	Prevention Tips
Coding and Modifier Errors	Incorrect coding is one of the most common causes of claim denials. Claims must include accurate diagnosis, procedure, and modifier information that supports medical necessity and billing requirements.	• Invalid CPT/HCPCS codes. • Incorrect ICD-10 diagnosis codes. • Missing or invalid modifiers. • Coding inconsistencies between diagnosis and procedures.	• Perform coding quality reviews before submission. • Keep coding resources updated, using only the most current information. • Validate modifier requirements and code combinations.



Lightning Round 2: Common Denials



1. **A provider submits a claim 7 months after the date the member was seen. What is the likely outcome?**
 - a. The claim will be paid at a reduced rate.
 - b. The claim will automatically be sent to another payer.
 - c. The claim will be placed on hold for manual review.
 - d. The claim will be denied for exceeding timely filing requirements.

Answer:

d.



Lightning Round 2: Common Denials

2. True or False:

A patient has active commercial insurance and Indiana Medicaid. The provider should bill Medicaid first.

Answer:

False



Lightning Round 2: Common Denials

3. Which of the following is NOT a common reason for an IHCP claim denial?

- a. Missing or incorrect authorization.
- b. Invalid CPT/HCPCS codes or missing modifiers.
- c. Provider NPI/LPI keyed incorrectly.
- d. The claim was submitted on the weekend.

Answer:

d.



Denial Resolution Options

Claim Denials



Providers are **strongly encouraged** to review their claim denials and do their due diligence in resolving claim issues. If you need assistance in understanding a denial, please reach out to your [Provider Relations Consultant](#) for assistance.

- Providers are encouraged to use the [IHCP Portal](#) for **secure correspondence** inquiries for ***fastest response time***.
- While mailing paper inquiries is permissible; providers can expect delays in getting a response when submitted via the USPS.





Claim Submission Guidance

Information about IHCP claim completion and processing for services billed to Gainwell are located in the [Claim Submission and Processing](#) provider reference module, including the following topics:

- **Claim completion guidelines**
- **Claim processing overview**
- **Crossover claim processing procedures**
- **Suspended claim resolution**
- **Claim filing limits**

Note: Providers are encouraged to submit claims electronically on the IHCP Portal or via an 837 file rather than use paper claim forms.



Claim Adjustments

Claim adjustments are changes to claim reimbursements that are made when a provider is correcting or modifying a previously processed or paid claim rather than submitting a brand-new initial claim. The Health Insurance Portability and Accountability Act (HIPAA) refers to claim adjustment transactions as voids or replacements:

- A **void** results in the ***full recoupment*** by the IHCP of the originally paid claim.
- A **replacement** is when a paid claim is reprocessed by the IHCP with the appropriate modifications.

For details on how and when to submit claim adjustments, please see the [Claim Adjustments](#) provider reference module.

Provider Relations Representatives



Should you need assistance in resolving a denial, your [Provider Relations Consultant](#) can assist in the following ways:

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

Note: The most efficient way of contacting your Provider Relations Consultant is via email.



Email Requirements

Required:

- National Provider Identifier (NPI) and/or Indiana Health Coverage Programs (IHCP) Provider ID
- Provider contact name
- The Member identification number (RID)
- Specific date of service/claim number
- Specific details regarding the information being requested should be included

Not Required:

- Taxpayer identification number (TIN)
- Member's date of birth (seldom required)

Remember:

- All protected health information (PHI) **must** be sent via secured or encrypted email.
- Voicemails are confidential; therefore, PHI may be left for review prior to the Provider Relations Consultant returning the call or email.



Lightning Round 3: Common Denials

1. True or False

Providers are *strongly encouraged* to review their claim denials and do their due diligence in resolving claim issues.

Answer:

True



Lightning Round 3: Common Denials

2. True or False

The most efficient way to resolve a denial is to print your claim and use white out to fix the issue causing the denial.

Answer:

False



Lightning Round 3: Common Denials

3. True or False

Information about IHCP claim completion and processing for services billed to Gainwell are located in the [Claim Submission and Processing](#) provider reference module.

Answer:

True



Putting the Pieces Together

Put the Pieces Together



- Clean, error-free claims mean faster payments.
- Ensuring that you have done your due diligence **prior to submission** yields expedited claim processing.
- Understanding how to correct billing errors, and using the tools available, prevent further claim delays.



Fast Payment

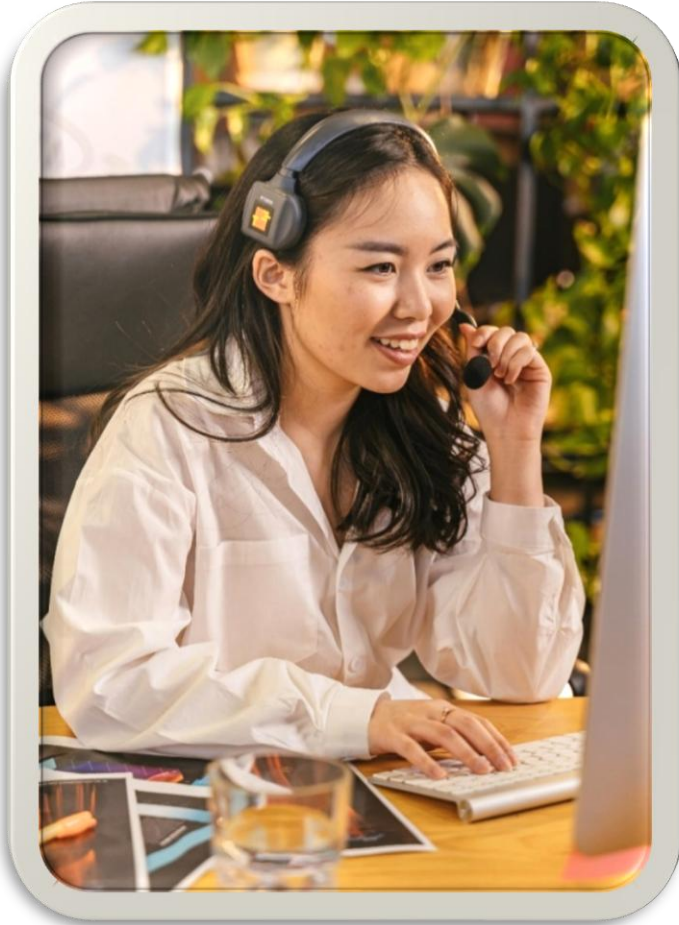


- Electronic submission via the IHCP Portal or via an 837 file is the most efficient way to submit claims for expedited processing and payment.
- If your claim is denied, make claim corrections on the [IHCP Portal](#).
- Utilize **Secure Correspondence** on the IHCP Portal for assistance with denial resolution for the fastest response times. Claim Inquiry, Administrative Reviews, and Claim Appeals should all be submitted electronically.



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. – 5 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	Open	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	Virginia Hudson	INXIXRegion5@gainwelltechnologies.com	317-488-5186
Region 6	Open	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.

