IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202590 JUNE 24, 2025

IHCP reminds providers of the FFS administrative review and appeals policy and processes

The Indiana Health Coverage Programs (IHCP) reminds providers of the policy and processes regarding fee-for-service (FFS) administrative reviews and appeals.

Administrative reviews

The first step in disputing a claim denial or incorrect payment is to submit an administrative review request. Providers can do this through the IHCP Provider Healthcare Portal (IHCP Portal) by using the Secure Correspondence feature. Access to the Secure Correspondence feature is available to all delegates for each service location to which they are linked. For users that do not have the Secure Correspondence feature when they log in to the IHCP Portal, their portal administrator can grant them that access. Administrative reviews may also be mailed in, but the IHCP Portal is the preferred method of outreach (except as noted for multiple denials).

Administrative review requests must be received by the IHCP within 60 days of the notification of claim payment or denial of the claim in question. The date of notification is considered to be the date on the most recent remittance advice (RA) for the claim. Administrative review requests received past the 60-day window will receive a response advising providers that the submission is past the administrative review timeline and cannot be considered.

Each administrative review can only address one claim at a time. For multiple denials for the same issue or same member, the best practice is for the providers to reach out to their IHCP Provider Relations consultant. The consultants are assigned to each county as listed on the *Provider Relations Consultants* webpage at in.gov/medicaid/providers. Providers can contact their consultant by leaving a voicemail or sending an email. Please ensure any emails with protected health information (PHI), which includes member's name, Medicaid identification number, IHCP claim number, date of birth or death, diagnosis, medical records, or any other information that makes the member identifiable must be sent encrypted. The Provider Relations consultant's email is not automatically encrypted.

Provider Relations consultants can assist providers in resolving issues with ***multiple claims with the same issue*** much quicker than going through the IHCP Portal.

In the event the administrative review is upheld, providers have 15 calendar days from the administrative review decision date to submit an appeal, which is considered a second-level dispute.

Common billing errors

Providers are strongly encouraged to review their claim denials and do their due diligence in resolving the claim issue prior to submitting for an administrative review. The following are common administrative review requests the IHCP receives:

- Claim denials in billing Medicare with coordination of benefits when submitting on the IHCP Portal
  - ⇒ The most common reason for this denial is the provider used the incorrect claim filing code. Providers should use the following claim filing codes:
    - **MA** or **MB** if Medicare is primary
    - **16** when the primary insurance is a Medicare Advantage Plan
    - **CI** (Commercial Insurance) only if the primary insurance is not a Medicare plan
- Denials for timely filing, when the provider did not submit the claim within the 180-day timely filing period
  - ⇒ For FFS claims, providers have 180 days from the date of service or 180 days from the date the primary insurance processed the claim to be within the timely filing period.
  - ⇒ If the date of service is more than 180 days, the timely filing limit can be extended to 180 days from the date on the primary insurance explanation of benefits (EOB). Coordination of benefits is made and the EOB attached to the claim to show date of processing by the primary insurance.
  - ⇒ For other exceptions to the 180-day timely filing period, see the *Claim Submission and Processing* provider reference module at in.gov/medicaid/providers.
- Claims submitted without proper prior authorization
  - ⇒ Providers are expected to know when prior authorization is required for services rendered and obtain a prior authorization before rendering the services.
  - ⇒ All services have a field indicating if prior authorization is required on the Professional Fee Schedule and the Outpatient Fee Schedule (accessible from the *IHCP Fee Schedules* webpage at in.gov/medicaid/providers).
  - ⇒ Submitting medical records to bypass the need for prior authorization will not allow the claim-processing system to bypass the prior authorization requirements. Gainwell does not review medical records for administrative review requests. Submitting medical records does not replace prior authorization requirements.

Appeals

If all the procedures required for administrative review have been exhausted and the provider is still not satisfied with the determination, the provider can send a request for an appeal. The appeal request should include all pertinent facts, proof of actions taken to resolve the payment or denial, and any associated documentation.

Appeal requests can be submitted through the IHCP Portal, choosing the Appeal option from the Secure Correspondence feature. Providers may also submit an appeal request with the Family and Social Services Administration (FSSA) by mail, email or fax, by following the guidance provided in the *Claim Administrative Review and Appeals* provider reference module at in.gov/medicaid/providers.

When submitting an appeal request, providers must include information showing that an administrative review was completed within the last 15 calendar days. An appeal request received without an administrative review being completed will not be reviewed as an appeal, but it will be considered as an administrative review. If an adverse decision is made on the administrative review, a new appeal request may be submitted within 15 calendar days.

If a provider elects to appeal, the provider must also file a statement of issues within 45 calendar days from the date of the adverse administrative review determination. The statement of issues should be sent to the same address as the appeal request and should conform to *Indiana Administrative Code 405 IAC 1-1.4-11(j)* and *Indiana Code IC 4-21.5-3-7*.

Reminders

Providers are reminded to only submit documentation with their administrative reviews and appeals that are relevant to the claim decision. For example, for a claim denied for timely filing or prior authorization, including medical records cannot change the claim determination.

For claims in which providers have a retroactive member eligibility change and managed care claims that have been recouped or need voided as shadow claims in the Gainwell system, please contact your Provider Relations consultant for assistance rather than submitting through the Written Correspondence process.

Providers are encouraged to use the IHCP Portal for secure correspondence inquiries for fastest response time. Documentation can be uploaded to the claim when submitting through the IHCP Portal and is trackable with a reference number assigned as soon as it is submitted. Mailing paper inquiries is permissible; however, providers can expect delays in getting a response when submitted via USPS mail.

For providers that use an outside vendor for claim follow-up, please ensure that the vendor is familiar with the IHCP administrative review and appeals process and follows that guidance.

For more information

Providers with any questions regarding the IHCP administrative review and appeals process are welcome to reach out to their IHCP Provider Relations consultant.

Individual managed care entities (MCEs) create their own administrative review and/or appeals processes. Please contact the member's MCE for requirements and submission instructions. See the *IHCP Quick Reference Guide* for contact information.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from the *IHCP Bulletins* page of the IHCP provider website at in.gov/medicaid/providers.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the IHCP provider website at in.gov/medicaid/providers.