INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Claim Administrative Review and Appeals

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Revision History

Version	Date	Reason for Revisions	Completed By
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1.1	Policies and procedures as of Aug. 1, 2016 Published: Dec. 13, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: March 21, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of Sept. 1, 2017 Published: Nov. 21, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of Oct. 1, 2018 Published: Nov. 20, 2018	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of Oct. 1, 2018 Published: Aug. 22, 2019	Correction	FSSA and DXC
4.0	Policies and procedures as of Nov. 1, 2019 Published: Jan. 7, 2020	Scheduled update	FSSA and DXC
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6.0	Policies and procedures as of Dec. 1, 2021 Published: Jan. 27, 2022	Scheduled update	FSSA and Gainwell
7.0	Policies and procedures as of Oct. 1, 2024 Published: Jan. 30, 2025	Scheduled update: • Edited text as needed for clarity • Updated the initial note • Updated the *Introduction* section • Updated the *For Paid Claims* section • Updated the *Filing an Administrative Review Request* section • Updated the *Administrative Review Responses* section • Updated the *Appeals* section	FSSA and Gainwell

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Claim Administrative Review and Appeals

*Note: The information in this module applies to administrative review and appeals related to claims for Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system, with the following exceptions:*

- *Pharmacy claims adjudicated by the FFS pharmacy benefit manager (PBM) – contact the Optum Rx helpdesk for information*
- *Nonemergency medical transportation (NEMT) claims adjudicated by the FFS transportation broker – contact Verida for information*

*For administrative review and appeals related to claims for services provided through the **managed care** delivery system – including the Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Indiana PathWays for Aging (PathWays) programs – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. Each MCE that participates in an IHCP managed care program is required to have a formal procedure for providers requesting reconsideration of claim determinations made by the MCE. For contact information, see the IHCP Quick Reference Guide, available at in.gov/medicaid/providers.*

Administrative review and appeals related to claims for services that are carved-out of managed care – such as Medicaid Rehabilitation Option (MRO) and school corporation services – follow the fee-for-service guidelines specified in this module.

For updates to the information in this module, see IHCP Bulletins at in.gov/medicaid/providers.

Introduction

Indiana Health Coverage Programs (IHCP) provider claims for payment of services rendered as fee-for-service (FFS) must be originally filed within 180 days of the date of service or date of discharge. See the *Claim Submission and Processing* module for more information, including circumstances that allow for extensions to the timely filing limit.

If a provider disagrees with the IHCP determination of claim payment, the provider's right of recourse is to file an administrative review and appeal, as provided for 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 to appeal an adverse administrative review decision must be filed within 15 calendar days of notification of the decision.

Before requesting a claim administrative review, providers should review the *Steps Taken Prior to the Administrative Review Process* section to determine if correcting and resubmitting the claim would resolve the issue, eliminating the need for an administrative review.

Steps Taken Prior to the Administrative Review Process

The provider must exhaust routine measures to obtain payment before filing an administrative review request.

For Claim Denials

Upon receipt of a claim denial, the provider must do the following:

1. Review the claim and the denial reason codes.

   If the provider cannot determine why the claim denied, the provider may contact Customer Assistance at 800-457-4584 or submit a secure correspondence message (using the Claim Inquiry category) through the IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers.

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.
   - For adjudication purposes, a denied claim that is resubmitted with corrected information is considered to be an initial claim and, as such, is subject to the same timely filing limit (based on date of service or date of discharge) as the original claim (see the *Claim Submission and Processing* module for timely filing limits).
   - A denied claim resubmitted **without** corrected information is considered to be a duplicate claim and will continue to deny for the same reasons as the original claim. Resubmitted claims with no correction will not be accepted as "reasonable and continuous attempts to resolve a claim problem," for consideration in waiving or extending the timely filing limit.

3. 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. See the *Filing an Administrative Review Request* section of this module.

For Paid Claims

If a claim is filed timely and is paid, including claims partially paid or paid at zero, and the provider disagrees with the reimbursement, the provider should:

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

   If the provider cannot determine the reason for the payment discrepancy, the provider may contact Customer Assistance at 800-457-4584 or submit a secure correspondence message (using the Claim Inquiry category) through the IHCP Portal.

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. The claim adjustment or void/replacement must be filed within 60 days of notification of the claim's disposition. Notification is considered to be the date on the RA.

   See the *Claim Adjustments* module for details, including special instructions for when the adjusted/replacement claim is submitted after the timely filing limit for the original claim has passed, but within 60 days of the RA for the paid claim.

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 written request for administrative review stating why the provider disagrees with the claim payment amount. See the *Filing an Administrative Review Request* section of this module.

For Claims With NCCI Edits

Providers that have questions about a National Correct Coding Initiative (NCCI) edit should exhaust routine measures of inquiry using resources listed in the *Introduction to the IHCP* module. Providers are further encouraged to access the *Medicaid NCCI Edit Files* page at cms.gov to review the NCCI Procedure-to-Procedure (PTP) edit and Medically Unlikely Edit (MUE) files. These files contain specific code pairs for the PTP edits. For more information about NCCI, see the *National Correct Coding Initiative* module.

If the provider still believes that a claim was coded correctly and would like reconsideration, the provider should follow the process described in the *Filing an Administrative Review Request* section of this module.

Filing an Administrative Review Request

> *Note: For providers on prepayment review, see the Provider and Member Utilization Review module for administrative review and appeal procedures.*

For reconsideration of an adjudicated claim, providers must file a formal request for an administrative review of the claim. The request must be submitted within **60 calendar days** of notification of claim payment or denial, as follows:

1. Create the request using one of the following methods:
   - Write a secure correspondence message on the IHCP Provider Healthcare Portal, accessible from the homepage at in.gov/medicaid/providers, selecting **Claim Administrative Review Request** as the message category.
   - Complete an *IHCP Claim Administrative Review Request* form, available on the *Forms* page at in.gov/medicaid/providers.
   - Write a letter on letterhead, with **Claim Administrative Review** clearly printed on the face of the letter.
2. Within the written request, note the Claim ID (as well as Claim IDs for any previous filing or adjustment attempts) and include a **detailed description** of the reason for disagreement with the denial or reimbursement amount.

> *Note: If the administrative review request is specific to the National Correct Coding Initiative, write **NCCI** at the beginning of the secure correspondence message or on the face of the letter. Or, if using the IHCP Claim Administrative Review Request form, select the box marked "**Request review of NCCI denial**" as the reason for the claim administrative review request.*
>
> *The request should document any unusual circumstances in which the provider believes the claim was coded correctly and would like a reconsideration of the NCCI editing.*

3. Attach the following to the request:
   - Any pertinent documentation supporting reconsideration, including items that were originally required with the claim, such as medical records, third-party liability (TPL) forms, filing limit documentation and other claim attachments
   - A properly completed claim form (optional, but recommended to expedite claim processing in the event the administrative review decision overturns the original claim decision)

> *Note: While claim administrative review requests submitted without all pertinent documentation will not immediately cause a denial of the administrative review, failure to submit the documentation necessary to support the request will result in the claim denial being upheld. If the claim administrative review decision results in a denial, whether due to insufficient information or for other reasons, Gainwell will notify the provider of their additional claim appeal rights, as described in the Administrative Review Responses section.*

4. Submit the request and any supporting documentation via the IHCP Portal or by mail to the following address:

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

   The request must be submitted within **60 calendar days** of notification of claim payment or denial. The date of notification is considered to be the date on the **most recent** RA for the claim.

Administrative Review Responses

Providers will receive a written confirmation of receipt of their request for administrative review within 10 business days. The IHCP fiscal agent, Gainwell Technologies, will respond to all administrative review requests within 45 calendar days of receipt of the request, regardless of the decision to pay or deny the claim. Each denial decision is specific, detailed and fully documented.

If the administrative review response is unfavorable to the provider, the provider may file an appeal. Providers will be notified of their additional claim appeal rights in the response from Gainwell.

> *Note: Administrative review responses are considered an administrative action by the state of Indiana, appealable to an administrative law judge from the state of Indiana Office of Administrative Law Proceedings.*

If the administrative review response is favorable to the provider, the original claim decision is overturned. If possible, Gainwell will reprocess the originally submitted claim with the new information. However, in some cases, a new claim form is required. If the provider did not submit a completed claim form with the request, Gainwell will provide instructions on submitting the claim form and required documentation to their Provider Relations consultant for special batching. Providers will need to submit the claim form within 30 days of notification of the decision. Failure to do so could result in the administrative review closing without reprocessing the claim.

Appeals

A provider must exhaust the formal administrative review process, as described in the *Filing an Administrative Review Request* section, before filing an appeal. The provider must comply with all requests to submit information or additional documentation and must receive a final written administrative review decision. 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 appeal under the provisions of *405 IAC 1-1.4.*

The appeal request should include all pertinent facts, proof of actions taken to resolve the payment or denial, and any associated documentation. In accordance with *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 notice on which the appeal is premised. The appeal request must be submitted as an

IHCP Portal secure correspondence message (using the Appeal category) or delivered in writing via hand delivery, mail, email or fax:

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

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 *405 IAC 1-1.4-11(j)* and *IC 4-21.5-3-7*. Appeal proceedings will be conducted by an administrative law judge appointed by the Office of Administrative Law Proceedings (OALP).

An administrative law judge's adverse decision can be appealed by filing objections with the ultimate authority for the agency within **15 calendar days** of receipt of the decision. An appellant can file a petition for judicial review in accordance with *IC 4-21.5-5*, if the appellant is not satisfied with the agency review decision.

Gainwell does not receive the appeal decisions. If providers have follow-up questions or requests regarding decision, they will need to contact the OALP.

> *Note: For information about audit-related appeals, see the Provider and Member Utilization Review module. For information about appeals of prior authorization decisions, see the Prior Authorization module.*