Claim Administrative Review and Appeals
## Revision History

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<td>1.0</td>
<td>Policies and procedures as of October 1, 2015 Published: February 25, 2016</td>
<td>New document</td>
<td>FSSA and HPE</td>
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<td>1.1</td>
<td>Policies and procedures as of August 1, 2016 Published: December 13, 2016</td>
<td>Scheduled update</td>
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<td>1.2</td>
<td>Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: March 21, 2017</td>
<td>CoreMMIS update</td>
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<td>2.0</td>
<td>Policies and procedures as of September 1, 2017 Published: November 21, 2017</td>
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| 3.0     | Policies and procedures as of October 1, 2018 Published: November 20, 2018 | Scheduled update:  
- Reorganized and edited text as needed for clarity  
- Added a note box to the beginning of the module to reflect new standard verbiage  
- Merged the former Administrative Review and Appeals for Managed Care Claims section into the new note box and added school corporation as an example of a carved-out service  
- Merged the former Administrative Review and Appeals for Fee-for-Service Claims section into the Introduction section, and made the following updates:  
  - Added a reference to the Claim Submission and Processing module for exceptions to timely filing limit  
  - Added a note about an upcoming change to the timely filing limit  
- In the Filing an Administrative Review Request section, added that the Claim ID should be included in the administrative review request | FSSA and DXC |
| 3.0     | Policies and procedures as of October 1, 2018 Published: August 22, 2019 | Correction:  
- Updated room number in the address in the Appeals section | FSSA and DXC |
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Claim Administrative Review and Appeals

Note: For updates to the information in this module, see IHCP banner pages and bulletins, available from the News, Bulletins, and Banner Pages page at indianamedicaid.com.

The information in this module applies to administrative review and appeals related to claims for services provided under the fee-for-service delivery system. Administrative reviews and appeals related to claims for services provided under a managed care program, such as Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise, are the responsibility of the managed care entity (MCE) in which the member was enrolled at the time of service.

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 specific information related to the MCE process, contact the individual MCE directly. MCE contact information is available from the IHCP Quick Reference Guide at indianamedicaid.com.

Administrative reviews and appeals related to claims for services carved-out-of managed care – such as 1915(i) State Plan Home and Community-Based Services (HCBS), Medicaid Rehabilitation Option (MRO), and school corporation services – follow the fee-for-service guidelines specified in this module.

Introduction

If a provider disagrees with the Indiana Health Coverage Programs (IHCP) determination of 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.

All provider claims for payment of services rendered as fee-for-service (FFS) to IHCP members must be originally filed with DXC Technology within 12 months of the date of service (see the Claim Submission and Processing module for circumstances that allow extensions). The guidelines in this module apply to administrative review and appeals related to FFS claims.

Note: The timely filing limit will change from 1 year to 180 days, effective January 1, 2019. The current 1-year timely filing limit will continue to apply to claims with dates of service or dates of discharge on or before December 31, 2018.

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 1-800-457-4584 or submit a secure correspondence message (using the Claim Inquiry category) through the IHCP Provider Healthcare Portal (Portal) at indianamedicaid.com. Providers can also submit an inquiry by completing the Indiana Health Coverage Programs Written Inquiry form (available on the Forms page at indianamedicaid.com) and mailing it to the address on the form.
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 1-year timely filing limit.
   - For adjudication purposes, a denied claim resubmitted without corrected information is considered to be a duplicate claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the 1-year timely filing limit and 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 1-800-457-4584 or submit a secure correspondence message (using the Claim Inquiry category) through the Portal. Providers can also submit a written inquiry to DXC using the Indiana Health Coverage Programs Written Inquiry form (available on the Forms page at indianamedicaid.com).

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.

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 National Correct Coding Initiative (NCCI) Edits 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

For reconsideration of an adjudicated claim, providers must file a written request for an administrative review of the claim, as follows:

1. Write the request, including the Claim ID and the reason for disagreement with the denial or the amount of reimbursement, using one of the following methods:
   - Create a secure correspondence message on the Provider Healthcare Portal, using the Administrative Review Request category.
   - Write a letter on letterhead stating the reason for disagreement with the denial or the amount of reimbursement and clearly note Administrative Review on the face of the letter.

   **Note:** If the formal 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; if submitting the IHCP Administrative Review Request form, select “Request review of NCCI denial” as the reason for the administrative review request.

2. Include all pertinent documentation supporting reconsideration with the secure correspondence, form, or letter.
   - Document the unusual circumstances in which the provider believes the claim was coded correctly and would like a reconsideration of the NCCI editing.
   - Document the reason for disagreement.
   - Document the denial reason and the reason the payment is being disputed.

3. File the formal administrative review request within 60 calendar days of notification of claim payment or denial from DXC. The date of notification is considered to be the date on the most recent RA for the claim.

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

**Administrative Review Requests**
DXC Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

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

Administrative Review Responses

Providers will receive a written confirmation of receipt of their request for administrative review within 10 business days. DXC will respond to all administrative review requests within 90 business 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.
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 1-1.5.

The appeal request should include all pertinent facts, proof of actions taken to resolve the payment or denial, and any associated documentation. The IHCP must receive the appeal request within 15 business days after the provider receives the adverse administrative review decision notice on which the appeal is premised. The appeal request must be submitted as a Portal secure correspondence message (using the Appeal category) or delivered by mail to the following address:

MS07
Secretary
Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
402 W. Washington St., Room W374
Indianapolis, IN 46204-2739

If a provider elects to appeal, the provider must also file a statement of issues within 45 days of 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 1-1.5-2(d) and Indiana Code IC 4-21.5-3. Appeal proceedings will be conducted by a Family and Social Services Administration (FSSA)-appointed administrative law judge.

An administrative law judge’s adverse decision can be appealed by filing objections with the ultimate authority for the agency within 15 business 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.

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