Claims Rejected, Voided or Denied, Now What?

2025 Indiana Health Coverage Programs (IHCP) Annual Works Seminar

Agenda

- 277 Rejections
- Top Medical Claim Denials
- Disputes
- Claim Appeals
- Clinical Appeals
- Medicaid Arbitration
- How to Contact CareSource

277 Rejections

Claim rejected, now what?

- Rejected claims are not in the CareSource system.
  - Neither the Heath Partner Representative nor our Provider Services Representatives have access to the claim image.
- Rejected claims are not clean claims.
  - Do not submit as corrected claims.
- Rejected/voided claims can not be disputed and/or appealed.
- Sending in screenshots of rejection claims does not waive timely filing.
- Rejected claims can not be used as proof of timely filing.
  - Clean claim must be received within 90 calendar days of date of service or the primary payer's Explanation of Payment (EOP) date.

For more information on how to correct rejection claims, please follow this link:
https://www.caresource.com/in/providers/provider-portal/claims/claim-rejection-notifications/medicaid

Common Rejections Corrected Claim

Rejection Error: Corrected claim, with no original claim ID

If you are sending a corrected claim with frequency of 7, you must include the last adjudicated Claim ID in the REF*F8 segment.

If the last adjudicated claim ID is unknown:

Review CareSource Provider Portal or

contact Provider Services at 1-844-607-2831.

Common Rejections NPI

Rejection Error: Claim marked for rejection because no active provider is found in Master Provider List (MPL) based on Billing National Provider Identifier (NPI). Claims marked for rejection because there were multiple matches found in MPL based on different combinations of NPI.

For this error, please review the IHCP Provider Healthcare Portal and verify enrollment using the following:

Is the group NPI enrolled with Medicaid?

If no, please register this group in Medicaid by following this link: https://www.in.gov/medicaid/providers/provider-enrollment/

Is the group NPI showing active in Medicaid system?

If no, please register this group in Medicaid by following this link: https://www.in.gov/medicaid/providers/provider-enrollment/

Is the active date of the group on or after the date of service?

If no, this group cannot bill for services if not effective on Date of Service (DOS).

Does this group enrollment have multiple locations and specialties?

If yes, are you billing the correct NPI and/or taxonomy for the group?

Check the address, does the address in box 33 match the service location in Medicaid?

If no, please correct the claim and re-submit.

Does the zip+4 in box 33 match the zip+4 in Medicaid?

If no, please correct the claim and re-submit

Common Rejections Rendering Provider

Rejection Error: Rendering provider not linked to billing group in Indiana MPL

For this error, please review the IHCP Provider Healthcare Portal and verify the following:

Is the individual practitioner NPI registered in Medicaid?

If no, please register this practitioner in Medicaid by following this link:
https://www.in.gov/medicaid/providers/provider-enrollment/

Is the individual practitioner showing active in Medicaid system?

If no, please follow the above link to update the practitioner enrollment in Medicaid.

Is the individual practitioner enrolled as a rendering provider?

If no, please enroll the practitioner as a rendering practitioner. Please follow this link for guidance
https://www.in.gov/medicaid/providers/provider-enrollment/

Is this individual practitioner showing linked to this location?

If yes, Is the effective date on the rendering tab on or after the date of service?

If no, please follow this link to enroll the practitioner:
https://www.in.gov/medicaid/providers/provider-enrollment/

Are you billing the correct NPI and/or taxonomy of the group in box 33?

If no, correct and resubmit claim.

Common Rejections Attending Provider

Rejection Error: Claim marked for rejection because the attending provider's NPI submitted on the claim is not valid in IN MPL or not present on the claim.

For this error, please review the IHCP Provider Healthcare Portal and verify the following:

Is the individual practitioner NPI registered in Medicaid?

If no, please register this practitioner in Medicaid by following this link:
https://www.in.gov/medicaid/providers/provider-enrollment/

Is the individual practitioner showing active in Medicaid system?

If no, please follow the above link to update the practitioner enrollment in Medicaid.

Is the individual practitioner enrolled as a rendering provider?

If no, please enroll the practitioner as a rendering practitioner. Please follow this link for guidance
https://www.in.gov/medicaid/providers/provider-enrollment/

Is this individual practitioner showing linked to this location?

If yes, Is the effective date on the rendering tab on or after the date of service?

If no, please follow this link to enroll the practitioner:
https://www.in.gov/medicaid/providers/provider-enrollment/

Are you billing the correct NPI and/or taxonomy of the group in box 33?

Top Medical Claim Denials

Claim Denied For No Prior Authorization (PA)

Do you have an approved prior authorization on file?

No: Services that require authorization cannot be reimbursed without Prior Authorization or Retro Authorization.

Medicaid: Review the CareSource Medicaid Provider Manual page 111 on printed version or page 115 on the online version for timeline for retroactive submission timelines.

Claim Denied For No Prior Authorization (PA) Continued

Do you have an approved prior authorization on file?

Yes: Review following scenarios.

Was the prior authorization requested using the correct rendering provider?

- Confirm rendering provider on claim matches authorization on file.
- If rendering provider changed after authorization was requested the PA will need to be updated. Authorization should be updated prior to services.
- If the provider changed on the date of service, post audit review can be completed within 30 calendar days of date of service.

Does the procedure code listed on the claim match the PA request?

No: Review to see if the PA can be updated.

Medicaid: Review the CareSource Medicaid Provider Manual page 111 on printed version or page 115 on the online version for timeline for retroactive submission timelines.

Yes: Follow the dispute and appeal process.

MEDICAID RETRO AUTHORIZATIONS GUIDELINES

Upon written request, CareSource shall not permit retro authorization submission after the date of service or admission where a prior authorization was required but not obtained except in the following circumstances as outlined in the Indiana Administrative Code 405 IAC 5-3-12 (IAC) rule.

RETRO AUTHORIZATIONS

- **Prior Authorization will be given after services have begun or supplies have been delivered only under the following circumstances:**
  - Pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date when the member's caseworker entered the eligibility information
  - Mechanical or administrative delays or errors by the contractor or county office of Family and Social Services Administration (FSSA) Division of Family Resources (DFR).
  - Services rendered outside Indiana by a provider who has not yet received a provider manual.
  - Transportation services to or from an out-of-state area or rendered by a provider located out of state or by an airline or air ambulance. The prior authorization request must be submitted within twelve (12) months of the date of service.

MEDICAID RETRO AUTHORIZATIONS – UNAWARE OF COVERAGE

The provider was unaware that the member was eligible for services at the time services were rendered.

Prior authorization will be granted in this situation only if the following conditions are met:

- The provider's records document that the member refused or was physically unable to provide the Member ID (MID) number.
- The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
- The provider submitted the request for prior authorization within sixty (60) calendar days of the date Medicaid eligibility was discovered.

Behavioral Health Claim Denied For No Prior Authorization (PA)

Was the denial related to a Substance Use Disorder (SUD) Rehabilitation Treatment Center (RTC) denial?

- **Yes: Review following scenarios.**

If the facility is providing services, then the facility's name should be the requesting provider.

If the practitioner is providing services, then the practitioner's name should be the requesting provider.

SUD Residential initial requests should be submitted for 14 calendar days, and concurrent requests should be submitted in increments of 7 calendar days

Please make sure **ALL** clinicals are submitted for each PA request.

Please make sure **ALL** American Society of Addiction (ASAM) dimensions have clinical documentation to support the boxes checked.

Claim Submission Timelines

Initial Claim Contracted Provider	90 calendar days from date of service or discharge to submit a clean claim.
Initial Claim Non-Contracted Provider (IN Medicaid)	180 calendar days from date of service or discharge to submit a clean claim.
Secondary Claims	90 calendar days from the date of the primary payer's explanation of payment (EOP) to submit a clean claim.
Corrected Claim	60 calendar days from the date of the EOP to submit a corrected claim.
Newborn	Same timely filing guidelines apply for newborns. Newborns receiving retroactive coverage are not subject to timely filing requirements.

Timely Filing

For CareSource Primary Claims: Was the claim submitted within 90 calendar days of date of service?

Review

- Was this the first claims submission or a corrected claim?
  - If corrected claim was claim was the frequency “7” submitted?
- Was the original claim number submitted?
  - Rejected and Voided claims can not be used as proof for timely filing, corrected, or disputed claims.
- Was the claim received within 90 calendar days of the original date of service if claim paid?

For CareSource Secondary Payer Claims: Was the claim submitted within 90 calendar days of date of primary payer EOP?

Review

- Was the primary payer reported on the claim?
- Was the primary payment reported on the electronic claim or copy of primary EOP included uploaded, keyed or mailed claim?
- Was this a corrected claim?

Denied Claim Clarification on Filing Limit

CareSource will not be able to pay a claim if there is incomplete, incorrect, or unclear information on the claim, as the claim will be denied or voided.

A corrected claim may be submitted for the denied claim with corrected information. For processing this is still considered an initial claim and initial claims filing limits are enforced.

Reminder: A claim that was rejected at the clearinghouse or accepted and voided when processed cannot be used as proof of timely filing

Coordination of Benefits (COB)

Review – First step is to review the member's eligibility on the CareSource Provider Portal

Does CareSource list a primary payer?

Yes: Was the claim submitted with the Primary EOP?

Is CareSource the primary payer per CareSource enrollment?

No: Was the claim submitted with the Primary EOP?

Is the primary payer listed on member's profile active?

No:

- Contact member and have them update their information with CareSource.
- Provider can submit COB update on the CareSource Provider Portal.

3 Ways to Submit Claims to CareSource

1 Electronically

- EDI transaction sent to CareSource through Availity. For list of EDI vendors who transmit to Availity EDI Gateway, click **here**.
- CareSource Payer ID **INCS1**
- Availity's Client Services
  1-800-282-4548

2 Portal

- Medical claims can be keyed on the CareSource Provider Portal.
- Medical Claim forms (CMS-1500/UB04) can be uploaded.
- Upload attachments for both keyed claims and uploaded claims forms.

3 Mail

- Ensure printing is aligned to the form and legible.
- Paper claims have the same NPI, TIN, and taxonomy code requirements as electronic claims.
- Mail claims to: **CareSource**
  Attn: Claims Department
  P.O. Box 3607
  Dayton, OH 45401

NPI – KNP Denial

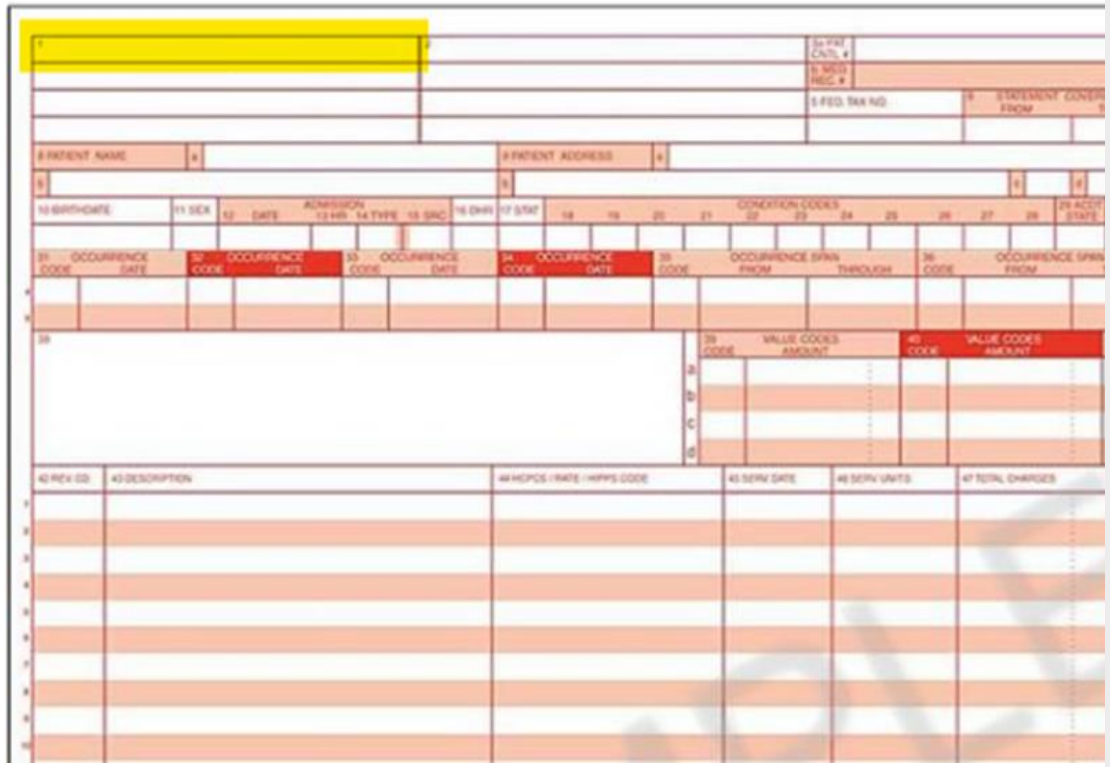
Claim goes into a 99 closed status

- Can not be disputed
- Does not count as a clean claim - Provider still has 90 calendar days from the DOS or discharge to submit a clean claim.

Per the IHCP provider portal please confirm

- The rendering provider is linked to the service location in box 33.
- The rendering provider is active and enrolled as a rendering provider.
- The group taxonomy matches Core MMIS/IHCP provider portal.

UB-04



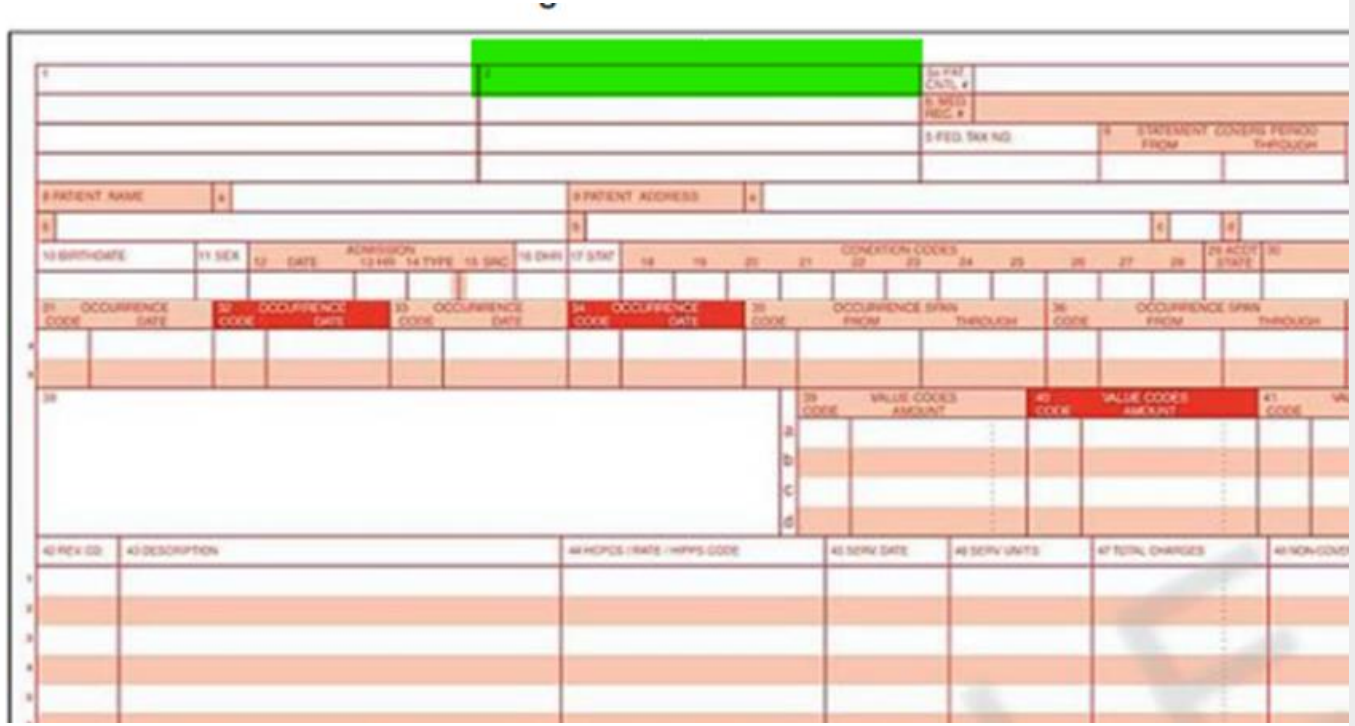
UB-04 Box 1

[SERVICE LOCATION INFORMATION] – Enter the service location name and address (including the expanded ZIP code+4) where the patient was seen (this address must match the service location address currently on file with the IHCP for the group or billing provider where the service was rendered). This is a Required field.

Reference:

Claim Submission and Processing

UB-04 – Box 2



UB-04 Box 2

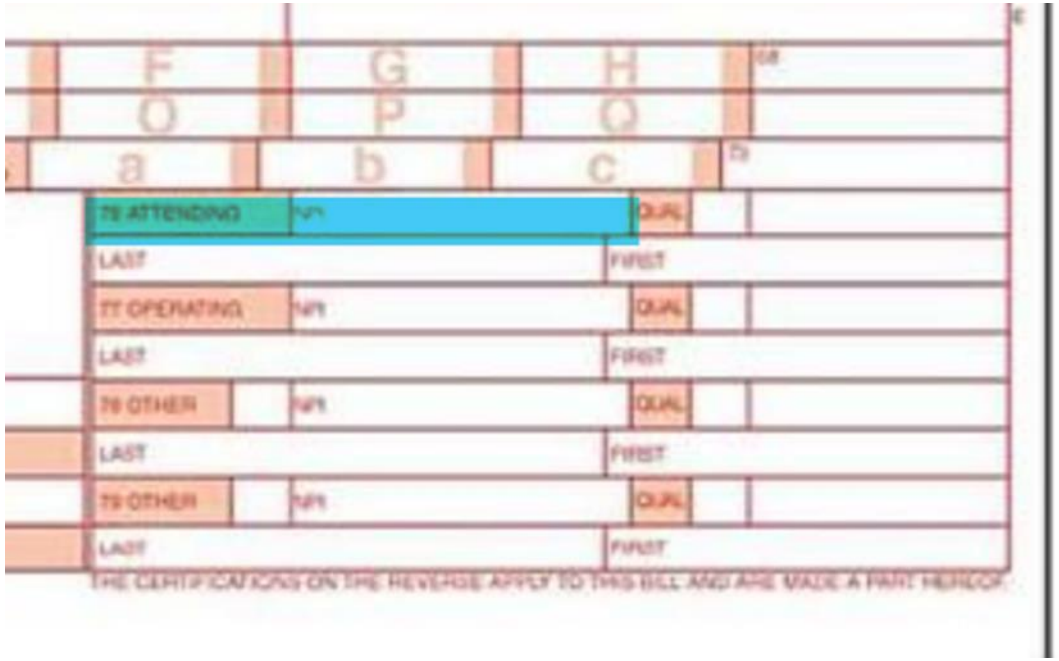
UNLABELED FIELD – Not applicable.

Reference:

Claim Submission and Processing page 30.

Medicare Claims Processing Manual Crosswalk

UB-04 – Box 76



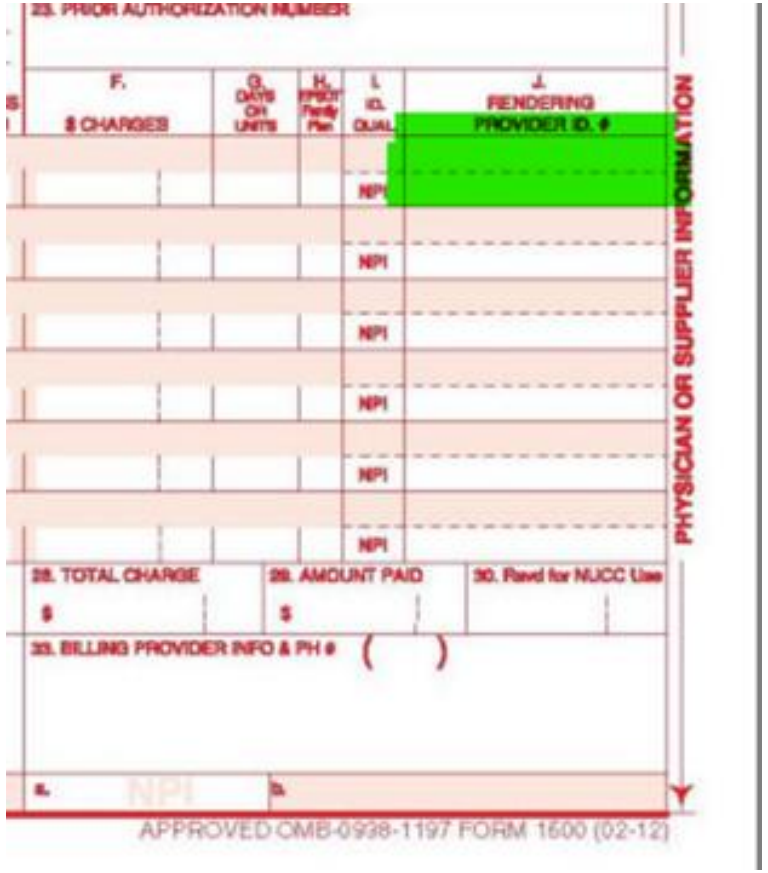
UB-04 Box 76

ATTENDING – NPI – Enter the attending physician's 10-digit numeric NPI. Do not use the NPI of a group provider. The attending provider should always be an individual person. Required for inpatient, outpatient, Ambulatory Surgery Center (ASC), and Long-Term Care (LTC)

Reference:

Claim Submission and Processing

Medicaid CMS-1500 – Box 24j



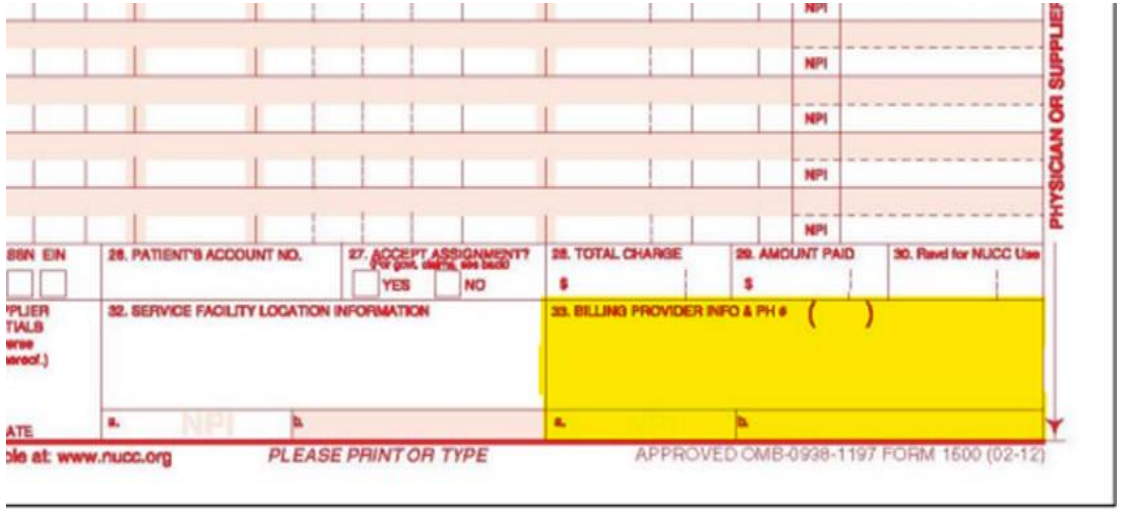
Medicare Claims Processing Manual - HCFA 1500 CMS
*IHCP Claim Submission and Processing

• RENDERING PROVIDER ID. # – Enter the IHCP Provider ID or taxonomy code of the provider that rendered the service. Required, if applicable.

• Provider ID – Atypical providers (for example, waiver providers and non-ambulance transportation providers) are required to submit their IHCP Provider ID. (If billing for case management, the case manager's Provider ID must be entered here. (Provider ID is indicated by qualifier G2 in field 24I.)

• Taxonomy – The taxonomy code includes 10 alphanumeric characters. The taxonomy code is optional unless required for a one-to-one NPI/Provider ID match. (Taxonomy is indicated by qualifier ZZ or PXC in field 24I.)

Medicaid CMS-1500 – Box 33 – 33a/b



Box 33 - BILLING PROVIDER INFO & PHONE # – Enter the service location name and address (including ZIP code+4) as listed on the provider enrollment profile for the billing provider. The address in this field should match the service location address (**not** the legal [home office], pay-to, or mail-to address) on file for the billing provider. Required. Note: The billing provider on the claim must be enrolled in the IHCP under either the billing or group enrollment classifications. If the U.S. Postal Service provides an expanded ZIP Code (ZIP code+4) for a geographic area, this expanded ZIP code must be entered on the claim form.

33a - BILLING PROVIDER – NPI – Enter the billing provider NPI. Required unless the billing provider is an atypical (nonhealthcare) provider. Atypical providers should follow instructions in 33b.

33b - BILLING PROVIDER – [QUALIFIER AND ID NUMBER] – If the billing provider is an atypical provider, enter the qualifier G2 and the billing provider's IHCP Provider ID. Required for atypical billing providers. Healthcare providers enter a qualifier of ZZ or PXC and the billing provider taxonomy code in this field. Taxonomy may be needed to establish a one-to-one NPI/Provider ID match if the provider has multiple locations. Required for healthcare providers if necessary for establishing a one-to-one match the for the NPI in filed 33a.

Claim Submission and Processing

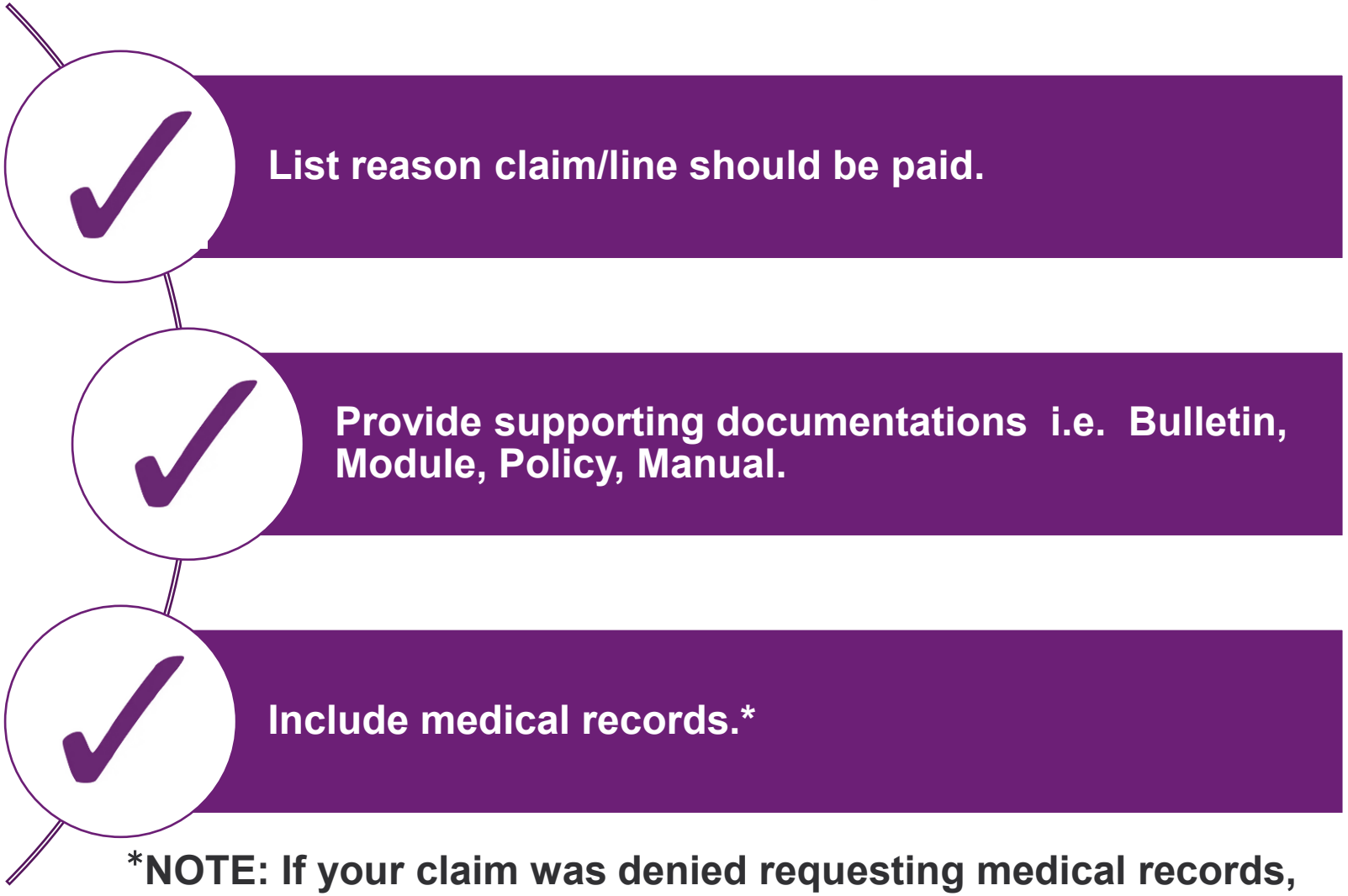
Dispute

Definition of a Claims Dispute

A dispute is the **first** formal review of the processing of a claim by CareSource (excluding denials based on medical necessity) and is submitted prior to submitting a claim appeal.

You can submit a claim payment dispute when you disagree with payment and any other post-service claim denial.

Key Information to Include with Dispute



*NOTE: If your claim was denied requesting medical records, those should be submitted via the CareSource Provider Portal.

Timeframe to Dispute

Ways to Submit a CareSource Claims Dispute

1 Portal

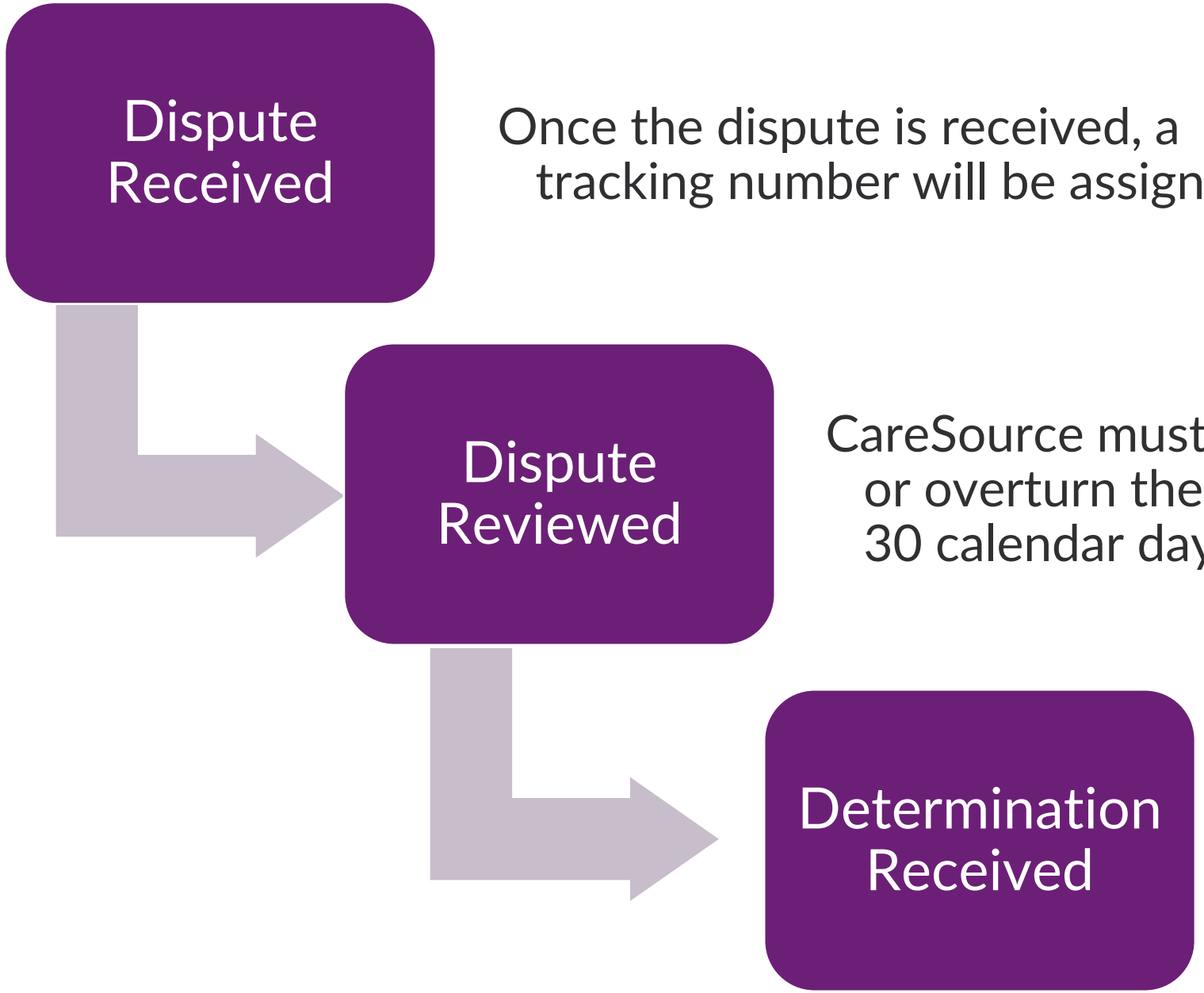
The preferred method of submission is through the CareSource Provider Portal.

2 Postal Mail

CareSource Grievance & Appeals Department
P.O. Box 2008
Dayton, OH 45401

Submit dispute form along with documentation to substantiate reason for dispute.

For questions, please call CareSource Health Partner Appeals at 1-888-880-4889, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET)


Dispute Received
Once the dispute is received, a tracking number will be assigned.
Dispute Reviewed
CareSource must either uphold or overturn the dispute within 30 calendar days.
Determination Received
The provider will receive a letter with the dispute results.

Rejected or Voided Claims

Do Not Dispute

Claims are not eligible since the claims were not received as clean claims.

Claim will need to be resubmitted, and timely filing guidelines will apply.

If the Dispute Response States, a Corrected Claim is Needed

Corrected claims should be sent through Electronic Data Interchange (EDI) or mailing a red and white claim form and the primary insurance EOP to:

CareSource Claims Department
P.O. Box 3607
Dayton, OH 45401-3607

Claim Appeals

Definition of a Claims Appeal

An appeal is the **second** formal review of the processing of a claim by CareSource (excluding denials based on medical necessity) and is typically submitted after submitting a claim dispute.

You can submit a claim payment appeal when you disagree with payment and any other post-service claim denial.

Providers must exhaust the claim dispute process as outlined above before filing a claim appeal.

Key Information for a Claims Appeal

Include the following required documentation:

• Progress notes including symptoms and their duration, physical exam findings, conservative treatment that the member has completed, preliminary procedures already completed, and the reason service is being requested.

• Any documentation of specialists' reports or evaluations, any pertinent previous diagnostic reports and therapy notes.

• If the service has already been provided, a copy of the original remittance advice and/or the denied claim.

• If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.

Timeframe to Appeal

Ways to Submit a Medicaid Claims Appeal

1 Portal

The preferred method of submission is through the CareSource Provider Portal.

2 Postal Mail

CareSource Grievance & Appeals Department
P.O. Box 2008
Dayton, OH 45401

Submit appeal form along with documentation to substantiate reason for appeal.

For questions, please call CareSource Health Partner Appeals at 1-888-880-4889, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET)

Appeal Received

Once the appeal is received, a tracking number will be assigned.

Appeal Reviewed

CareSource must either uphold or overturn the appeal within 45 calendar days.

Determination Received

The provider will receive a letter with the appeal results.

Claims NOT to Appeal

Claims that have not been disputed.

Claims must be disputed before filing an appeal.

A claim that has already been appealed.

Providers have **ONE** chance to appeal a claim.

Clinical Appeals

Definition of a Clinical Appeal

A clinical appeal is a written request by a provider to review a prior authorization denial with a clinical decision regarding medical necessity. Clinical denials are issued from the CareSource Utilization Management department.

All appeal requests and associated information are reviewed by clinicians not previously involved with the case.

Medicaid Clinical Appeal of a PA Denial

Pre-Service

- Must be submitted with written member consent.
- 48 hours from the date of action notice to submit a pre-service appeal.

Post-Service

- Must be submitted with written member consent.
- You have 60 calendar days from date on the notice of action, discharge or authorization denial.

If you have not received an authorization denial from the CareSource Utilization Management Department for a service that requires a PA, you must submit a retro-authorization request prior to filing a clinical appeal.

Expediting Appeals

If you feel that your patient's life or health is at risk if a decision about care is not made in a timely manner, you may ask us to expedite a clinical appeal.

Call us at **1-844-607-2831** or mail in an **Expedited Appeal Form** to request an expedited clinical appeal.

Notification of Resolution

CareSource will decide whether to expedite an appeal within 48 hours/two calendar days. We will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal; the attempt will be made by phone.

Expedited appeals will be resolved, and verbal notification will be made within 48 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution time frame is extended. CareSource will send written notification to both the provider and the member on the same business day of the decision.

Extending an Appeal

Members may verbally request that CareSource extend the time frame to resolve any medical necessity appeal request up to 14 calendar days. CareSource may also request an extension.

CareSource will provide a written notice for the extension.

External Review for a Clinical Appeal

The member or their authorized representative has the right to request an independent external review within **120 calendar days from the date of the appeal determination.**

The Independent Review Organization (IRO) will decide to uphold or reverse the decision within **72 hours for an expedited appeal, or 15 business days for a standard appeal.** The determination made by the independent review organization is binding.

Providers may send external review requests to:

CareSource

Attn: Independent Review – Appeals Dept.
P.O. Box 8738
Dayton, OH 45401-8738
Fax: 844-417-6262

Medicaid Arbitration

What is Arbitration?

If you are dissatisfied with the decision of the claim appeal, you may submit the matter to binding arbitration. The binding arbitration process must be conducted in accordance with the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the State of Indiana at IC-34-57-2-2.

Arbitration Process

The binding arbitration process must be conducted in accordance with the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the State of Indiana at IC-34-57-2-2 unless:

The provider and CareSource mutually agree to some other binding resolution procedure or process in the agreement between the parties; or

CareSource or the providers are subject to statutorily imposed arbitration procedures for the resolution of these claims. In that case, the statutorily imposed arbitration procedures shall be followed.

- The arbitration process may include, in a single arbitration proceeding, matters from multiple formal claim resolution procedures involving CareSource and the provider.
- The fees and expenses of arbitration or other binding resolution procedure shall be borne by the non-prevailing party

Providers can submit issues to:
CareSource Attn: Arbitration
251 N Illinois Street Suite 300
Indianapolis, IN 46204

How to Contact CareSource

Communicating with CareSource

Provider Services		
Medicaid	1-844-607-2831	Monday to Friday 8 a.m. to 8 p.m. (EST)
Member Services		
Medicaid	1-844-607-2829	Monday to Friday 8 a.m. to 8 p.m. (EST)

Health Partner Engagement Representatives – Regional Specialist

Tammy Garrett
219-221-7065
Tammy.Garrett@CareSource.com
Franciscan Alliance, Fresenius (Statewide)

Amy Dagon
317-417-9652
Amy.Dagon@CareSource.com
Community Health Network, Union Hospital, American Health Network

Paula Egan
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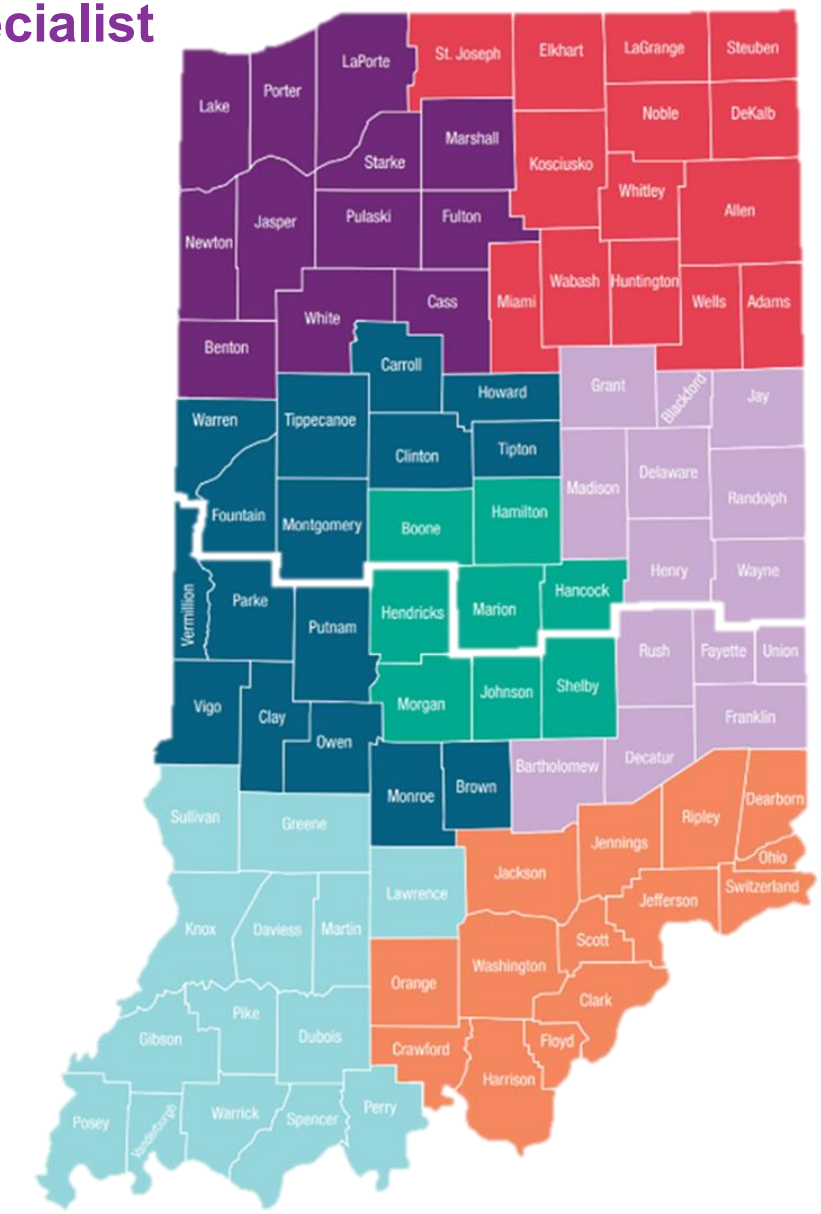
Paula.Egan@CareSource.com
Deaconess, Ascension – St. Vincent Health



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Indiana University, Suburban Health Organization

Bonnie Waelde
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Bonnie.Waelde@CareSource.com
University of Louisville, Norton, Baptist Health Floyd, ATI Physical Therapy (Statewide)

Contact Us | Indiana – Medicaid | CareSource

Health Partner Engagement Representatives – **Behavioral Health**

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765-620-6722
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Stephanie Gates, Behavioral Health
Resolution Specialist (Southern Territory)
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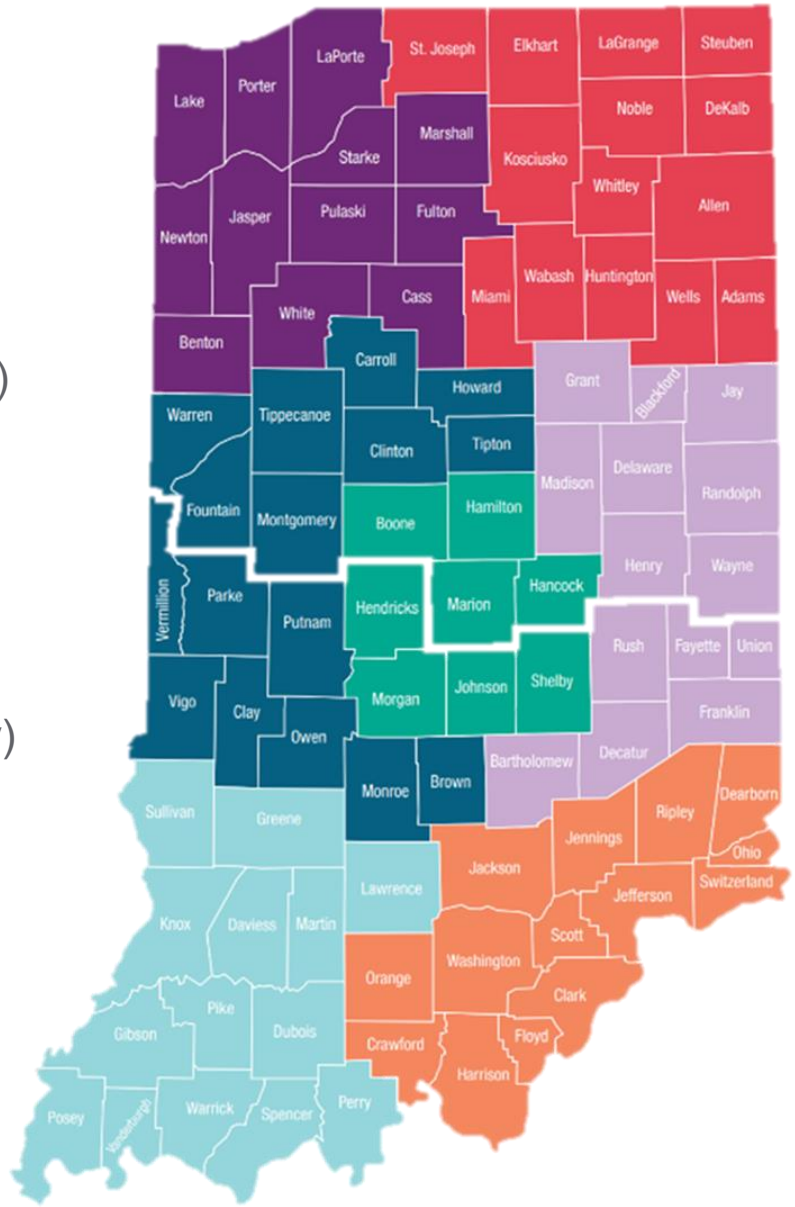
Stephanie.Gates@CareSource.com



Contracting Managers – **Hospitals/Large Health Systems**

Maria Crawford (Northern Territory)
317-416-6854
Maria.Crawford@CareSource.com

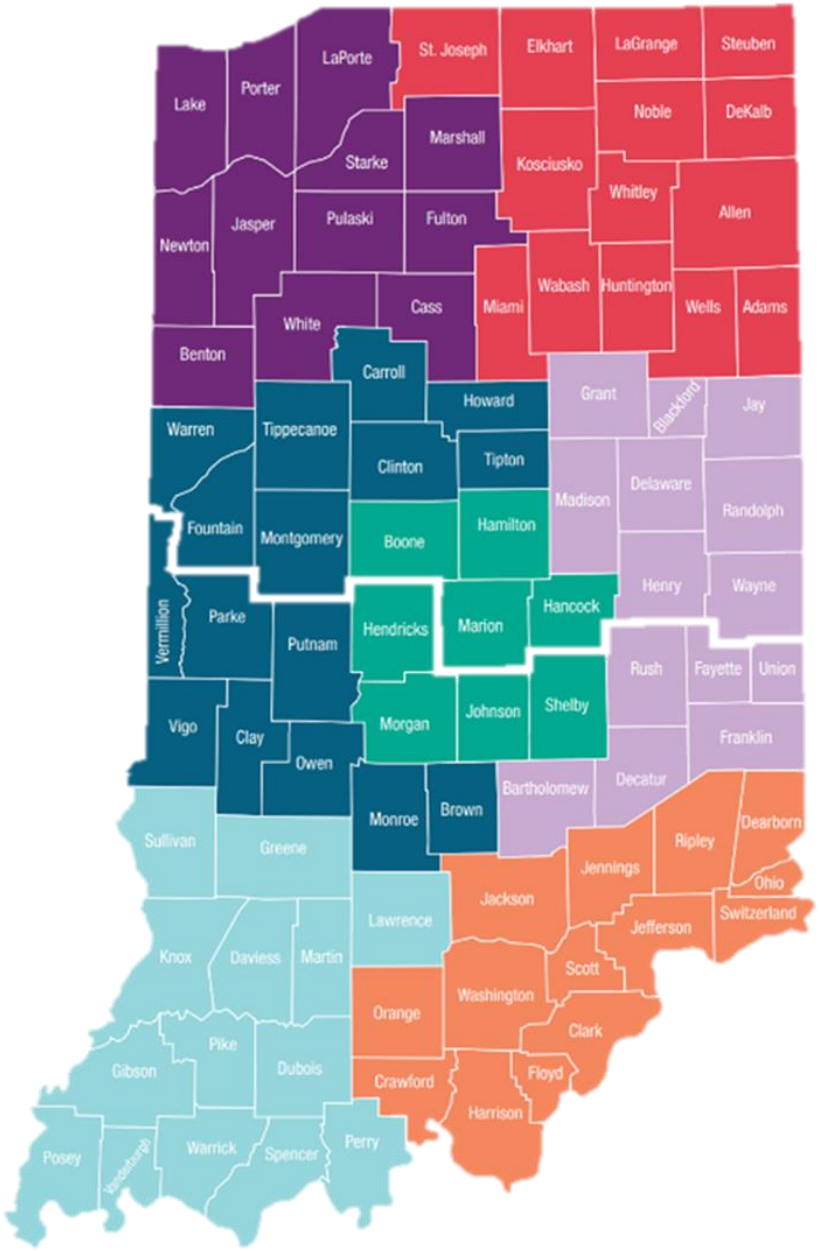
Sara Culley (Southern Territory)
765-256-0423
Sara.Culley@CareSource.com

Contact Us | Indiana – Medicaid | CareSource

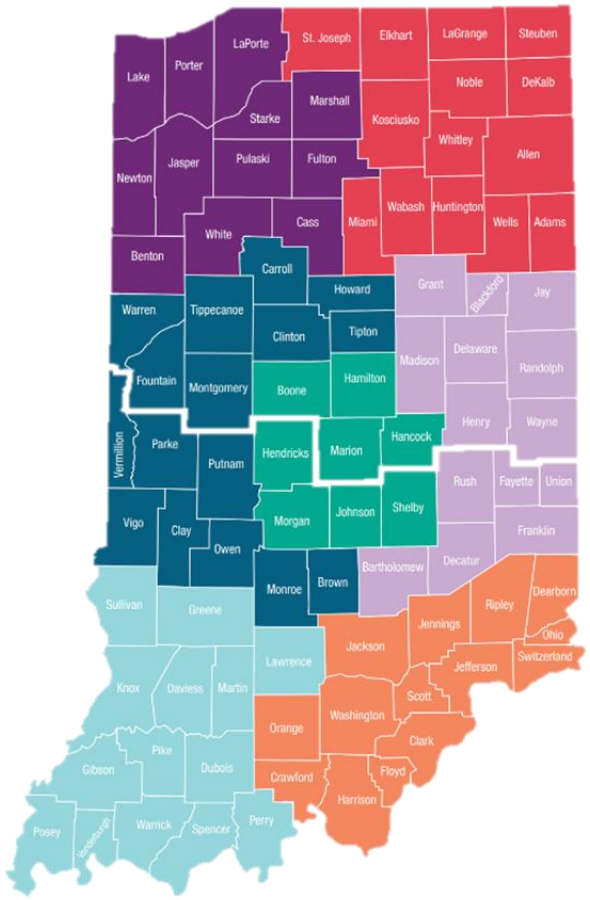
Health Partner Engagement Representatives – **Manager**

Amy Williams
Manager Health Partnerships
317-741-3347
Amy.Williams@CareSource.com

Contact Us | Indiana – Medicaid | CareSource



SCAN FOR A COPY OF THE HP ENGAGEMENT SPECIALIST MAP



SCAN ME

CARESOURCE.COM

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.

gainwell

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