



Indiana | Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan,
Hoosier Care Connect, and Indiana PathWays for
Aging

Top Denials and How a Few Quick Tips Can Improve Your Accounts Receivable

IHCP Works Annual Seminar
Fall 2026

Agenda

- Review Top Five Denials:
 - Billing NPI not registered with the state.
 - Submitted after plan filing limit.
 - Deny pre-auth not obtained.
 - PEGA — Explanation of Benefits (EOB) required from primary carrier.
 - Duplicates.
- Discuss Prevention and Resolution
- Resources



Anthem Medicaid Top Five Provider Denials

1. Billing National Provider Identifier (NPI) not registered with the state (\$196k) or Rendering NPI not affiliated with billing (\$145k).
2. Submitted after plan filing limit (\$182k).
3. Deny pre-auth not obtained (\$99k).
4. PEGA —Explanation of Benefits (EOB) required from primary carrier (\$95k).
5. Duplicate claim (\$68k).

Data is based on claims processed from January through July 2026

Denial #1

Billing NPI Not Registered with the State

Denial: NPI Not Registered or Rendering Not Affiliated with Billing

- NPIs should be used with the following guidelines:
 - Claims must be filed with the appropriate NPI for billing, rendering, ordering, referring, attending, and operating providers.
 - Provider is enrolled with the Indiana Health Coverage Program (IHCP) in the same manner as contracted with Anthem, including effective dates for individual providers within groups:
 - Claims will be denied when the NPI listed is not the same number attested with IHCP.
 - To be reimbursed for services, all providers must be enrolled with the IHCP:
 - If the NPI submitted on the claim does not match the state provider enrollment records, the claim will be denied for provider not attested.

Resolution: NPI

- Providers will receive a unique Legacy Provider Identifier (LPI) for each service location at which they see members and each provider type enrolled
- Insurance plans must be able to make a 1:1 match from the billing provider NPI and an Indiana Medicaid Provider ID
- If the NPI crosswalks to more than an Indiana Medicaid Provider ID, the billing taxonomy code and/or billing provider ZIP code may be used as a tiebreaker
 - If more than one LPI shares the same NPI, taxonomy, and ZIP code, a match cannot be made
 - Refer to Gainwell Provider Enrollment for assistance
 - [Indiana Medicaid: Providers: Provider Relations Consultants](#)

Resolution: NPI (Cont.)

- The billing provider service location address must be entered in box 33 of the *CMS-1500* claim form and in box 1 of the *UB-04* claim form:
 - The IHCP does not use box 32 of the *CMS-1500* for the service location for the purpose of conducting a 1:1 matching process.
 - Billing providers are encouraged to always include the billing taxonomy code that matches the taxonomy code registered with the state.
- Doing so can assist in successful matching and denial reduction for NPI validation.
- Review the provider affiliation/linkage effective and end dates using the IHCP Provider Healthcare Portal (IHCP Portal):
 - If the rendering provider is not affiliated with the location, you may submit an enrollment update via the IHCP Portal.
 - If there is a gap in the effective/end date due to a late revalidation, contact Gainwell Provider Enrollment to discuss remedies.
- Refer to the [IHCP Claims Submission and Processing provider reference module](#) for additional information.

Denial #2 Submitted After Plan Filing Limit

Denial: Timely Filing

- Claims were not filed timely according to the insurance plan:
 - Participating providers have 90 calendar days from the date of service (DOS).
 - Nonparticipating providers have 90 calendar days from the DOS.
- If Anthem is the:
 - Primary payer--providers have 90 calendar days between the last DOS on the claim and the Anthem receipt date to submit the claim to Anthem.
 - Secondary payer—providers have 90 calendar days between the other payer's remittance advice (RA) date and the Anthem receipt date to submit the claim to Anthem.

Resolution: Timely Filing

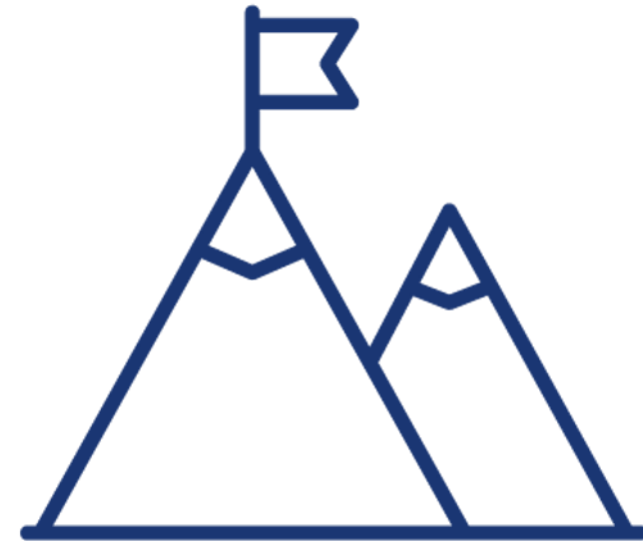
- Timely filing exceptions:
 - Originally filed incorrectly to Anthem.
 - Denied for EOB when there is no coordination of benefits.
 - Denied for no authorization, and authorization is now loaded or no longer required.
 - Denied after the filing limit, but the member becomes retroactively eligible.
 - Other conditions established by FSSA in rule or policy.

Resolution: Timely Filing (Cont.)

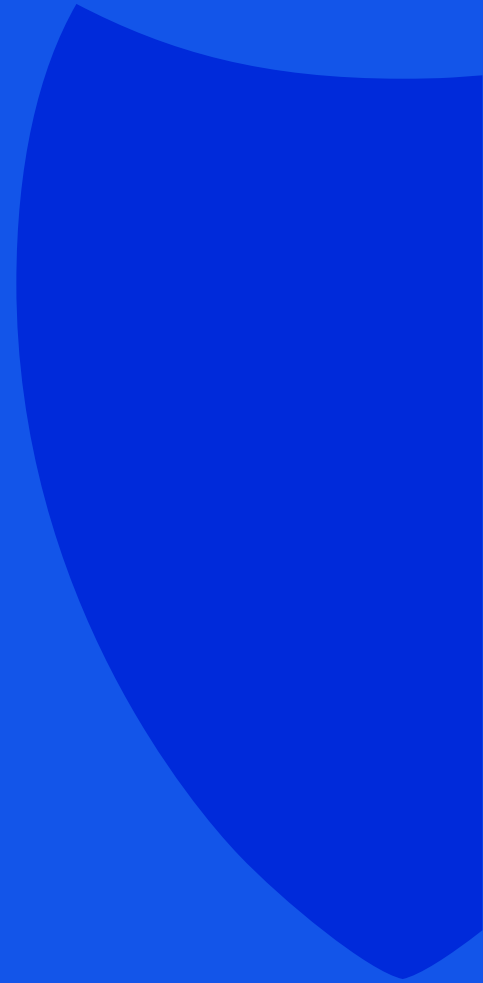
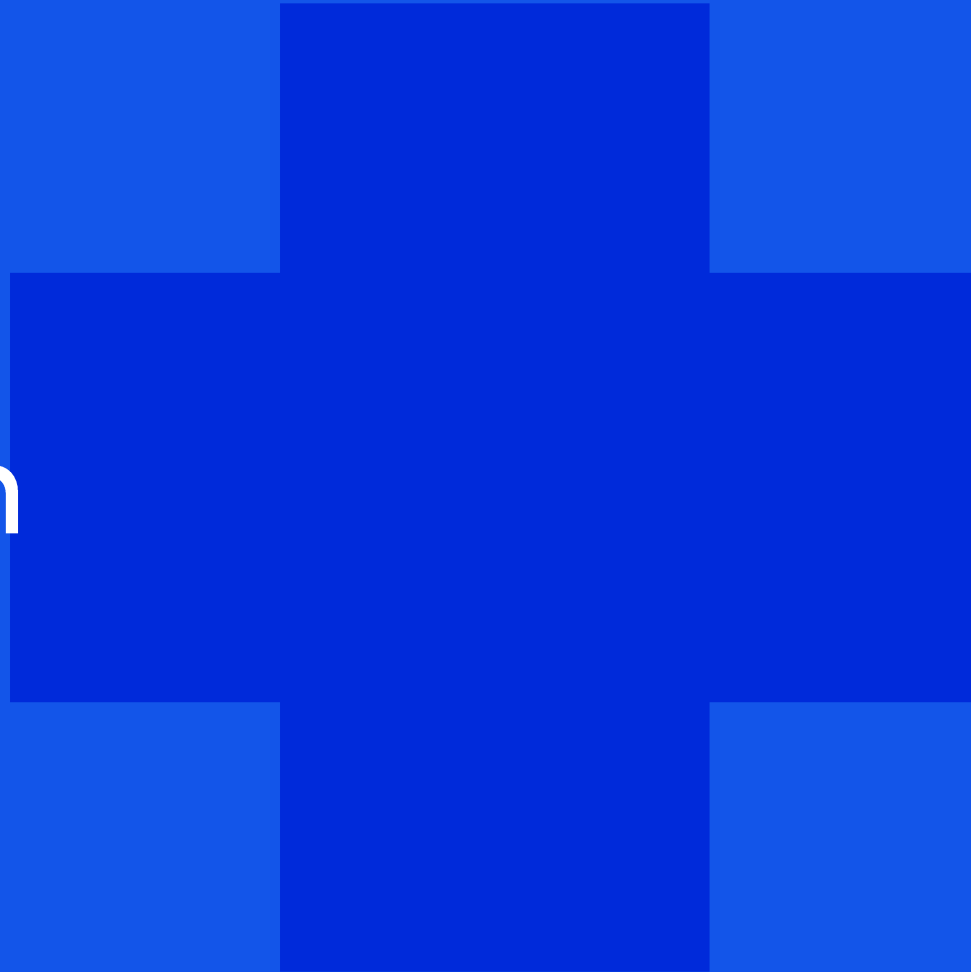
- Claims filed with the wrong plan:
 - If you file a claim with the wrong insurance carrier, Anthem will process your claim without denying it for failure to file within the timely filing limits if:
 - There is documentation verifying that the claim was initially filed in a timely manner.
 - The corrected claim was filed within 90 calendar days of the date of the other carrier's denial letter or RA.
 - The claim was paid by the wrong insurance company, and payment is later recouped.

Resolution: Timely Filing Resubmission Options

- Anthem will review reimbursement of a claim that has been denied for timely filing if the provider can:
 - Provide documentation that the claim was submitted timely.
 - Demonstrate good cause exists.



Denial #3
Deny Pre-Auth
Not Obtained



Denial: Pre-Authorization Not Obtained

- The authorization number is missing.
- The approved services do not match the services described in the claim.

Resolution: Pre-Authorization Not Obtained

- Confirm the correct authorization number is provided on the claim form:
 - Box 24 on a *CMS-1500*.
 - Box 63 on a *UB-04*.
- Confirm the approved services match the provided services.
- Contact Utilization Management (number on back of ID card) to revise the service for authorization if changes occur.
- Use the [Precertification Lookup Tool](#) to determine which codes require authorization.

Denial #4 PEGA — EOB Required from Primary Carrier

Denial: EOB Required from Primary Carrier

- Anthem Medicaid is the payer of last resort.
- We coordinate Anthem's Medicaid benefits with any other healthcare program that covers our members, including Medicare.
- Paper Coordination of Benefits (COB) claims will be mailed back with a request to submit to the other payer first.
- Electronic COB claims will be denied with a code indicating the need for more materials.

Resolution: EOB Required from Primary Carrier Resolution

- If there is a need to coordinate benefits, include at least one of the following items from the other healthcare program:
 - Third-Party RA or Explanation of Payment (EOP).
 - Third-party letter explaining either the denial of coverage or reimbursement.
- Ensure the information submitted explains all coding listed on the other carrier's RA/EOP or letter:
 - Anthem cannot process the claim without this specific information.
 - Anthem must receive COB claims within 90 calendar days from the date on the other program's RA/EOP or letter of denial of coverage.

Denial #5 Duplicates



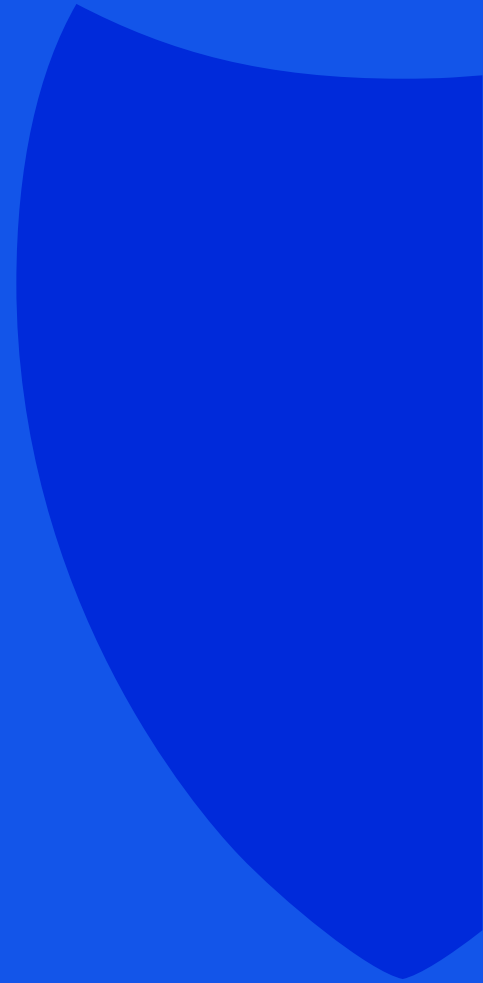
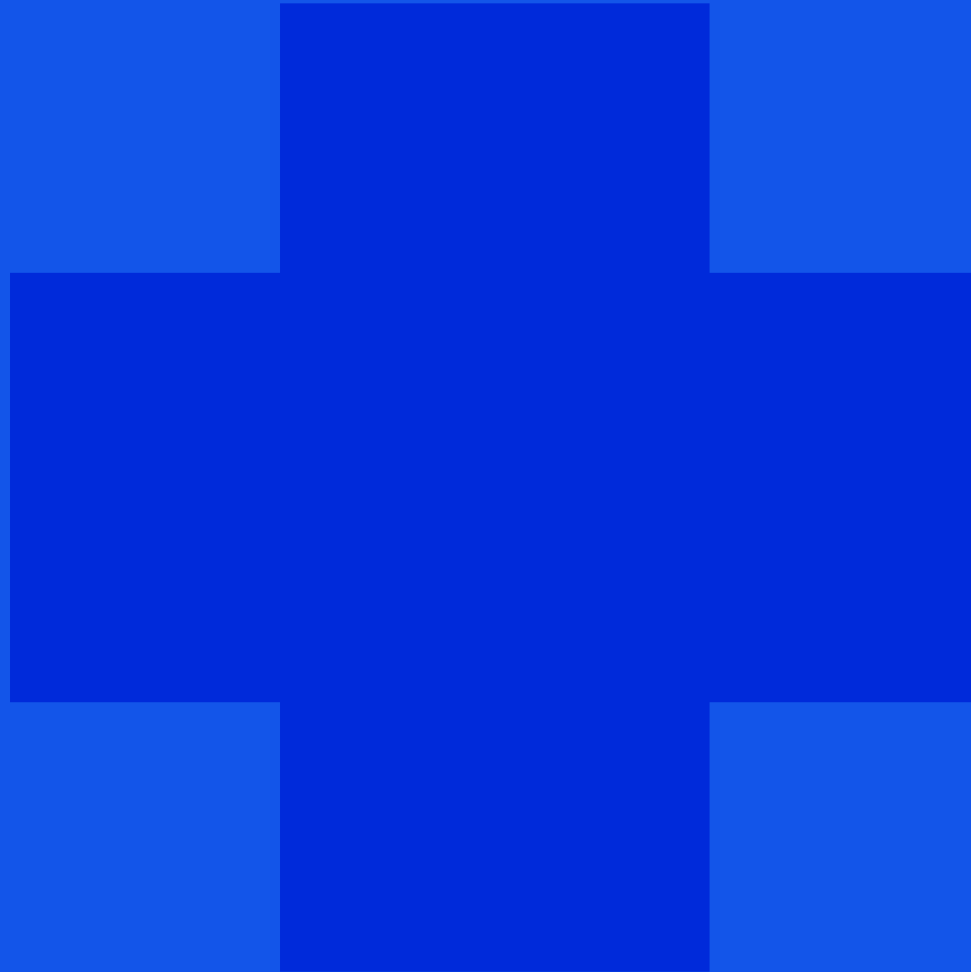
Denial: Duplicate Claims

- Overlapping service dates for the same service.
- Claim submitted to Anthem twice without additional information for consideration.
- Corrected claims that are not submitted appropriately.

Resolution: Duplicate Claims

- List each date of service, line by line, on the claim form:
 - Avoid spanning dates, except for inpatient billing.
- Make sure to read the Remittance Advice and Claim Determination Notice (CDN) for important claim determination information before resubmitting a claim as additional information may be needed:
 - The CDN may be located on the IHCP portal or the specific Managed Care Organization (MCO) portal.
- A corrected claim needs to be clearly marked *Corrected*. Also include the original claim number so that it doesn't get processed as a duplicate.

Processes to Resolve Claim Issues



How to Resolve Claim Issues

Issue	Action
Provider disagrees with a full or partial claim denial	Submit claims dispute A complete Provider Dispute Resolution Request form must be received by Anthem within 60 calendar days from the date on the EOB. Multiple claims for the same situation can be submitted on one form via mail or Availity Essentials (available 24/7). Anthem Blue Cross and Blue Shield Provider Disputes and Appeals P.O. Box 61599 Virginia Beach, VA 23466 Use the secure Provider Availity Payment Appeal Tool at https://Availity.com. Through Availity Essentials, you can upload supporting documentation and will receive immediate acknowledgment of your submission. It is the responsibility of the provider to check EOBs and submit claim disputes timely.

How to Resolve Claim Issues (Cont.)

Issue	Action
Provider disagrees with claims dispute response	Submit claims appeal This is the 2nd step after a claim dispute and is considered a formal appeal. An appeal request must be received by Anthem within 60 calendar days from the date on the claims dispute response. Send to: Anthem Blue Cross and Blue Shield Provider Disputes and Appeals P.O. Box 61599 Virginia Beach, VA 23466
Follow-up on claim dispute or claims appeal	Log in to Availity Essentials at https://Availity.com > select Indiana as state > Payer Spaces > Anthem > chat with Payer or contact Anthem by calling provider services (Hours of operation: 8 a.m.–8 p.m. Eastern time). • Hoosier Healthwise: 866-408-6132 • Healthy Indiana Plan: 844-533-1995 • Hoosier Care Connect: 844-284-1798 • Indiana PathWays for Aging: 833-569-4739 Allow 60 calendar days for adjustments but follow-up before 90 calendar days. All follow-ups to previous actions or interactions must be within 90 calendar days.

Resources



Resource Links

- [Anthem Indiana Medicaid Provider Manual](#)
- [Indiana Provider | State & Federal Programs | Anthem](#)
- [IHCP Provider Reference Module, Claim Submission and Processing](#)



Thank you

We'd like to know how this presentation helped you and if there is any additional information or clarification we could offer.

Please take a moment to complete the survey by scanning the QR code or following [this link](#).





Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative. Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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