



Common Denials and How to Resolve Them

2026 IHCP Works Annual Seminar



Agenda

- Common Claim Denials
- Timely Claim Denials
- Coordination of Benefit Denials
- Prior Authorization Denials
- Invalid or Missing Clinical Laboratory Improvement Amendments (CLIA)
- T1015 Denials
- Member Eligibility Denials
- How to Submit Claim Corrections
- How to Resolve Claim Denials
- MHS Provider Engagement Team
- Questions

Common Claim Denials



Frequent Claim Denials

- Time limit for filing has expired (EX29)
- Bill Primary Insurer 1st (EXL6)
- Authorization not on file (EXA1)
- Invalid or missing modifier (EXIM or EX86)
- Invalid or missing Clinical Laboratory Improvement Amendments (CLIA) (EXN5)
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) claim billed without T-code encounter
- Member not eligible

Timely Claim Denials



Time limit for filing has expired (EX29)

For contracted providers, all claims must be submitted within 90 calendar days of the date of service

Claims with primary insurance must be received within 365 days of the date of service with primary EOB information

Claims for non-contracted providers must be submitted within 90 calendar days of the date of service.

Coordination of Benefit Denials



Primary Insurance (EXL6)

- A Third-Party Liability (TPL) is a source of payment for medical services other than the Indiana Health Coverage Programs (IHCP) benefit package and the member
- Federal and state law requires Medicaid be the payer of last resort
- MHS makes every attempt to obtain TPL data in order to process claims accordingly
- Providers are expected to collect accurate and current insurance information at the time of service

Prior Authorization Denials



Authorization Denials (EXA1)

- A prior authorization (PA) is approval from MHS to provide designated services *prior* to treatment
- All procedures requiring authorization must be obtained by contacting MHS *prior* to rendering services
- PA is required for certain services or procedures as outlined on the Medicaid Pre-Auth.
- PA is required for all out of network providers as of 11/1/25. Exceptions include emergency and urgent care services
- PA is not a guarantee of payment as normal claims processing criteria is applicable

Invalid or Missing Clinical Laboratory Improvement Amendments (CLIA)



Invalid or Missing CLIA (EXN5)

A CLIA number is a unique 10-digit identification number assigned to a certified laboratory

CLIA confirms the labs certification status and links the performed test to an approved facility

Submit a corrected claim with appropriate CLIA number

T1015 Denials



FQHC/RHC Claims billed without T1015 Encounter

- The T1015 code is required for FQHC/RHC Medicaid billing to identify a qualifying, all - inclusive encounter, ensuring proper reimbursement under the Prospective Payment System (PPS) and supporting quality of care tracking
- If needed, submit a corrected claim with appropriate T-code encounter
- Crossover claims do not require T1015

Member Eligibility Denials



Member Not Eligible

Providers are responsible
for verifying member
eligibility for each visit

Mismatched member
information should be
verified on the IHCP
Provider Healthcare Portal
prior to rendering services

How to Submit Claim Corrections



Claim Resubmissions

- The preferred method is via the **MHS Secure Portal**
- Hard copy resubmissions:
 - All resubmissions must include acceptable documentation
 - Such as proof of eligibility, timely filing, coordination of benefits

Providers have **60 calendar days** from the date of Explanation of Payment (EOP) to file a resubmission. *Please note, claims will not be reconsidered after this timeline.*

Submitting Corrected Claims

- *CMS-1500* should be submitted with the appropriate resubmission code (value of 7) in field 22 of the submitted claim, along with the claim number needing correction
- *UB-04* (CMS-1450) should be submitted with the appropriate resubmission code in the 4th place of the bill type (4th digit =7 for a corrected claim) in Field 4, along with the claim number in Field 64 needing correction
- If a corrected claim has already been filed for the original claim, the latest submitted claim number should be provided on the claim form

How to Resolve Claim Denials



Provider Dispute Process

- **Level 1:** Informal Claims Dispute or Objection Form
- **Level 2:** Formal Claim Dispute — Administrative Claim Appeal
- **Level 3:** Arbitration
- For assistance or questions after completing step one:
 - Provider Services Phone Requests & Web Portal Inquiries
- If additional assistance is needed anytime after Level 1 and after calling the Contact Center or completing Web Portal inquiry:
 - Contact your Provider Engagement Account Manager (PEAM) **MHS PEAM MAP**

Please note, this is different than an authorization appeal. A claim appeal cannot change denied authorization status. To change authorization status, you must appeal the denied authorization.

MHS Provider Engagement Team



Contact Information

MHS PEAM MAP



PEAM Contact Information

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
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Joy Diarra, Provider Engagement Account Manager
1-317-864-2378

NORTHWEST REGION

For claims issues, email:
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NORTH CENTRAL REGION

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CENTRAL REGION

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SOUTH CENTRAL REGION

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SOUTHWEST REGION

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SOUTHEAST REGION

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Large Provider Groups - Carolyn

CAROLYN VALACHOVIC MONROE

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PROVIDER GROUPS

Eskenazi/The Health and Hospital
Corp.
Baptist Health
Lifespring
Wellcare
Deaconess (including Little Company
of Mary)
Good Samaritan
Norton (including King's Daughters,
Clark & Scott Memorial)
Indiana University Health
Reid Hospital
St. Elizabeth Hospital
Community Health

Additional Contact Information

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Questions?

