IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202591 JUNE 26, 2025

New process developed for FFS claim inquiries, administrative reviews and appeals submitted in bulk

The Indiana Healthcare Coverage Programs (IHCP) receives claim inquiries, administrative reviews and appeals from providers and billers on paid and denied claims.

Issues such as the following are resulting in claims denying, and providers and billers submitting numerous inquiries, administrative reviews and appeals:

- No prior authorization with medical records submitted for claim review
  - ⇒ Medical records will not be clinically reviewed when submitted as an administrative review submission, and the claim denial will stand.
- Incorrect 837 claim submissions related to filing indicators
  - ⇒ Providers and billers should review IHCP companion guides prior to claim submission. The correct filing indicators must be used in 837 transactions. The companion guides can be accessed from the *IHCP Companion Guides* webpage at in.gov/medicaid/providers.

Because there have been so many bulk submissions, Gainwell Technologies has developed a process for handling fee-for-service (FFS) claim inquiries, administrative reviews and appeals.

New bulk submission process

Bulk submissions are 30 or more submissions by the same provider or biller on the same date. Written correspondence and secure correspondence, including inquiries, administrative reviews and appeals, are considered when identifying a bulk submission.

Effective immediately, inquiries, administrative reviews and appeals submitted in bulk will be responded to in total. The first claim in the batch will receive a response and subsequent submissions will refer to the response in the initial claim.

Upon identification of a bulk submission, a Provider Relations consultant will reach out to the provider or biller to complete education on the inquiry, administrative review and appeal process. This outreach will occur in three steps:

- Email
- Phone outreach
- In-person visit/meeting

If contact cannot be made with the provider or biller, the provider/biller information will be submitted to the Office of Medicaid Policy and Planning (OMPP) for review.

Reminders

Providers and billers should follow the steps outlined in the *Claim Administrative Review and Appeals* provider reference module prior to submission. *IHCP Bulletin* *BT202590* also provides reminders of the steps in submitting administrative review and appeal requests.

Providers are reminded that they are required to maintain a written contract with all subcontractors, which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to ensure that all activities under the contract are carried out.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

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