

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS

BT2026175

OCTOBER 22, 2026

IHCP reminds providers about FFS nonpharmacy claim appeals

The Indiana Health Coverage Programs (IHCP) is issuing this bulletin to address common issues identified as part of the fee-for-service (FFS) nonpharmacy administrative review and appeals process.

Timely submission requirements

Timely submission requirements for administrative reviews and appeals include:

- **Administrative reviews:** Must be submitted within **60 days** of the adverse claim action shown on the remittance advice (RA).
 - ⇒ Administrative reviews submitted after 60 days will be **denied**, and the original claim decision will stand (**upheld**).
 - ⇒ If the administrative review is received more than 60 days after the RA and therefore upheld, a substantiated reason for the submission delay must be included in the appeal submission if the provider chooses to pursue that option.
- **Appeals:** Must be filed within **15 calendar days** of the adverse administrative review decision.
 - ⇒ Appeals submitted after 15 calendar days also require a **substantiated reason for the delay**.



Hearing attendance

The IHCP has observed that providers frequently miss scheduled hearings for nonpharmacy claim appeals, often because they were unaware a claim had been appealed.

Billers must notify their provider agency when an appeal is filed.

The following are results of missed scheduled hearings:

- Missing a hearing typically results in the **appeal being dismissed**.
- Failure to attend also increases administrative burden and causes delays for other scheduled hearings.

Failure to respond to provider outreach

Before an appeal is sent to the administrative law judge, the IHCP conducts a thorough review. During this review, the IHCP consults subject matter experts (SMEs) and addresses any system configuration issues that may have caused the claim denial. In many cases, the IHCP identifies simple billing errors, clarifies unique claim circumstances, requests submission of a paper claim or provides education related to the denial.

These solutions often require follow-up communication with the provider representative who submitted the appeal. However, many of these outreach attempts go unanswered.

The IHCP asks providers to ensure their billing representatives understand that responding to this outreach is a critical part of the appeal process. Timely cooperation can resolve issues before a hearing becomes necessary, reducing the overall backlog and preventing delays for other appeals.

Other common issues

Claims are often denied because required prior authorization (PA) is missing or the authorized units have been exceeded.

When submitting an administrative review or appeal for a claim denied due to lack of PA or overuse of authorized units, **medical records are not sufficient** to overturn the denial. Providers must obtain authorization through the IHCP FFS PA contractor, Acentra Health. If the initial request for authorization is denied, providers must follow the PA administrative review and appeals process.

For more information

More information on how to request PA is available on the [Prior Authorization](#) webpage at in.gov/medicaid/providers.

For complete information on claim administrative reviews and appeals, providers should consult the [Claim Administrative Review and Appeals](#) provider reference module at in.gov/medicaid/providers.

QUESTIONS

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

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from the [IHCP Bulletins](#) page of the IHCP provider website at in.gov/medicaid/providers.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the [IHCP provider website](#) at in.gov/medicaid/providers.

