INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Claim Administrative Review and Appeals

LIBRARY REFERENCE NUMBER: PROMOD00013
PUBLISHED: MARCH 21, 2017
POLICIES AND PROCEDURES AS OF AUGUST 1, 2016
(*Core*MMIS UPDATES AS OF FEBRUARY 13, 2017)
VERSION: 1.2

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 Published: December 13, 2016	Semiannual update: • Reorganized or edited text throughout for clarity • Removed outdated information related to the *Care Select* program • Updated the mailing address in the *Filing an Administrative Review Request* section	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: March 21, 2017	• Added carved-out service examples and MCE contact information in the *Administrative Review and Appeals for Managed Care Claims* section • Changed Customer Assistance telephone number • Added Provider Healthcare Portal instructions throughout the module	FSSA and HPE

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Claim Administrative Review and Appeals

Claim Reconsideration Policy

If a provider disagrees with the Indiana Health Coverage Programs (IHCP) determination of payment, the provider's right of recourse is to file an administrative review and appeal, as provided for in *Indiana Administrative Code 405 IAC 1-1-3.*

Administrative Review and Appeals for Managed Care Claims

Administrative reviews and appeals related to claims for members enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise are the responsibility of the managed care entity (MCE) in which the member was enrolled at the time of service. Administrative reviews and appeals related to claims for services carved-out of managed care, such as home and community-based services and Medicaid Rehabilitation Option (MRO) services, follow the fee-for-service guidelines specified in this document.

Each MCE that participates in an IHCP managed care program is required to have a formal procedure for providers requesting reconsideration of claim determinations made by the MCE. For specific information related to the MCE process, contact the individual MCE directly. MCE contact information is available from the *IHCP Quick Reference Guide* at indianamedicaid.com.

Administrative Review and Appeals for Fee-for-Service Claims

All provider claims for payment of services rendered as fee-for-service to IHCP members must be originally filed with Hewlett Packard Enterprise within 12 months of the date of service. The following guidelines apply to administrative review and appeals related to fee-for-service claims.

Steps Taken Prior to the Administrative Review Process

The provider must exhaust routine measures to obtain payment before filing an administrative review request.

For Claim Denials

Upon receipt of a claim denial, the provider must do the following:

1. Review the claim and the denial reason code(s).
2. If the provider cannot determine why the claim denied, the provider may contact Customer Assistance at 1-800-457-4584 or submit a written inquiry to Hewlett Packard Enterprise using the *IHCP Written Inquiry* form (available on the *Forms* page at indianamedicaid.com) or a secure correspondence message (using the Claim Inquiry category) through the Provider Healthcare Portal at indianamedicaid.com.
3. If the claim denial is due to a provider's incorrect or inaccurate claim information, the provider should make applicable corrections and resubmit the claim via routine claim-processing channels.
   - For adjudication purposes, a denied claim that is resubmitted with corrected information is considered to be an initial claim and, as such, is subject to the one-year timely filing limit.
   - For adjudication purposes, a denied claim resubmitted without corrected information is considered to be a duplicate claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the one-year timely filing limit and will not be accepted as "reasonable and continuous attempts to resolve a claim problem" for consideration in waiving or extending the timely filing limit.

4. After the provider has made reasonable attempts to correct a claim, if the provider remains dissatisfied with the claim denial, the provider may submit a written request for an administrative review stating why the provider disagrees with the denial. See the *Filing an Administrative Review Request* section of this document.

For Paid Claims

If a claim is filed timely and is paid, including claims partially paid or paid at zero, and the provider disagrees with the reimbursement, the provider should:

1. Review the claim and the Remittance Advice (RA) information.

   If the provider cannot determine the reason for the payment discrepancy, the provider may contact Customer Assistance at 1-800-457-4584 or submit a written inquiry to Hewlett Packard Enterprise using the *IHCP Written Inquiry* form or a secure correspondence message (using the Claim Inquiry category) through the Provider Healthcare Portal.
2. If the claim was paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider should submit a claim adjustment or void/replacement. The claim adjustment or void/replacement must be filed within 60 days of notification of the claim's disposition. Notification is considered to be the date on the RA. See the *Claim Adjustments* module for details.
3. After the provider has made reasonable attempts to correct or adjust a claim, if the provider remains dissatisfied with the reimbursement, the provider may submit a written request for administrative review stating why the provider disagrees with the claim payment amount. See the *Filing an Administrative Review Request* section of this document.

For Claims with NCCI Edits

Providers that have questions about a National Correct Coding Initiative (NCCI) edit should exhaust routine measures of inquiry using resources listed in the *Introduction to the IHCP* module. Providers are further encouraged to access *The National Correct Coding Initiative in Medicaid* page at medicaid.gov to review the NCCI procedure-to-procedure (PTP) edit and Medically Unlikely Edit (MUE) files. These files contain specific code pairs for the PTP edits. For more information about NCCI, see the *National Correct Coding Initiative* module.

If the provider still believes that a claim was coded correctly and would like reconsideration, the provider should follow the process described in the *Filing an Administrative Review Request* section of this document.

Filing an Administrative Review Request

For reconsideration of an adjudicated claim, providers must file a written request for an administrative review of the claim, as follows:

1. Write the request, including the reason for disagreement with the denial or the amount of reimbursement, using one of the following methods:
   - Create a secure correspondence message on the Provider Healthcare Portal, using the Administrative Review Request category.
   - Complete an *IHCP Administrative Review Request* form, available on the *Forms* page at indianamedicaid.com.
   - Write a letter on letterhead stating the reason for disagreement with the denial or the amount of reimbursement and clearly note **Administrative Review** on the face of the letter.

> *Note: If the formal administrative review request is specific to the National Correct Coding Initiative, write **NCCI** at the beginning of the secure correspondence message or on the face of the letter; if submitting the IHCP Administrative Review Request form, select "Request review of NCCI denial" as the reason for the administrative review request.*

2. Include all pertinent documentation supporting reconsideration with the secure correspondence, form, or letter.
   - Document the unusual circumstances in which the provider believes the claim was coded correctly and would like a reconsideration of the NCCI editing.
   - Document the reason for disagreement.
   - Document the denial reason and the reason the payment is being disputed.
3. File the formal administrative review request within 60 calendar days of notification of claim payment or denial from Hewlett Packard Enterprise. The date of notification is considered to be the date on the RA.

   Submit the request and any supporting documentation via the Provider Healthcare Portal or by mail to the following address:

   Administrative Review Requests
   HPE Written Correspondence
   P.O. Box 7263
   Indianapolis, IN 46207-7263

> *Note: For providers on prepayment review, see the Provider and Member Utilization Review module for administrative review and appeal procedures.*

Administrative Review Responses

Providers will receive a written confirmation of receipt of their request for administrative review within 10 business days. Hewlett Packard Enterprise will respond to all administrative review requests within 90 business days of receipt of the request, regardless of the decision to pay or deny the claim. Each denial decision is specific, detailed, and fully documented. If the administrative review response is unfavorable to the provider, the provider may file an appeal.

Appeals

A provider must exhaust the formal administrative review process, as described in the preceding section, before filing an appeal. The provider must comply with all requests to submit information or additional documentation and must receive a final written administrative review decision. If all the procedures required for administrative review have been exhausted and the provider is still not satisfied with the determination, the provider can send a request for appeal under the provisions of *405 IAC 1-1.5*.

The appeal request should include all pertinent facts, proof of actions taken to resolve the payment or denial, and any associated documentation. The IHCP must receive the appeal request within 15 business days after the provider receives the adverse administrative review decision notice on which the appeal is premised. The appeal request must be submitted as a Provider Healthcare Portal secure correspondence message (using the Appeal category) or delivered by mail to the following address:

MS07
Secretary
Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204-2739

If a provider elects to appeal, the provider must also file a statement of issues within 45 days of the date of the adverse administrative review determination. The statement of issues should be sent to the same address as the appeal request and should conform to *405 IAC 1-1.5-2(d)* and *Indiana Code IC 4-21.5-3*. Appeal proceedings will be conducted by a Family and Social Services Administration (FSSA)-appointed administrative law judge.

An administrative law judge's adverse decision can be appealed by filing objections with the ultimate authority for the agency within 15 business days of receipt of the decision. An appellant can file a petition for judicial review in accordance with *IC 4-21.5-5*, if the appellant is not satisfied with the agency review decision.

Note:	*For information about Surveillance and Utilization Review audit appeals, see the Provider and Member Utilization Review module. For information about appeals of prior authorization decisions, see the Prior Authorization module.*