Provider Enrollment
## Revision History

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Provider Enrollment

Introduction

To receive reimbursement for services covered under the Indiana Health Coverage Programs (IHCP), a provider must be eligible and actively enrolled in the IHCP (Indiana Administrative Code 405 IAC 5-4-1).

For information about charging members for services not covered by the IHCP, see the Charging Members for Noncovered Services section of this document.

Provider Eligibility

Provider enrollment requirements are based on the type and specialty of the prospective provider (see the Provider Type and Specialty Requirements section) and on rules established under Code of Federal Regulations 42 CFR 455, Indiana Code IC 12-15, and Title 405 Office of the Secretary of Family and Social Services.

Federal regulations passed by Congress in 2010 include mandates meant to address concerns related to increased financial risk of fraud, waste, and abuse through claims submitted to Medicare, Medicaid, and Children’s Health Insurance Program (CHIP). The regulations include enhancements to the screening requirements based on the level of financial risk to the program. Additional information about federal guidelines for provider screening and enrollment criteria is found in the Federal Register, Volume 76, No. 22, Pg. 5862.

A provider is enrolled when the following conditions are met for the applicable provider type:

- The provider is licensed, registered, or certified by the appropriate professional regulatory agency pursuant to state or federal law, or otherwise authorized by the Indiana Family and Social Services Administration (FSSA) or the Indiana State Department of Health (ISDH).

  Note: Out-of-state providers are certified, licensed, registered, or authorized as required by the state in which the provider is located and must fulfill the same conditions as an in-state provider. A list of eligible out-of-state provider types is located in the Out-of-State Providers module.

- The provider has completed, signed, dated, and submitted either an electronic or paper version of the provider agreement and all other applicable sections of the enrollment application, as required by the FSSA. The IHCP Provider Enrollment Transactions page at indianamedicaid.com includes a link to the Provider Healthcare Portal (Portal) for online enrollment, as well as Indiana Health Coverage Programs Enrollment and Profile Maintenance Packets (IHCP provider packets) that can be completed, printed, and submitted via mail.

- Provider types identified as needing to pay an application fee have paid the application fee for each service location they wish to enroll. A list of providers subject to the application fee can be found in the IHCP Provider Enrollment Risk Category and Application Fee Matrix (for nonwaiver and waiver providers), available at indianamedicaid.com.

- Providers categorized as high-risk providers in the Medicaid program are required to obtain a fingerprint-based national criminal background check of any person who:
  - Holds at least a 5% ownership interest in a facility or entity
  - Is a member of the board of directors of a nonprofit facility or entity

  Note: For more information on the fingerprint-based background check for high-risk providers, see the Fingerprinting and Criminal History Check section.
• Outcome of unannounced site visits, performed pre- and post-enrollment for provider types considered at moderate or high risk for fraud, is successful.

• Out-of-state providers have shown proof of participation in the Medicare program or the appropriate state’s Medicaid program. See the IHCP Provider Enrollment Type and Specialty Matrix, available at indianamedicaid.com, for details, as some provider types require proof of participation in Medicare or the appropriate state’s Medicaid program, and some may require both.

• The provider is eligible to participate in all applicable federal or state programs. Eligibility is verified by searching databases that include the TIBCO® Managed File Transfer (MFT) sanction list (formerly the CHIP State Information Sharing System [MCSIS] sanction list), System for Award Management (SAM), Social Security Death Master File, and the List of Excluded Individuals and Entities (LEIE).

### Application Fee

Providers referred to as “institutional providers” are required to pay an application fee. The application fee is used for program integrity efforts. The amount is set by the Centers for Medicare & Medicaid Services (CMS) and is subject to change annually. See the Provider Enrollment Application Fee page at indianamedicaid.com for the correct application fee amount. Institutional providers include, but are not limited to, the following:

• Ambulance service supplier
• Ambulatory surgical center
• Community mental health center (CMHC)
• Comprehensive outpatient rehabilitation facility (CORF)
• Durable medical equipment (DME), home medical equipment (HME), or medical supply dealer
• End-stage renal disease clinic
• Federally qualified health center (FQHC)
• Histocompatibility laboratory
• Home health agency
• Hospice
• Hospital
• Critical access hospital
• Independent clinical laboratory
• Independent diagnostic testing facility (IDTF)
• Intermediate care facility for individuals with intellectual disability (ICF/IID)
• Mammography center
• Mass immunizers (roster billers)
• Nonemergency transportation provider
• Nursing facility
• Organ procurement organization
• Outpatient physical therapist (application fee required when enrolling as a group provider)
• Outpatient occupational therapist (application fee required when enrolling as a group provider)
• Outpatient speech/hearing therapist (application fee required when enrolling as a group provider)
• Personal care agency
• Portable x-ray supplier
• Psychiatric residential treatment facility (PRTF)
• Radiation therapy center
• Religious nonmedical healthcare institution
• Residential treatment center
• Rural health clinic (RHC)

The enrollment fee must be paid electronically. Go to the Provider Enrollment Application Fee page at indianamedicaid.com and choose IHCP Bill Pay site to begin the payment process. Providers may pay the fee using a credit card, debit card, or electronic funds transfer from a checking account. Contact Customer Assistance toll-free at 1-800-457-4584 for assistance with the online payment system.

Proof of payment must accompany the enrollment packet. Providers receive a confirmation number when the electronic payment has been accepted. Write the confirmation number in the appropriate field on the IHCP Provider Application Fee Addendum, which is included in the IHCP provider packet, or when enrolling electronically via the Portal.

Application Fee Exemptions

Physicians, nonphysician practitioners, and some medical groups and clinics are not included in the definition of “institutional provider” and are not required to pay an application fee.

Providers that are enrolled in Medicare are not required to pay an application fee to Medicaid.

Providers that are enrolled in another state’s Medicaid program, and have already paid an application fee to the other state’s Medicaid program, are not required to pay the IHCP, but they must submit proof of that payment with their application. (If the enrollment is pending, the application fee will be required.)

Hardship Exception

Federal regulation includes provisions that allow providers to apply for a hardship exception to the application fee, on a case-by-case basis, based on circumstances that are appropriate to the provider’s respective situation.

Any providers that believe they should be entitled to a hardship exception from the application fee should enclose a letter with their enrollment packet explaining the nature of the hardship and all steps taken to try to raise the required fee from other sources, such as loans, grants, and so forth.

Note: If a hardship exception is requested, the provider’s application will not be processed until a decision is made by the CMS to grant the exception.

If the hardship exception is not granted, the provider has 30 days from the date on which the notice of rejection was sent to pay the required application fee.
Risk Category Requirements

All provider types are assigned to a risk level – high, moderate, or limited. See the IHCP Provider Enrollment Risk Category and Application Fee Matrix (for nonwaiver and waiver providers) to identify the risk level for a provider type.

Note: A provider’s risk level can be modified to a higher risk level on an individual provider basis. Imposition of a payment suspension or an outstanding overpayment raises the provider’s risk level to high.

All provider enrollments designated as limited risk are subject to standard screening activities that include the following:

- Verification of provider-specific requirements
- License or certification verifications
- Database checks for identity verification, exclusions, and restrictions

Screening for providers designated as moderate risk includes the “limited risk” screening requirements, plus unannounced pre-enrollment and post-enrollment site visits. See the Site Visits section.

Screening for providers designated as high risk includes the “limited risk” and “moderate risk” screening requirements, plus submission of a set of fingerprints for a national criminal background check. See the Fingerprinting and Criminal History Check section.

Site Visits

Upon receipt of an enrollment packet from a provider categorized as moderate or high risk, an IHCP representative will make an unannounced pre-enrollment site visit to verify that the information submitted is accurate and to determine compliance with federal and State enrollment requirements. After enrollment has been activated, an unannounced post-enrollment site visit will be conducted within the first year. Failure to permit access to provider locations for any site visits will result in denial or termination of enrollment (42 CFR 455.416).

Fingerprinting and Criminal History Check

Effective October 1, 2016, providers categorized as high risk must undergo a fingerprint-based criminal background check through the State-authorized vendor. For any provider in this category, criminal background checks are required for any person with a 5% or greater direct or indirect ownership or control interest. All affected newly enrolling providers or providers revalidating their enrollments must comply with this requirement at the time their application is submitted. Instructions are provided on the Provider Enrollment Risk Levels and Screening page at indianamedicaid.com and in IHCP provider enrollment packets. The IHCP is required to apply this requirement retroactively to all providers assigned to the high-risk category that enrolled or revalidated as of August 1, 2015. Provider types affected at enrollment and revalidation are identified on the IHCP Provider Enrollment Risk Category and Application Fee Matrix.
Provider Responsibilities

All providers must sign and abide by the IHCP Provider Agreement. The provider agreement is in force and legally binding for the entire program eligibility period.

Note: All providers have an obligation under federal civil rights laws to ensure access to services for members with limited English proficiency.

Updating Provider Information

It is the provider’s responsibility to ensure that the enrollment information on file for that provider is complete and current, and to notify the IHCP of any changes within 10 business days of the change. Returned mail may cause termination of the provider’s program eligibility, resulting in denials for reimbursement of services; therefore, it is very important to keep profile information updated, including address changes.

Providers are required to submit all updates to their enrollment information either electronically, via the Portal, or by mail, using the appropriate enrollment packet or profile maintenance form. See the Provider Information Maintenance section of this document for more information.

Screening for Excluded Individuals

All providers are obligated to screen potential employees and contractors to determine whether they are excluded individuals prior to hiring or contracting them and on a periodic basis thereafter. Additionally, providers are expected to review the calculation of overpayments paid to excluded individuals or entities by Medicaid. Federal law prohibits Medicaid payments from being made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity that is excluded from participation – unless the claim for payment meets an exception listed in 42 CFR 1001.1901(c). Any such payments claimed for federal financial participation constitute an overpayment under sections 1903(d)(2)(A) and 1903(i)(2) of the Social Security Act, and are therefore subject to recoupment.

The U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) maintains the List of Excluded Individuals and Entities (LEIE), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other federal healthcare programs. The LEIE is located on the HHS OIG website at oig.hhs.gov.

Maintaining Records

As outlined in 405 IAC 1-5-1, all providers participating in the IHCP must maintain such medical or other records, including x-rays, as are necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the IHCP.

- Records must be maintained for a period of seven years from the date services are provided.
- A copy of a claim form submitted by the provider for reimbursement is not sufficient documentation to comply with this requirement. Providers must maintain records that are independent of claims for reimbursement.
• Such medical or other records must be legible and must include, at the minimum, the following information and documentation:
  – Identity of the individual to whom service was rendered
  – Identity of the provider rendering the service
  – Identity and position of provider employee rendering the service, if applicable
  – Date that the service was supplied, dispensed, or rendered to the member
  – Diagnosis of the medical condition of the individual to whom service was rendered
  – A detailed statement describing services rendered
  – The location at which the services were rendered
  – Amount claimed through the IHCP for each specific service rendered
  – Written evidence of physician involvement and personal patient evaluation to document the acute medical needs
  – A current plan of treatment and progress notes about the necessity and effectiveness of treatment available, for audit and prior authorization (PA) purposes

• When a member is enrolled in therapy, physician progress notes as to the necessity and effectiveness of therapy and ongoing evaluations to assess progress and redefine goals must be a part of the therapy documentation. The following information and documentation are to be included in the medical record:
  – Location (place of service code) at which services were rendered
  – Documentation of referrals and consultations
  – Documentation of test orders
  – Documentation of all services performed and billed
  – Documentation of medical necessity
  – Treatment plan

Records maintained by providers are to be openly and fully disclosed and produced to the FSSA, ISDH, or authorized representative with reasonable notice and request. This notice and request can be made in person, in writing, or by telephone, although some situations may require a request to review records without notice.

The performing provider must authorize records and documentation.

**Solicitation, Fraud, and Other Prohibited Acts**

Solicitation or a fraudulent, misleading, or coercive offer by a provider to supply a service to an IHCP member is prohibited as specified in 405 IAC 5-1-4. Examples of provider solicitation include the following:

• Door-to-door solicitation

• Screenings of large or entire inpatient populations, except where such screenings are specifically mandated by law

• Any other type of inducement or solicitation to cause a member to receive a service that the member does not want or does not need

**Note:** Solicitation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services as specified in 405 IAC 5-15 does not violate the solicitation prohibitions in this section.

Providers are advised to be aware of federal penalties for fraudulent acts and false reporting as set out in 42 CFR Section 1396a. For more details, see the Provider and Member Utilization Review module.
IHCP Provider Enrollment Partner Agencies

The IHCP provider enrollment procedures are designed to ensure timely, efficient, and accurate processing of provider enrollment applications and updates to information on file for existing providers. The provider master file (PMF) is an integral reference for provider participation, and claim processing depends on PMF information.

The IHCP partners with key agencies to perform provider enrollment tasks. The primary agencies and their roles in the enrollment process are as follows:

- Hewlett Packard Enterprise, in its role as fiscal agent for the IHCP, performs the following provider enrollment functions:
  - Enrollment of all providers
  - Maintaining the PMF with changes as reported and authorized by the Indiana State Department of Health (ISDH)
  - Processing enrollment and PMF maintenance requests
  - Verifying licensure and certification requirements
  - Assigning Provider ID numbers
  - Storing National Provider Identifier (NPI) and taxonomy information submitted by providers
  - Maintaining active, terminated, and denied provider files
  - Disenrolling providers at the direction of the FSSA, ISDH, Indiana Professional Licensing Agency (IPLA), CMS, Office of the Inspector General (OIG), or Attorney General (AG) when such action is warranted
  - Maintaining provider-specific rate information as supplied by the rate-setting contractor

- The Indiana Division of Mental Health and Addiction (DMHA) certifies community mental health centers, freestanding psychiatric facilities and psychiatric residential treatment facilities (PRTFs), Adult Mental Health Habilitation (AMHH) service providers, Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW) service providers.

- The IPLA issues licenses and certifications for physicians, nurses, dentists, mobile dentists, podiatrists, chiropractors, therapists (speech, language, physical, and occupational), hearing aid dealers, optometrists, audiologists, pharmacies, home medical equipment providers, and health service providers in psychology. Licensed providers in state and out of state are subject to licensure requirements (see 405 IAC 5-4-1 for enrollment requirements).

- Motor Carrier Services of the Indiana Department of Revenue certifies for-profit intrastate common carrier transportation providers including ambulatory, nonambulatory, and buses. The U.S. Department of Transportation (DOT) certifies interstate common carriers. Providers must have Indiana Motor Carrier Services certification or DOT authority to be enrolled in the IHCP.

- Indiana Emergency Medical Service (IEMS) certifies ambulance and air ambulance carriers.

- The ISDH provides survey information for certain providers required to be licensed by the ISDH. These providers include hospitals, ambulatory surgery centers, long-term care facilities, home health agencies, rehabilitation facilities and agencies, hospices, rural health centers, labs, and end-stage renal disease (ESRD) clinics.

- The ISDH and the CMS certify providers for Clinical Laboratory Improvement Amendments (CLIA); CLIA certificates are updated by the CMS electronically on an ongoing basis.
Provider Classifications

The following are the four provider classifications used for enrollment purposes:

- **Billing** – A practitioner or facility operating under a unique taxpayer identification number (TIN). The TIN may be the practitioner’s Social Security number (SSN) or a Federal Employer Identification Number (FEIN), but a sole proprietor’s TIN may not be shared or used by any other practitioner, group, or facility.

- **Group** – Any practice with one or more practitioners (rendering providers) sharing a common TIN. A group may be a corporation or partnership, or any other legally defined business entity. The group must have one or more rendering providers linked to the group.

- **Rendering** – The provider that performs the services. Reimbursement for these services is paid to the group and reported on the group’s TIN.

- **Ordering, Prescribing, and Referring (OPR)** – Practitioners who do not bill the IHCP for services rendered but may order, prescribe, or refer services or medical supplies for IHCP members. These nonbilling providers are required by the Affordable Care Act (42 CFR Parts 405, 447, 455, 457, and 498) to enroll in the Medicaid program to participate as an OPR provider.

Successful claim processing depends on accurate input of the billing provider information, as well as the rendering provider information, if applicable. See the [Claim Submission and Processing](#) module for more information about claim submission procedures.

Provider Enrollment Steps

Before applying to enroll with the IHCP, providers should visit the [IHCP Provider Enrollment Transactions](#) page at indianamedicaid.com. There, providers can view the [IHCP Provider Enrollment Type and Specialty Matrix](#) to determine the correct provider type and specialty enrollment requirements for their business entity.

Providers then have the option to submit an enrollment application online or by mail. Providers are highly encouraged to use the online enrollment option. Performing enrollment and maintenance processes online allows for faster submission and fewer errors than submitting forms via paper.

Online Enrollment Using the Provider Healthcare Portal

Access the [Provider Healthcare Portal](#) at portal.indianamedicaid.com and select the Provider Enrollment link to begin the enrollment process. The Portal allows providers to enroll in the IHCP based on provider type and provider classification (group, billing, rendering, or OPR).

The Portal provides step-by-step instructions and help information. Prospective IHCP providers are able to submit an enrollment application, resume an enrollment application, and check their enrollment status on the Portal. After they are enrolled, providers can register to use the Portal to update their enrollment information, complete revalidation tasks, and deactivate their enrollment in the program.

IHCP Provider Packet for Paper Enrollment Submission

To enroll by mail using a printed IHCP provider packet, go to the [IHCP Provider Enrollment Transactions](#) page at indianamedicaid.com and select New Enrollment as the type of transaction desired.
Providers without Internet access may request a paper copy of any of the forms by contacting Provider Enrollment Customer Assistance at 1-800-457-4584 or by sending a written request to the following address:

Provider Enrollment Unit  
P.O. Box 7263  
Indianapolis, IN 46207-7263

Enrollment packets vary based on provider type (see the IHCP Provider Enrollment Type and Specialty Matrix) and provider classification (group, billing, rendering, or OPR). For example, a hospital application is different from a transportation provider’s application, and a billing provider application is different from a rendering provider application.

Current and appropriate provider enrollment and profile maintenance forms are necessary to facilitate accurate enrollment and profile updates. Use the most current version of the forms, and read the instructions carefully before completing and submitting the form. (See the Provider Information Maintenance section for information on updating existing information for an enrolled provider.)

Note: Providers should always verify that the form is the most current version available. Previous versions of provider enrollment forms are not acceptable and are returned with a request for the correct version.

- All provider enrollment and profile maintenance forms on the web are available as Adobe PDF files and have a “Save As” function. Providers may complete forms on-screen before printing them.
- Appropriate signatures are required. All signatures must be in blue or black ink and cannot be copies or any other facsimile. Signatures must be legible.
- The use of whiteout is not acceptable in any area of the enrollment or profile maintenance form.
- An enrollment is not processed without a signed provider agreement and a completed enrollment application with signed signature page. Rendering provider forms must contain a signed signature page with both an authorized official from the group’s signature and the rendering provider’s signature, along with a Rendering Provider Agreement signed by both the rendering provider and an authorized official from the group. Providers are required to submit copies of certifications or licenses applicable to the enrolling provider’s type and specialty. The IHCP Provider Enrollment Type and Specialty Matrix is available online at indianamedicaid.com for reference when determining supporting document and enrollment requirements.
- Mail completed forms to the Provider Enrollment Unit.

Note: Faxed enrollment packets and provider profile updates cannot be accepted unless specifically requested by the Provider Enrollment Unit. Due to the large volume of faxes Provider Enrollment receives daily, faxed documents may not remain intact. Providers should not send documents by overnight or express mail unless requested to do so by the Provider Enrollment Unit.

**Enrollment Application Details**

To enroll as an IHCP provider, the provider must do the following:

- Complete the appropriate online enrollment application or IHCP provider packet (based on provider type and classification).
- Sign the provider agreement and signature authorization sections. (The Portal accepts electronic signatures.)
• Submit applicable certifications or licenses required for the enrolling provider’s type and specialty. (The Portal allows electronic file transfer of attachments.)

• Provide proof of Medicare and Medicaid participation, when required.

• Submit the documents to the Provider Enrollment Unit, either via the Portal or by mail.

See the following instructions for each component of the IHCP provider packet. For online enrollment, follow instructions provided in the Portal. Note that the specific sections of the enrollment application and information requested vary by provider type and classification. Follow the quality checklist and instructions in the beginning of the packet to help ensure that the enrollment application is completed and submitted correctly.

**Note:** Providers are encouraged to enroll online, using the Provider Healthcare Portal at portal.indianamedicaid.com. Most of the following forms are built into the electronic application process, eliminating the need to submit them separately. When separate addendums or attachments are required, the Portal will prompt the provider on the attachment page.

• **Schedule A** – This section indicates who the provider is and what the provider would like to do:
  
  – **Type of Request** – Choose to enroll for the first time, perform a change of ownership, add a new service location, revalidate enrollment, or update existing information.
  
  – **Provider Information** – Provide requested provider information, which includes NPI, nine-digit ZIP Code, current and past IHCP enrollment status, all relevant taxonomy codes (identifying healthcare provider type and specialty), and so on.

  **Note:** If the NPI is used for multiple Provider IDs or service locations, identifiers, such as ZIP+4 and taxonomy code, will be used to identify the specific service location.

  Healthcare provider taxonomy codes are designed to categorize the type, classification, and specialization of healthcare providers. More information about taxonomy, as well as a crosswalk between provider types and taxonomy codes, can be found on the Taxonomy page at cms.gov. Providers can also locate the taxonomy code assigned to the provider NPI through the NPPES Registry at cms.gov.

  – **Contact Information** – Provide the name, telephone number, and email address for an individual who can answer questions about information provided in the packet.

  – Provide information about the following four addresses:
    
    – **Service Location Name and Address** identifies the address of the location where services are rendered and related records are kept. This address must be a physical location; a post office box or UPS store cannot be used.
    
    – **Legal Name and Home Office Address** must match the name and address information on the W-9. The home office (legal) address must be the same for all IHCP service locations using the same Federal Employer Identification Number (FEIN), SSN, or TIN. The home office address is the legal address of the provider as reported to the IRS. The IHCP mails annual 1099 forms and other legal or tax-related communication to this address.
    
    – **Mailing Name and Address** is the address where notifications and general correspondence is sent. A post office box is acceptable.
    
    – **Pay-to Name and Address** is the location where the IHCP sends checks (if the provider is not set up for electronic funds transfer) and general claim payment information. A post office box is acceptable.

  – **Provider Specialty Information** – Identify the provider type and primary specialty (see the Provider Type and Specialty Requirements section), any applicable additional specialties, and associated taxonomy codes.
- **Licensing/Certification Information:** Provide any requested license or certification information; required licensure and certification varies by provider type. A copy of the license or certificate from the appropriate board or authority must be included as an attachment to the packet. Providers may be required to provide:
  - ISDH certification information
  - CLIA certification information

- **Schedule B** – This section identifies how the business is structured and other information:
  - **Organizational Structure** – Provide information about how the provider entity is legally organized and structured, whether it is registered to transact business in Indiana with the Secretary of State, incorporation status, and so on.
  - **Other IHCP Program Participation** – Note any additional IHCP programs to include in the enrollment, such as 590 Program, Preadmission Screening and Resident Review (PASRR), and Medical Review Team (MRT).
  - **Medicare Participation** – Medicare providers must provide their Medicare identification numbers and associated service location address.
  - **Out-of-State Providers** – Out-of-state providers indicate whether they are currently enrolled in their state’s Medicaid program. If so, proof of participation must be attached to the packet.
  - **Patient Population Information** – Indicate the funding sources for the patient population; be sure the percentages equal 100%.

- **Schedule C** – This section collects full and complete disclosure information, required by federal regulation, about ownership or control interest in the business entity (see **Schedule C – Disclosure Information** for definitions):
  - **Section C.1** must show all individuals and corporations with ownership or control interest in the provider entity, per the requirements stated in the schedule.
    - C.1.(A) must include the percent of ownership, Social Security number (SSN), date of birth (DOB), and title (such as chief executive officer, owner, or board member) for each individual with ownership or control interest in the provider entity. Attach additional pages as needed.
    - C.1.(B) must include the tax identification number (TIN), the percent of ownership in the applicant, and the primary business address, every business location, and P.O. box addresses for each corporation with ownership or control interest in the provider entity. Attach additional pages if needed.
  - **Section C.2** must list all subcontractors in which the applicant has a 5% or more ownership or control interest. This section may be marked as “not applicable” if it does not apply. The name, address, and TIN for each subcontractor must be listed. Attach additional pages as needed.
  - **Section C.3** must list all agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers or government-owned business must also list their managing individuals.
  - **Section C.4** must show familial relationships between individuals listed in previous sections of this schedule, and also, for the individuals noted, identify any past convictions. In addition, identify whether any of the owners included in C.1 have an ownership or control interest in another organization that would qualify as a disclosing entity.

- **IHCP Provider Signature Authorization** – This page must be signed by an individual who is listed in section C.1 or C.3 of Schedule C, and who has the authority to bind the provider to the terms of the provider agreement. The signer must also agree to abide by and comply with terms and conditions of the program. For group enrollment packets, an authorized official of the group or clinic provider must sign this page. For rendering providers, the provider must sign Schedule B of the rendering provider packet (included after the **IHCP Provider Signature Authorization** section). Original signatures are required; a stamped signature is not acceptable. The Portal accepts electronic signatures.
• **IHCP Provider Agreement** – This document becomes the contract between the provider entity and the IHCP. Be sure to carefully read the agreement in its entirety. The agreement must be signed by the owner or authorized official ultimately responsible for operating the business. **A delegated administrator is not permitted to sign a provider agreement** (A Rendering Provider Agreement must also be completed for each rendering provider linked to a group.) Original signatures are required; a stamped signature is not acceptable. The Portal accepts electronic signatures.

The provider agreement is in effect for the entire period of an IHCP provider’s contract eligibility segment. The effective start date and end date of the provider’s contract eligibility segment are listed on the IHCP welcome letter and stored electronically in the PMF. The IHCP welcome letter lists the enrollment data entered on the PMF, which includes the following information:

- Provider ID
- NPI
- Provider name as entered in the Core Medicaid Management Information System (CoreMMIS (must match name on license, if applicable)
- Enrollment effective start and end dates
- Provider type and specialty
- Taxonomy codes
- Taxpayer identification number
- All addresses, including home office, mail-to, pay-to, and service location
- EFT bank account and the bank’s routing number, when EFT is requested

• **IHCP Provider Federal W-9 Addendum** – Providers must submit the most current version of the W-9 from the IRS website at irs.gov. The legal name, doing business as (DBA) name (when applicable), and the address on the W-9 must match the information in the Legal Name and Home Office Address section of the enrollment application.

• **IHCP Provider Application Fee Addendum** – Certain enrolling providers are subject to an application fee and must complete and submit this addendum with the provider enrollment packet. The IHCP Provider Enrollment Risk Category and Application Fee Matrix provides a full list of provider types and indicates which types are subject to application fees.

• **IHCP Provider Screening Addendum** – Providers in the high-risk category must complete and submit this addendum with the enrollment application. See the IHCP Provider Enrollment Risk Category and Application Fee Matrix.

• **IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form** – Providers that wish to have their claim payments deposited directly into a bank account need to complete the IHCP Electronic Funds Transfer Addendum, which is included in the enrollment packet, or use the Portal to add or change banking information for EFTs.

• **IHCP Provider Delegated Administrator Addendum/Maintenance Form** – If the owner or authorized official completing this enrollment packet wishes to grant authority to an additional trusted individual within his or her organization to make changes or updates to the provider information on file, completion of this addendum allows him or her to indicate the name of that person and which specific actions may be delegated. Delegated administrators cannot sign a provider agreement on behalf of any owner or rendering provider.

• **IHCP Provider Change of Ownership Addendum** – If an enrolled entity has experienced a change of ownership, this addendum must be completed and included with the enrollment packet submitted by the new owner. This information helps identify the entity that is affected by the change.

• **IHCP Hospital and Facility Additional Information Addendum** – Certain hospitals and extended-care facilities need to complete this one-page addendum when enrolling as an IHCP provider.
Provider Enrollment

- **IHCP Psychiatric Hospital Bed Addendum/Maintenance Form** – For psychiatric hospitals that have 16 beds or less that wish to enroll in the IHCP, the *Psychiatric Hospital Addendum* must be completed and included with the enrollment packet. Federal regulation restricts reimbursement when a psychiatric hospital has more than 16 beds. See 42 CFR 435.1008(a)(2).

- **IHCP PRTF Attestation Letter/Maintenance Form** – Providers wishing to enroll as PRTFs must be licensed under 470 IAC 3-13 as private, secure, child-caring institutions. To enroll as PRTFs, facilities must comply with the requirements in 42 CFR 482, Subpart G governing the use of restraint and seclusion, and submit an attestation letter stipulating that they comply with federal and State requirements. See 405 IAC 5-20-3.1(3). The *PRTF Attestation Letter* must be completed and included with the enrollment packet.

- **IHCP Outpatient Mental Health Addendum** – Providers wishing to enroll as an outpatient mental health facility or clinic, or as a community mental health center, or as a group under one of the mental health specialties (health service provider in psychology-HSPP, Adult Mental Health and Habilitation-AMHH, Children’s Mental Health Wraparound-CMHW, and Behavioral and Primary Healthcare Coordination-BPHC) must complete and include the *Outpatient Mental Health Addendum*, which provides information about the supervising practitioner and a complete list of individual practitioners, who will provide outpatient mental health services, and their qualifications.

- **IHCP Rendering Provider Enrollment and Profile Maintenance Packet** – This enrollment packet allows a group provider to identify the practitioners associated with the group, those who actually provide the services offered by the entity. Only a group provider may enroll and link rendering providers that are employed by the group. A *rendering provider packet* must be completed for each practitioner providing care. The provider *IHCP Signature Authorization* section must be signed by the rendering provider and the owner or authorized official of the entity. The *Rendering Provider Agreement* must be signed by both the rendering provider and an authorized official of the entity. Both documents are required for enrollment.

The Provider Enrollment Unit verifies that all the packet’s schedules, which include ownership disclosure and management information, are complete, appropriate signatures are present, date of birth and Social Security number are included for anyone listed on section C.1 or C.3 of Schedule C, licenses and credentials are enclosed, and other necessary documentation per the requirements specific to the provider’s type and specialty is present before completing the request.

The *IHCP Provider Enrollment Type and Specialty Matrix*, available at indianamedicaid.com, contains document requirements by provider type and specialty, and should be reviewed prior to submitting documents to the IHCP. If the enrollment packet is incomplete or the required documentation is not included, the Provider Enrollment Unit contacts the provider in an attempt to complete the application. If the application cannot be completed after contacting the provider, a letter is sent to the enrolling provider outlining what is missing.

**Note:** Be sure to keep a copy of all submitted forms for your records.

**Enrollment Confirmation**

The enrollment effective start date for providers within the state of Indiana is the date the Provider Enrollment Unit receives the completed IHCP provider packet or online enrollment application. As such, providers should not begin treating IHCP members until confirmation is received that the enrollment paperwork has been processed.
An enrollment confirmation letter is mailed to the provider upon successful enrollment in the IHCP. After receiving an enrollment confirmation letter, the provider can bill for covered services for dates of service that fall within the enrollment eligibility period.

**Enrollment Denial or Rejection**

An application to enroll in the IHCP can be denied if the screening process determines that the provider does not meet the requirements for participation, or an application can be rejected if required supporting documentation or information is missing from the submission. A letter is sent to notify providers of this decision and advise them of the necessary actions needed for resubmission of the rejected application.

Providers have the right to appeal an enrollment denial under IC 4-21.5-3-7 and 405 IAC 1-1.5-2. To preserve an appeal, providers must specify the reason for the appeal in writing and file the appeal with the ultimate authority for the agency within 15 calendar days of receipt of a notification letter.

The appeal should be sent to the following address:

MS07  
Gwen Killmer  
Secretary, Indiana Family and Social Services Administration  
402 West Washington Street, Room W382  
Indianapolis, IN 46204

If providers elect to appeal a determination, they must also file a statement of issues within 45 calendar days after receipt of notice of the determination. The statement of issues must conform to 405 IAC 1-1.5-2(e) and IC 4-21.5-3 and be sent to the same address as the appeal request.

**Enrollment Tips – Avoiding Common Errors**

Note: To eliminate the potential for the following errors and return of improperly completed enrollment packets, providers are encouraged to perform enrollment processes online via the Portal.

To help avoid delays in processing an application, review the following list of common reasons IHCP enrollment packets are returned to the provider:

- **Signature Authorization Addendum** – Enrollment packets must contain a signature authorization page signed by the owner or authorized official; for group enrollments, rendering providers must also sign the signature authorization section of the rendering provider packet.

- **Incomplete Documents** – Examples include missing telephone numbers, specialty designations, license numbers, and banking information for EFTs. Be sure to complete all required provider agreements with all appropriate signatures.

- **Schedule C, Sections C.1 (A and B), C.2, C.3, and C.4** – Section C.1 and C.3 must be completed based on the business structure. Please make sure name, Social Security number, and date of birth are included for any listed individual. Refusal to provide a Social Security number results in rejection of the application.
Provider Agreement Missing from Packet – A current version of the IHCP Provider Agreement or Rendering Provider Agreement must be submitted for every provider that bills or renders services that are reimbursed by the IHCP. If an older, retired version of the agreement is submitted, it is rejected.

Incorrect Signature on Provider Agreement – A delegated administrator is not permitted to sign a provider agreement. The IHCP Provider Agreement must be signed by an owner, board member, or officer, with the signer being listed in section C.1 or C.3 of Schedule C. The Rendering Provider Agreement must be signed by the rendering provider and an authorized official of the entity.

Schedule A and W-9 are Inconsistent – The legal name, DBA name, and tax identification information must be consistent on both the Legal Name and Home Office Address section of Schedule A and the W-9. If a DBA name is used, this name must match the name registered with the Secretary of State or the County Recorder’s Office.

Current W-9 Form Missing – Submit the most current W-9 available from the IRS; earlier versions are rejected and providers are asked to submit the most current version. Submission of a copy of the provider’s IRS TIN registration confirmation letter is helpful to support the TIN reported to the IHCP.

Missing License or Certificates – Include a copy of the provider’s professional license, if applicable. Include certificates that support the licensure specialty when a state does not license a specific specialty. See the IHCP Provider Enrollment Type and Specialty Matrix to determine documentation needs.

Additional Service Location – Submit a complete enrollment packet including Schedule A, Schedule B, Schedule C, IHCP Provider Signature Authorization, W-9, IHCP Provider Agreement, and any other addenda related to each service location. At the top of the Schedule A, check the box “Additional Service Location.”

Rendering Provider Agreement – The packet must include rendering provider agreements, and the agreement must be signed by an authorized official of the group or clinic or the rendering provider.

EFT Information Errors on the Form – EFT submissions must contain the appropriate bank routing and bank account numbers. To ensure timely payment, complete the EFT form attached to the enrollment packet or download a form from the Update Your Provider Profile page at indianamedicaid.com. Submit a copy of a voided check or bank document that displays the correct bank account and routing numbers. A letter from the bank that lists the bank account number, routing number, TIN, and business name is also acceptable.

Old Form Copies Used to Request Enrollments and Updates – Use current forms found on the IHCP Provider Enrollment Transactions and Update Your Provider Profile pages at indianamedicaid.com. The website permits providers and their staff members to complete the forms online and save the forms. Older versions of the forms are not processed.

Instructions Not Followed – The enrollment and maintenance forms contain information about the form’s purpose and instructions about how to complete the forms. Read the forms’ instructions carefully and become familiar with required fields to avoid having the form rejected.

Schedule C – Disclosure Information

Federal program integrity regulations require states to obtain and validate certain disclosures from providers upon enrollment and periodically thereafter. When states obtain these disclosures and search exclusion and debarment lists and databases, they can take appropriate action on providers’ participation in the Medicaid program. The provider enrollment packet includes Schedule C – Disclosure Information, which is divided into four sections: C.1 (A and B), C.2, C.3, and C.4.
Providers must complete all four sections when applicable, and, at a minimum, C.1 and C.3 (N/A is not acceptable on section C.3), of the enrollment packet for disclosure information. Nonprofit providers must provide information for the business entity that owns their TIN. When completing the Schedule C sections, whether during the initial application or to make changes as part of an update, make sure to include the names of all individuals that meet the disclosure requirements, even if the individuals had been previously disclosed. When an update is processed, any previously disclosed individuals that are not shown on the update form will be removed. In other words, the previous list of disclosed individuals will be replaced with the updated list of disclosed individuals.

Schedule C is used to collect information required by state and federal regulations. Social Security numbers disclosed on this form are used to determine whether persons and entities named in an enrollment packet are federally excluded parties. Refusal to provide a Social Security number will result in rejection of this enrollment packet. Birth dates are also required to correctly identify the individual when performing sanction checks.

C.1 – Disclosure Information – Individuals and/or Corporations with an Ownership or Control Interest in the Applicant

Note: As defined in 42 CFR 455.101, a “person with an ownership or control interest” means a person or corporation that —

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- (f) Is a partner in a disclosing entity that is organized as a partnership.

Section C.1.(A) – Individuals with Ownership or Control Interest

- Providers use this section to list any individuals that have an ownership or control interest, including officers, directors, or partners as defined in 42 CFR 455.101 sections (e) and (f).

If the entity is publicly held and no person owns 5% or more of the corporation, or if it is a not-for-profit or government-owned entity, complete fields 1a and 4a in this section. Then, use section C.3 to list the Board of Directors.

Section C.1.(B) – Corporations with an Ownership or Control Interest

Providers use this section to list all corporations with an ownership or control interest in the provider entity.

C.2 – Disclosure Information – Subcontractors

Providers use this section to list all subcontractors, in which the applicant has a 5% or more ownership or control interest.
C.3 – Disclosure Information – Managing Individuals

Providers use this section to list all agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers must also list their managing individuals. Sole proprietors must list owner name on C.1 and C.3.

- An agent is any person who has express or implied authority to obligate or act on behalf of an entity.
- An officer is any person whose position is listed as an officer in the provider’s articles of incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing body.
- A director is a member of the provider’s board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word “director” in his or her job title, such as director of operations or departmental director.
- A managing employee is a general manager, business manager, administrator, director, owner, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of the provider entity.

C.4 – Disclosure Information – Relationships and Background Information

This section has five different parts that need to be completed if applicable:

1. If any parties listed in sections C.1 or C.3 are related to each other as spouse, parent, child, or sibling, provide the name of each person and note their relationship.

2. If any parties listed in sections C.1 or C.3 are related to any individual with an ownership or control interest in any of the subcontractors listed in section C.2, provide the name of each person and note their relationship.

3. Indicate whether any persons or entities listed in section C.1 have an ownership or control interest in another organization that would qualify as a disclosing entity. If yes, list the name of each owner and the name of the other disclosing entities in which the owner has an ownership or control interest. If the entity is a nonprofit organization and does not have any owners, check NA.

Note: As defined in 42 CFR 455.101, “other disclosing entity” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

b) Any Medicare intermediary or carrier; and

c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Whereas “disclosing entity” is limited to Medicaid providers, “other disclosing entity” can include entities that are not enrolled in Medicaid.

4. List any party with an ownership or control interest, or who is an agent or managing employee, who has ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid, or Title XX services programs. Provide the name of the convicted party and the date of the conviction.

5. If any former agent, officer, director, partner, or managing employee, has transferred ownership to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion, provide the names of both parties and note their relationship.
Nonrequired Provider Documents

Documents other than IHCP forms and the documents identified in the IHCP Provider Enrollment Risk Category and Application Fee Matrix are not required. The following examples of nonrequired documents need not be submitted with an enrollment or update request:

- Diplomas
- Certificates other than those noted in the preceding paragraphs and IHCP Provider Enrollment Risk Category and Application Fee Matrix (for nonwaiver and waiver providers)
- Resumes and curricula vitae
- Lists of previous employment
- Lists of published works
- Letters of reference or commendation
- Medical doctors’ insurance documents

Provider Enrollment for Specific IHCP Programs

The following sections contain information for providers enrolling in specific IHCP programs.

Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise Provider Enrollment

To become a Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise managed care primary medical provider (PMP), providers must first enroll as an IHCP provider. HIP, Hoosier Care Connect, and Hoosier Healthwise MCE providers that qualify to enroll as PMPs are identified by provider type 31 – Physician or 09 – Advanced practice nurse by the IHCP. Providers may enroll in one or more of the programs with separate panels. Each PMP must designate a panel size; that is, the number of managed care members he or she is willing to accept.

Physicians must choose one of the following provider specialty codes associated with provider type 31:

- 316 – Family practitioner
- 318 – General practitioner
- 328 – Obstetrician/gynecologist
- 344 – General internist
- 345 – General pediatrician

Advanced practice nurses (APNs) must choose one of the following provider specialty codes associated with provider type 09:

- 090 – Pediatric nurse practitioner
- 091 – Obstetric nurse practitioner
- 092 – Family nurse practitioner
- 093 – Nurse practitioner (other, such as clinical nurse specialist)
- 095 – Certified nurse midwife
HIP, Hoosier Care Connect, and Hoosier Healthwise MCE enrollment specifics are as follows:

- Qualifying physicians and APNs must be IHCP-enrolled prior to establishing their PMP enrollments.

- The prospective PMP must contact the MCEs to initiate the PMP enrollment process. The MCE verifies that the PMP is an IHCP-enrolled provider and sends a credentialing application and contract to the prospective PMP. After the PMP has been approved by the MCE’s credentialing committee and has an executed provider contract on file, the MCE submits the PMP’s enrollment information through the Portal for the PMP’s enrollment into CoreMMIS. PMPs may enroll with one or more MCEs.

- Rendering providers must be linked to an IHCP group prior to being linked to a group practice or clinic in the HIP, Hoosier Care Connect, and Hoosier Healthwise managed care programs. All updates to IHCP enrollment information (address, EFT, linkage, and other similar changes) must be submitted via the Portal or on the appropriate form to the Provider Enrollment Unit for processing prior to submission of PMP enrollment changes. The forms are available by request from the Provider Enrollment Customer Assistance telephone line at 1-800-457-4584 or can be downloaded from the [Update Your Provider Profile](#) page at indianamedicaid.com.

Hewlett Packard Enterprise reports PMP-related updates to the appropriate MCE.

**Provider Enrollment in the Medical Review Team Contract Option**

Participation in the MRT program requires IHCP enrollment. Providers must enroll with the MRT program to submit claims for payment of MRT services. Nonlicensed providers are eligible to enroll as providers under the MRT program for reimbursement of medical records copying and provision only. To complete the enrollment process for the MRT program, prospective providers must complete the designated area that applies to the MRT program.

Existing IHCP providers can indicate a desire to participate as an MRT provider by using the Provider Maintenance > Other Information Changes link on the Portal or by submitting a provider packet from the [Complete an IHCP Provider Packet](#) page at indianamedicaid.com. Complete the Provider Information section of Schedule A and the Other IHCP Program Participation section of Schedule B. An owner, authorized official, or delegated administrator must sign the form’s Signature Authorization section (located after Schedule C).

New providers that want to participate in Medicaid or Hoosier Healthwise Package C and the MRT program for medical testing services can download the appropriate packet from the [Complete an IHCP Provider Packet](#) page at indianamedicaid.com or follow the appropriate enrollment processes on the Portal. The provider must complete the form in full; submit a signed provider agreement and W-9; and comply with any requirements for the provider type and specialty. See the IHCP Provider Enrollment Type and Specialty Matrix for the provider type requirements. To participate with the MRT program for medical review testing, the provider must complete the Other IHCP Program Participation section in Schedule B.

New providers that do not elect to enroll in the Medicaid or Hoosier Healthwise Package C programs may choose to provide Medical Review Testing services only. Those providers must check Yes in the box next to Medical Review Program ONLY, located in the Other IHCP Program Participation section of Schedule B. The provider must complete the enrollment form in full and comply with any requirements for the provider type.
Providers can enroll in the MRT program as a copy center to bill only for the copying and provision of medical records, when medical record copies are requested by the MRT. The following documents (or equivalent sections of the enrollment process on the Portal) are required for enrollment:

- An IHCP Billing Provider Enrollment and Profile Maintenance Packet (use the one available for MRT copy center, type 34)
- Completed Schedule A; enter type 34 and specialty code 366 to indicate MRT
- Completed Schedule B; indicate the type of MRT participation in box 10
- Completed Schedule C, sections C.1 and C.3, and, if applicable, C.2 and C.4
- Signed IHCP Provider Signature Authorization Addendum
- Signed IHCP Provider Agreement
- W-9

**Preadmission Screening and Resident Review Level II Provider Enrollment**

The nursing facility Preadmission Screening and Resident Review (PASRR) was federally mandated under the 1987 nursing facility reform. All individuals applying for admission to Medicaid-certified nursing facilities, regardless of their source of payment, must be prescreened through the PASRR Level I process to identify those individuals who may be mentally ill (MI) or intellectually disabled/developmentally disabled (ID/DD). All PASRR Level II assessments are conducted by the community mental health centers (CMHCs) for nursing facility residents who may be MI, and by the Diagnostic and Evaluation (D&E) Team for nursing facility residents who may be ID/DD. Nursing facility residents may also require assessment under the Resident Review (RR) Level II process if they are identified as one of the following:

- Possibly being MI or ID/DD and were not assessed through the PASRR program prior to admission
- Have had a substantial change in condition related to their MI or ID/DD condition that may require a change in services or placement

Only D&E teams can participate in MRT and PASRR.

All D&E teams and CMHCs are required to be enrolled in the Medicaid or Hoosier Healthwise Package C program.

All D&E teams must be contracted and approved by the Division of Disability Rehabilitative Services (DDRS). CMHCs must be contracted and approved by the DMHA. The appropriate State agencies must determine provider eligibility and send a letter of notification – approval or disapproval – to the provider. This letter is required for enrollment.

PASRR program participation can be indicated upon initial enrollment with the IHCP or added as an update to an enrolled provider’s information on file:

- Providers not already enrolled in the IHCP are encouraged to use the Portal to enroll, or they can download and submit the appropriate IHCP provider packet from the [Complete an IHCP Provider Packet](#) page at indianamedicaid.com. The provider must complete the application in full and comply with any requirements for their provider type, as indicated in the IHCP Provider Enrollment Type and Specialty Matrix. To participate with the PASRR program, the provider must check the Yes box in the Participate in the PASRR Program field. A copy of the DDRS PASRR approval letter must be submitted with the IHCP enrollment application.
• Existing IHCP providers that want to participate in the PASRR program and have been approved by the DDRS may use the Other Information Changes option on the Provider Maintenance page of the Portal to update PASRR information, or they may submit the appropriate IHCP provider packet, available from the Complete an IHCP Provider Packet page at indianamedicaid.com, as follows:
  – Select Profile Update as Type of Request.
  – Complete the Provider Information section.
  – Go to the Other IHCP Program Participation page and choose Yes in the box marked Contracted to provide PASRR services.

Whether the update is submitted via the Portal or by mail, a copy of the DDRS PASRR approval letter must be attached.

For details about PASRR processes, see the Long-Term Care module.

Waiver Programs

Becoming a waiver provider begins with the FSSA certification process and is finalized with the IHCP provider enrollment process. The appropriate FSSA Home and Community-Based Services (HCBS) Waiver division, which varies depending on the waiver services being provided, must certify providers of HCBS waiver services with the IHCP. Prospective providers interested in becoming certified waiver providers must contact the appropriate FSSA HCBS Waiver Unit.

For the ICF/IID level-of-care waivers (Community Integration and Habilitation [CIH] Waiver and Family Supports Waiver [FSW]), contact:

**MS18**
Director of Provider Relations
DDRS – Division of Disabilities and Rehabilitative Services
402 West Washington Street, Room W453
Indianapolis, IN 46207-2773
Email: BDDSprovider@fssa.IN.gov

For the nursing facility level-of-care waivers (Aged and Disabled [A&D] and Traumatic Brain Injury [TBI] Waivers) and the Money Follows the Person [MFP] demonstration grant, contact:

**MS07**
Waiver/Provider Analyst
Family and Social Services Administration
Indiana Health Coverage Programs (IHCP)
Division of Aging Home and Community-Based Services Waivers
402 West Washington Street, Room W382
P.O. Box 7083
Indianapolis, IN 46027-7083

For the 1915(c) PRTF Transition Waiver, contact:

**MS15**
Waiver/Provider Analyst
Indiana Family and Social Services Administration
Division of Mental Health and Addiction
402 West Washington Street, Room W353
Indianapolis, IN 46204-2739
Telephone: (317) 232-7800
Fax: (317) 233-1986
Revalidation

Federal regulations require all providers participating in the IHCP to revalidate their enrollment at least every five years. Durable medical equipment (DME) providers and pharmacy providers with DME or home medical equipment (HME) specialties revalidate every three years.

Note: Providers are encouraged to use the Provider Healthcare Portal at indianamedicaid.com for revalidation processes. The Portal allows for electronic signatures.

Revalidation of an enrollment requires submission of a new IHCP provider packet or use of the Revalidation option in the Portal and, for designated provider types, completion of screening activities. Effective January 1, 2016, an application fee is required for certain revalidations as well as new enrollments.

The following information is intended to help providers better understand revalidation requirements:

- Providers are required to revalidate their enrollment with Medicare and the IHCP separately. Revalidating with Medicare will not revalidate a provider’s IHCP enrollment.
- Revalidation is a reenrollment process, not an update process. When revalidating enrollment by mail, providers must indicate revalidation by checking the Revalidate Enrollment box on the IHCP provider packet, and then complete all applicable fields, not just those fields with new information. If a packet is submitted with only “Revalidate Enrollment” marked in item 1, and the rest of the packet blank, or with only some fields completed, the packet will be considered incomplete. Incomplete packets will be returned to providers with a request that they be resubmitted with the missing information added.
- A properly completed W-9 must be submitted with the IHCP provider packet or Portal revalidation. Discrepancies on the W-9 will result in the application being returned to the provider, delaying revalidation.
- Disclosures on Schedule C of the application must contain complete and thorough information about all disclosed individuals, including name, Social Security number, and date of birth. The Schedule C must contain a complete list of disclosures, not just those individuals added or deleted from a prior disclosure.
- Group providers should disregard the IHCP Rendering Provider Enrollment and Maintenance Packet portion of the IHCP group provider enrollment packet when revalidating. Instead, as an attachment to the group’s enrollment packet, a group should include a list of rendering providers linked to the service location at the time of revalidation. The list of rendering providers must include the information outlined in the instructions on page 1 of the IHCP group provider enrollment packet. Any new rendering provider must first enroll and then be linked to the group.
- A revalidation notice is mailed to providers 90 days before their revalidation due date, using the mail-to address on file. A second notification letter is mailed 60 days before the revalidation due date. Providers with multiple service locations (practice sites) must revalidate each location individually and will receive a separate letter for each location.
- Providers that fail to submit properly completed revalidation paperwork by their revalidation due date will be disenrolled. After being disenrolled, the provider will need to complete the provider enrollment process on the Portal or submit a new IHCP Enrollment and Profile Maintenance Packet to reenroll with the IHCP.
- Disenrollment with subsequent reenrollment may result in a gap in the provider’s eligibility. Providers should not revalidate until they receive their notification letter.
• Providers that do not intend to revalidate their enrollment should complete the disenrollment process on the Portal or submit the IHCP Provider Disenrollment Form available at indianamedicaid.com, which allows the IHCP to complete a voluntary disenrollment and keep its provider database up-to-date.

Note: Providers should not take any steps to revalidate until they receive their notification letters. It is important that providers keep their address information up to date to ensure that they receive this notice. Failure to submit the required documentation prior to the deadline will interrupt the ability to have claims paid.

Provider Type and Specialty Requirements

This section identifies the enrollment requirements by provider type and specialty. A prospective provider can choose only one provider type per enrollment packet, but can choose any number of specialties under the selected provider type. If a prospective provider requires more than one provider type, another packet must be submitted and another provider number assigned.

Hospital (Type 01)

All hospitals are enrolled as billing providers and must be enrolled in Medicare to qualify for Medicaid enrollment. There are four hospital specialties under the provider type 01 – Hospital. The four specialties are:

• 010 – Acute care
• 011 – Psychiatric
• 012 – Rehabilitation
• 013 – Long-term acute care (LTAC)

All in-state acute care and rehabilitation hospitals are certified by the Indiana State Department of Health (ISDH) and enrolled as billing providers. Out-of-state hospitals must submit a copy of their current license. The rate-setting contractor furnishes Hewlett Packard Enterprise with rate information on medical education rates and costs-to-charge ratio information, if applicable.

All in-state psychiatric hospitals (specialty 011) are licensed by the Division of Mental Health and Addiction (DMHA), and are also enrolled as billing providers. A license from the DMHA is required.

All in-state rehabilitation hospitals (specialty 012) are licensed by the ISDH, which forwards their information Hewlett Packard Enterprise before enrollment is completed.

All in-state LTAC hospitals (specialty 013) are first enrolled as licensed acute care hospitals. To change the provider specialty from 010 – Acute care hospital to 013 – Long-term acute care hospital, the provider must be designated by the CMS as a long-term hospital for the Medicare program, or have an average inpatient length of stay greater than 25 days, based on the same criteria used by the Medicare program. Providers should contact the rate-setting contractor for assistance in determining their qualifications as an LTAC hospital. Out-of-state LTACs are not eligible for enrollment in the IHCP.

Ambulatory Surgical Center (Type 02)

All ambulatory surgical centers (ASCs) are enrolled as billing providers. For IHCP enrollment purposes, only one specialty is associated with provider type 02 – Ambulatory surgical center, and the specialty number is 020 – Ambulatory surgical center. ISDH certifies ASCs and forwards information to Hewlett Packard Enterprise before enrollment is completed.
Extended Care Facility (Type 03)

All extended care facilities are enrolled as billing providers. Out-of-state extended care facilities are not eligible for enrollment in the IHCP. There are five specialties under provider type 03 – Extended Care Facility. The five specialties are:

- 030 – Nursing facility (NF)
- 031 – Intermediate care facility for individuals with intellectual disability (ICF/IID)
- 032 – Pediatric nursing facility
- 033 – Residential care facility
- 034 – Psychiatric residential treatment facility (PRTF)

All type 03 specialties require ISDH certification, and that information must be forwarded to Hewlett Packard Enterprise before enrollment is completed.

The final rule published in the Federal Register modified 42 CFR 442.15 and eliminates the requirement for time-limited agreements for ICF/IID and residential care facility providers. Providers no longer need to recertify each year by submitting a new provider agreement. Providers are still subject to enrollment revalidation requirements.

PRTFs require the following:

- A Department of Child Services (DCS)-issued residential childcare license for a private, secure care facility
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) or Council on Accreditation (COA) accreditation
- An attestation letter for facility compliance

PRTFs are required to submit a new attestation letter to Hewlett Packard Enterprise annually.

Note: The PRTF Model Provider Attestation Letter Addendum (shown in Figure 1) has been updated to include a State Survey Provider ID, so that the ISDH and the FSSA can track facilities. The ISDH issues a State Survey Provider ID after reviewing the PRTF Attestation Form. Because the State Survey Provider ID is used for internal purposes, providers should disregard this field. Providers should direct questions about this update to Customer Assistance at 1-800-457-4584.
Figure 1 – PRTF Model Provider Attestation Letter Addendum

Model Provider Attestation Letter

Facility Name
Address
City, State, ZIP
Telephone Number
Provider Number:

Dear Indiana Medicaid:

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the (Name of the Facility) hereby complies with all the requirements set forth in the interim rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (Psych Under 21 rule).

I understand that the Centers for Medicare & Medicaid Services (CMS formerly HCFA), the State Medicaid Agency, or its representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 431.610, have the right to validate that (Name of the Facility) is in compliance with the requirements set forth in the Psych Under 21 rule, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the Indiana Medicaid program immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify the State Medicaid Agency if it is my belief that (Name of the Facility) is out of compliance with the requirements set forth in the Psych Under 21 rule.

Signature

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Printed Name

Title

Date

Instructions: Remove “Model Provider Attestation Letter” from the header and replace with your company name.
Rehabilitation Facility (Type 04)

All outpatient rehabilitation facilities are enrolled as billing providers. Out-of-state outpatient rehabilitation facilities are not eligible for enrollment in the IHCP. For IHCP enrollment purposes, two specialties are associated with provider type 04:

- 040 – Rehabilitation Facility
- 041 – Comprehensive Outpatient Rehabilitation Facility (CORF)

ISDH certifies rehabilitation facilities and agencies, as well as the comprehensive outpatient rehabilitation facilities (CORFs). ISDH certifies rehabilitation facilities. The ISDH forwards the information to Hewlett Packard Enterprise before the enrollment is completed.

Home Health Agency (Type 05)

All home health agencies are enrolled as billing providers. Out-of-state home health agencies are not eligible for enrollment in the IHCP. Some exceptions apply as noted in the Out-of-State Providers module. For IHCP enrollment purposes, the only specialty associated with the provider type 05 is 050 – Home health agency. The ISDH is the sanctioning body that certifies home health agencies. The ISDH forwards the information to Hewlett Packard Enterprise before the enrollment is finalized.

Hospice (Type 06)

Hospice providers are enrolled as billing providers. A hospice provider must be enrolled in Medicare to be eligible to enroll in Medicaid. Out-of-state hospice facilities are not eligible for enrollment in the IHCP. Some exceptions apply, as noted in the Out-of-State Providers module. For IHCP enrollment purposes, the one specialty associated with provider type 06 – Hospice is 060 – Hospice. Before hospice enrollment is completed, the enrollment requires ISDH certification information is forwarded to Hewlett Packard Enterprise, a copy of the CMS letter for each service location (identified as a satellite site), and a copy of the hospice license.

Clinic (Type 08)

Clinics are enrolled as group providers, and the specialty of the rendering providers linked to the group is dependent on the specialty of the clinic. This provider type is used for freestanding clinics that have multiple provider types and specialties linked to one clinic. The exception is a dental clinic, whose linkage is only provider type 27 – Dentist, and all dental specialties except 276 – Mobile dentist. Eight provider specialties are associated with provider type 08 – Clinic. The specific clinic provider specialties and the required documentation for each are as follows:

- 080 – Federally qualified health center (FQHC) must be enrolled as a group provider and must have a nurse practitioner on staff and a physician linked to the group. Out-of-state FQHCs are not eligible for enrollment in the IHCP. Before enrollment is finalized, a CMS approval letter is required for each location. A usual and customary charge (UCC) rate for encounter code T1015 is also required before the provider may submit encounter claims. The rate-setting contractor sends Hewlett Packard Enterprise the UCC rate, and that rate is specific to the service location (practice site).
- 081 – Rural health clinic (RHC) must be enrolled as a group provider and must have a nurse practitioner on staff and a physician linked to the group. Out-of-state RHCs are not eligible for enrollment in the IHCP. Before the enrollment is finalized, the ISDH must send Hewlett Packard Enterprise information that verifies Medicare participation approval for the provider. A UCC rate for encounter code T1015 is required before the provider may submit encounter claims. The rate-setting contractor sends Hewlett Packard Enterprise the UCC rate, and that rate is specific to the service location (practice site).
• 082 – Medical clinic must be enrolled as a group provider classification with different rendering provider specialties – usually at different levels, such as nurses and doctors – linked to the clinic.

• 083 – Family planning clinic must be enrolled as a group provider with nurse practitioners and physicians linked to the clinic.

• 084 – Nurse practitioner clinic must be enrolled as a group provider with one or more nurse practitioners linked to the clinic.

• 086 – Dental clinic must be enrolled as a group provider with one or more dentists linked to the clinic. The term “dental” can only be used in the name of a corporation if all shareholders are licensed dentists.

• 087 – Therapy clinic must be enrolled as a group with one or more therapy specialties such as 17/170 – Physical therapist, 17/171 – Occupational therapist, and 17/173 – Speech or hearing therapist and a minimum of two physicians, according to CMS Medicare provider enrollment guidelines for therapy clinics.

• 088 – Birthing center must be enrolled as a group provider with advanced practice nurses or certified midwives or physicians linked to the clinic.

Advanced Practice Nurse (Type 09)

Advanced practice nurses (APNs) may be enrolled as billing, group, or rendering providers. Six specialties are associated with provider type 09. The specialties are as follows:

• 090 – Pediatric nurse practitioner
• 091 – Obstetric nurse practitioner
• 092 – Family nurse practitioner
• 093 – Nurse practitioner (other)
• 094 – Certified registered nurse anesthetist (CRNA)
• 095 – Certified nurse midwife

For enrollment with prescriptive authority, the provider packet must include a current license issued by the appropriate state’s licensing agency giving prescriptive authority. A copy of the nurse practitioner certification issued by an organization accredited for certifying nurse practitioners is also required for enrollment.

Mental Health Provider (Type 11)

A mental health provider’s classification depends on the provider’s specialty. Specific requirements for each specialty associated with provider type 11 – Mental health provider are as follows:

• 110 – Outpatient mental health clinic must be enrolled as a group with an HSPP, psychiatrist, or medical physician group members (rendering providers). A completed Outpatient Mental Health Addendum is required and is included in the enrollment packet. Out-of-state outpatient mental health clinics are not eligible for enrollment in the IHCP.

• 111 – Community mental health center (CMHC) must be enrolled as a group with group members (rendering providers). Out-of-state CMHCs are not eligible for enrollment in the IHCP. Certification from the FSSA’s DMHA and a completed Outpatient Mental Health Addendum are required. CMHCs may provide primary care services to IHCP members. Services must be provided by IHCP-enrolled providers authorized to provide primary healthcare.

• 114 – Health service provider in psychology (HSPP) may be enrolled as a billing provider, a group with members, or a rendering provider linked to a group. A copy of the provider’s current license from the appropriate state’s licensing agency with the HSPP endorsement is required.
• 613 – MRO clubhouse may be enrolled as a rendering provider that can render psychosocial rehabilitation services when linked to a DMHA-approved, IHCP-enrolled Medicaid Rehabilitation Option (MRO) provider.

The following specialties are associated with the 1915(i) Home and Community-Based Services (HCBS) programs under the Indiana State Plan and administered by the DMHA:

• 115 – Adult Mental Health and Habilitation (AMHH) may be enrolled as a group with group members, rendering, and billing. Out-of-state providers are not eligible. DMHA adult provider certification is required to add these specialties. Contact DMHA for certification process information.

• 611 – Child Mental Health Wraparound (CMHW) may be enrolled as a billing provider, a group with members, or renderings. Out-of-state providers are not eligible. Certification from DMHA is required. Contact DMHA for certification process information.

• 612 – Behavioral and Primary Healthcare Coordination (BPHC) is a specialty that is only added to an enrolled CMHC with certification by DMHA.

School Corporation (Type 12)

School corporations and charter schools are enrolled as billing providers. Out-of-state school corporations are not eligible for enrollment in the IHCP. One specialty is associated with the provider type 12 – School corporation. The specialty is provider specialty 120 – School corporation. The school corporation or charter school must be listed on the approved Indiana Department of Education’s school corporation or charter school listings. Cooperatives (co-ops) within school corporation districts are not enrolled in the IHCP; only the school corporation is enrolled.

Public Health Agency (Type 13)

Public health agencies are enrolled as billing and group providers with a single specialty, provider specialty 130 – County health department. Out-of-state public health agencies are not eligible for enrollment in the IHCP. Public health agencies enrolled as groups must have rendering providers linked to the group.

Podiatrist (Type 14)

Podiatrists may be enrolled as billing providers, groups with group members (rendering providers), or rendering providers linked to a group. Individual providers must submit a copy of their current and active license from the appropriate state’s licensing agency. Podiatrists have one specialty, provider specialty 140 – Podiatrist.

Chiropractor (Type 15)

Chiropractors may be enrolled as billing providers, groups with group members (rendering providers), or rendering providers linked to a group. Individual providers must submit a copy of their current and active license from the appropriate state’s licensing agency. Chiropractors have one specialty, provider specialty 150 – Chiropractor.

Therapist (Type 17)

Therapists may be enrolled as billing providers, groups with members, or rendering providers linked to a group. A copy of a current and active license from the appropriate state’s licensing agency is required. Three specialties are associated with provider type 17 – Therapist:

• 170 – Physical therapist
• 171 – Occupational therapist
• 173 – Speech/hearing therapist
Optometrist (Type 18)

Optometrists may be enrolled as billing providers, groups with members, or rendering providers linked to a group. In accordance with IC 25-1-9-5, optometry groups must be owned by optometrists. A copy of a current and active license from the appropriate state’s licensing agency is required. Provider specialty 180 – Optometrist is associated with provider type 18 – Optometrist.

Optician (Type 19)

Opticians are enrolled as billing providers or rendering providers linked to an optometrist group, and may not be a group provider with members (rendering providers). Provider specialty 190 – Optician is associated with provider type 19 – Optician.

Audiologist (Type 20)

Audiologists may be enrolled as sole practitioner (billing) providers, groups with members (rendering providers), or rendering providers linked to a group. A copy of a current and active license from the appropriate state’s licensing agency is required. Provider specialty 200 – Audiologist is associated with provider type 20 – Audiologist. Audiologists who are also hearing aid dealers do not need to enroll separately as a hearing aid dealer.

Hearing Aid Dealer (Type 22)

Hearing aid dealers can be enrolled as billing providers only and cannot be a group with members. A single specialty, provider specialty 220 – Hearing aid dealer is associated with provider type 22 – Hearing aid dealer. A copy of a current and active hearing aid dealer license from the appropriate state’s licensing agency is required.

Pharmacy (Type 24)

Pharmacies are enrolled as billing providers only and have a single specialty, provider specialty 240 – Pharmacy. A copy of the current and active pharmacy license must be submitted for enrollment in the IHCP. Nonresident pharmacy providers that deliver drugs to Indiana patients via United States Postal Service or other delivery services, such as FedEx or DHL, are required to have an IPLA nonresident pharmacy permit and a license issued by the home state (other than Indiana). Pharmacy providers can add the provider specialty 250 – DME/medical supply dealer and 251 – HME/home medical equipment when applicable. Those pharmacies adding the 251 specialty that are located out of state and deliver devices to Indiana patients via the United States Postal Service or other delivery services, such as FedEx or DHL, are required to submit an IPLA nonresident pharmacy license and a pharmacy license issued by their state (other than Indiana). If providers are Medicare-enrolled, they must report that information during their IHCP enrollment.

One provider number is assigned to the provider for all the specialties. When a pharmacy chain is enrolled, each store receives an individual provider number. Each new provider number can be assigned one or all of the specialties.

Durable Medical Equipment (Type 25)

Stand-alone DME providers can be enrolled as billing providers only. A DME provider is assigned specialty 250 – DME/medical supply dealer. DME providers can add specialty 251 – HME/home medical equipment to their enrollment when applicable. For Indiana providers only, to add the HME specialty to a DME provider’s enrollment, a copy of the HME license must be submitted with the enrollment packet. A copy of the provider’s Retail Merchant’s Certificate is required at the time of enrollment. Out-of-state DME providers require prior authorization for services unless the provider has a service location (practice site) in Indiana. If providers are Medicare-enrolled, they must report that information during their IHCP enrollment.
Home Medical Equipment (Type 25)

Stand-alone HME providers can be enrolled as billing providers only. An HME provider is assigned specialty 251 – HME/home medical equipment. HME providers can add specialty 250 – DME/medical supply dealer to their enrollment when applicable. All HME providers providing services to Indiana clients must be licensed by the IPLA and must present a copy of the license with the enrollment packet. A copy of the provider’s Retail Merchant’s Certificate is required at the time of enrollment. Out-of-state HME providers must possess an Indiana HME license and require prior authorization for services unless the provider has a service location (practice site) in Indiana. If providers are Medicare-enrolled, they must report that information during their IHCP enrollment.

Transportation (Type 26)

Transportation providers can be enrolled as billing providers only and must be recertified annually or based upon permits, certificates, and liability insurance coverage periods. Seven specialties are associated with transportation providers. The following list includes specialty types and specific requirements for enrollment in the IHCP and provider maintenance:

- **260 – Ambulance**
  Ambulance providers must submit a copy of their emergency medical services (EMS) commission certificate for enrollment and recertification in the IHCP, based on certificate end date.

- **261 – Air ambulance**
  Air ambulance providers must submit a copy of their EMS commission certificate for enrollment and annual recertification in the IHCP.

- **262 – Bus**
  Bus providers must submit a copy of their Motor Carriers Services (MCS) certificate issued by the Indiana Department of Revenue for enrollment and annual recertification in the IHCP.

- **263 – Taxi**
  Taxi providers must submit a document showing operating authority from a local governing body (city taxi or livery license); a copy of appropriate driver’s licenses for all drivers; and proof of livery insurance indicated by local ordinances or, if unspecified by local ordinance, a minimum of $25,000/$50,000 of public livery insurance covering all vehicles used in the business.

  Taxi providers cannot transport outside the jurisdiction designated by their city taxi license. To transport outside the jurisdiction, the taxi provider must be enrolled as a common carrier, provider specialties 264 and 265. If a taxi transports across county borders, the Indiana Department of Revenue’s Motor Carrier Services Division must certify as a common carrier.

- **264 – Common carrier (ambulatory) and 265 – Common carrier (nonambulatory)**
  Common carrier providers are categorized as for-profit and not-for-profit businesses. Each category has specific certification and supporting documentation requirements:
  - For-profit common carriers must submit a copy of their MCS certificate from the Indiana Department of Revenue, proof of insurance coverage, and appropriate and valid driver’s licenses for all drivers.
  - Not-for-profit common carriers must submit a copy of their not-for-profit status from the IRS, a copy of appropriate driver’s licenses for all drivers, and proof of insurance (the requirement is $500,000 combined single limit commercial automobile liability insurance).
Note: The IHCP provides reimbursement for transportation of ambulatory (walking) members to or from an IHCP-covered service. Commercial or common ambulatory service (CAS) transportation may be provided in any type of vehicle. The IHCP reimburses for nonambulatory services (NAS) or wheelchair services when a member must travel in a wheelchair to or from an IHCP-covered service.

- **266 – Family member**

Family member providers must submit an authorization letter from the local Division of Family Resources (DFR), proof of insurance (must be minimum state required limits), and a copy of driver’s licenses for all drivers. Out-of-state family member transportation providers are not eligible for enrollment in the IHCP.

**Note:** The authorization letter from the local county office of the DFR contains the member’s name and member identification number along with the following:
- Name, address, and relationship to the family member provider
- Description of the circumstances surrounding the request
- Statement of the financial impact on the family as a result of providing transportation services to the member
- Desired effective date for the enrollment of the family member
- Transportation provider

**Surety Bond Requirements**

The IHCP requires a surety bond from entities applying to enroll as a common carrier (ambulatory or nonambulatory) or a taxi transportation provider (Type 26/Specialties 263, 264, and 265). The surety bond must be in the amount of at least $50,000 and must last a minimum of three years.

The following are exceptions to the surety bond requirement:
- Not-for-profit status – a 501(c)(3) organization only
- Owned or controlled by a person that is licensed or certified by the Indiana Professional Licensing Agency (IPLA)
- Owned or controlled by a pharmacy with a permit issued by the Indiana Board of Pharmacy
- Owned or controlled by a hospital licensed by the Indiana State Department of Health (ISDH)
- Granted a waiver of the requirement at the discretion of the Secretary of Family and Social Services Administration (FSSA):
  - If transportation services are to be provided in a federal or state designated underserved area
  - If it has been determined the provider does not pose a significant risk of submitting fraudulent or false Medicaid claims

Providers seeking a waiver of the surety bond requirement must submit a written request with their enrollment packet. The letter must specify why the request is being made and how the enrolling provider believes they qualify for the waiver. The final decision whether to waive the requirement will be made by the FSSA.

**Note:** If a waiver is requested, the provider’s application will not be processed until a decision is made to grant or deny the waiver.

If the waiver is not granted, the provider has 30 days from the date on the notice of rejection to submit the required bond.
The required surety bond can be obtained by contacting a licensed insurance broker who will find a company to underwrite the bond. It is important that the broker be given the specific surety bond requirements to ensure that the bond is compliant with the new regulation. The Indiana Medicaid Surety Bond Requirements and the Surety Bond Form at indianamedicaid.com outlines the requirements and can be copied for reference by the insurance broker.

**Dentist (Type 27)**

Dentists may be enrolled in the IHCP as billing, group, or rendering providers. Dental practices must be owned by licensed dentists. Indiana law prohibits a non-dentist owner in any dental practice. Dental providers include the following specialties and require submission of a copy of a current license issued by the appropriate state’s licensing agency:

- 270 – Endodontist
- 271 – General dentistry practitioner
- 272 – Oral surgeon
- 273 – Orthodontist
- 274 – Pediatric dentist
- 275 – Periodontist
- 276 – Mobile dental van
- 277 – Prosthesis

Provider specialty 276 must be enrolled as a group with members and submit a copy of their current Mobile Dental License issued by the IPLA.

**Laboratory (Type 28)**

Laboratories must be billing providers only and cannot be enrolled as groups with members. A Clinical Laboratory Improvement Amendment (CLIA) certificate is required for Independent Labs and Mobile Labs for the location where services are rendered. Independent diagnostic testing facilities (IDTFs) and mobile IDTFs do not require a CLIA certificate. Four specialties are associated with laboratories:

- 280 – Independent lab
- 281 – Mobile lab
- 282 – Independent diagnostic testing facility (IDTF)
- 283 – Mobile independent diagnostic testing facility (IDTF)

**Radiology (Type 29)**

Radiology clinics can be enrolled as billing providers or groups with members. Radiology groups’ rendering members are enrolled with provider type 31 – Physician with provider specialty 341.

Two specialties are associated with radiology:

- 290 – Freestanding x-ray clinic
- 291 – Mobile x-ray clinic

Radiology providers are required to submit a copy of their registration certificate, ISDH Notice of Compliance, and operator certificates for all employee operators except positron emission tomography computed tomography (PET CT) scanner operators.
Out-of-state mobile radiology providers performing services in Indiana must be certified in Indiana and possess a Notice of Compliance in Indiana. All operators must be certified in the state of Indiana.

**End-Stage Renal Disease Clinic (Type 30)**

End-stage renal disease (ESRD) clinics must be enrolled as billing providers and cannot be enrolled as groups with members. Out-of-state ESRD clinics are not eligible for enrollment in the IHCP. A single specialty is associated with ESRD clinics, provider specialty 300 – *Free-standing renal dialysis clinic*. ISDH sends certification information to Hewlett Packard Enterprise. ESRD clinics are required to have a valid CLIA certificate on file with the IHCP, which can be the lab provider’s contract to perform lab services. It is the provider’s responsibility to update CLIA certifications if there are changes to the CLIA certification level, or if the CLIA number changes. The CMS regularly notifies Hewlett Packard Enterprise of updates to the end date for the CLIA number on file, but providers must still report as an update any change to the CLIA number on file.

**Physician (Type 31)**

Physicians may be enrolled as billing providers, groups with members, or rendering providers linked to a group. A copy of a current physician’s license issued by the State for the physical location where services are rendered must be submitted for enrollment in the IHCP. Physician groups are required to enroll each service location (practice site) they operate and submit rendering provider documents for linkage to the service locations (practice sites).

The following are the physician specialties associated with provider type 31:

- 310 – Allergist
- 311 – Anesthesiologist
- 312 – Cardiologist
- 313 – *Cardiovascular surgeon*
- 314 – Dermatologist
- 315 – *Emergency medicine practitioner*
- 316 – *Family practitioner*
- 317 – Gastroenterologist
- 318 – *General practitioner*
- 319 – *General surgeon*
- 320 – *Geriatric practitioner*
- 321 – *Hand surgeon*
- 323 – *Neonatologist*
- 324 – *Nephrologist*
- 325 – *Neurological surgeon*
- 326 – *Neurologist*
- 327 – *Nuclear medicine practitioner*
• 328 – Obstetrician/gynecologist
• 329 – Oncologist
• 330 – Ophthalmologist
• 331 – Orthopedic surgeon
• 332 – Otologist/laryngologist/rhinologist
• 333 – Pathologist
• 334 – Pediatric surgeon
• 336 – Physical medicine and rehabilitation practitioner
• 337 – Plastic surgeon
• 338 – Proctologist
• 339 – Psychiatrist
• 340 – Pulmonary disease specialist
• 341 – Radiologist
• 342 – Thoracic surgeon
• 343 – Urologist
• 344 – General internist
• 345 – General pediatrician
• 346 – Dispensing physician

Providers intending to be a primary medical provider (PMP) with HIP, Hoosier Care Connect, or Hoosier Healthwise must choose an appropriate primary provider specialty. See the Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise Provider Enrollment section of this document for a list of the applicable provider specialties.

Locum tenens and substitute physicians are physicians that fill in for a member’s regular physician. A locum tenens or substitute physician must be from the same discipline as the regular physician. A substitute physician is a physician who is asked to see a member in a reciprocal arrangement when the regular physician is unavailable to see the member. Substitute physicians are required to be enrolled in the IHCP. The locum tenens arrangement is made when the regular physician must leave his or her practice due to illness, vacation, or medical education opportunity and does not want to leave his or her patients without service during the period. The locum tenens physician cannot be a member of the group in which the regular physician is a member. The locum tenens physician must meet all requirements to practice in Indiana; however, the locum tenens physician is not required to be an enrolled IHCP provider. For more information about billing for locum tenens and substitute physicians, see the Substitute Physicians and Locum Tenens section of this document.

Home and Community-Based Services 1915(c) Waiver (Type 32)

Provider type 32 – Waiver provider may be enrolled as sole practitioners (billing), groups with members, or rendering providers linked to a group. Before an IHCP enrollment application can be submitted, the FSSA Division of Aging, Division of Developmental and Rehabilitative Services, or Division of Mental Health and Addiction waiver provider specialists must certify the waiver provider.
Seven specialties are associated with the waiver provider type. Each specialty has multiple secondary specialties. The Waiver Certification Form, issued by the waiver agency, lists the specialties and secondary specialties for which the provider has been approved.

The specialties are associated with the waiver provider type 32.

- 350 – Aged and Disabled (A&D) Waiver
- 356 – Traumatic Brain Injury (TBI) Waiver
- 359 – Community Integration and Habilitation Waiver
- 360 – Family Supports Waiver
- 363 – Money Follows the Person (MFP) Demonstration Grant
- 364 – Money Follows the Person (MFP) PRTF Grant
- 365 – PRTF Transition Waiver

For a list of the secondary specialties, see the IHCP Provider Enrollment Type and Specialty Matrix.

**MRT Copy Center (Type 34)**

Medical Review Team (MRT) copy center is the provider type used for entities that provide only medical record copying and provision for the MRT program. The provider specialty 366 – Medical Review Team (MRT) copy center is assigned as the primary specialty for provider type 34 – MRT copy center.

**Ordering, Prescribing, or Referring Providers (Type 50)**

For Medicaid to reimburse for services or medical supplies that are provided as a result of a provider’s order, prescription, or referral, federal regulations (42 CFR Parts 405, 447, 455, 457, and 498) require that the ordering, prescribing, or referring (OPR) provider be enrolled in Medicaid.

To address this requirement and to encourage nonenrolled practitioners to enroll in the IHCP, a category of enrollment has been created for OPR providers. This OPR provider category is appropriate for practitioners who:

- May occasionally see an individual who is an IHCP member and needs additional services or supplies that will be covered by the Medicaid program
- Do not want to be enrolled as another IHCP provider type
- Do not plan to submit claims to the IHCP for payment of services rendered
- Practitioners not otherwise enrolled as IHCP providers can enroll as OPR providers.

**Requirements**

Participating in the IHCP as an OPR provider allows Medicaid reimbursement for the covered services and supplies that the OPR provider orders, prescribes, or refers for IHCP-member patients. A simplified application process requires minimal information and time and makes participation easy.
Before enrolling, providers should note the following:

- If providers are already enrolled as another type of provider in the IHCP, they do not need to enroll as an OPR provider.
- OPR providers cannot submit claims to the IHCP for payment of services rendered. If a provider wants to be able to submit claims, enrollment as another IHCP provider type is required.
- A provider must have a National Provider Identifier (NPI).
  - The NPI is the standard, unique health identifier for healthcare providers and is assigned by the National Plan and Provider Enumeration System (NPPES).
  - Applying for the NPI is a process separate from IHCP enrollment.
  - To obtain an NPI, apply online at NPPES.cms.hhs.gov.

For more information about NPI enumeration, see the Enumeration Reports page at cms.gov.

### Enrolling as an OPR Provider

To enroll as a billing, group, or rendering provider, click the Provider Enrollment link on the Provider Healthcare Portal at portal.indianamedicaid.com, and follow the instructions provided. Or, to enroll by mail, see the Complete an IHCP Provider Packet page, available at indianamedicaid.com, and follow these steps:

1. Complete the IHCP Ordering, Prescribing, Referring Provider Enrollment and Profile Maintenance Packet. Detailed instructions are included in the packet.
   - The IHCP provider packet is an interactive PDF file, allowing providers to type information into the fields from your computer, save the completed file to your computer, and print the file for mailing.
   - OPR providers are not required to pay an application fee.

2. Submit the packet using the mailing instructions in the Mailing and Processing OPR Provider Transactions section.

### Updating OPR Provider Information

When an enrolled provider’s information changes (for example, when license information, contact information, name, or address changes), providers are required to submit updated information to the IHCP within 10 business days. Updates may be sent via the Portal or, as follows, by mail:

1. Complete the IHCP Ordering, Prescribing, Referring Provider Enrollment and Profile Maintenance Packet. Detailed instructions are included in the packet. Complete only the following:
   - Fields 1 through 3 in Section II – Provider Information
   - Any other fields with information that needs to be updated
   - Section VI – Provider Signature/Attestation

2. Submit the packet using the mailing instructions in the Mailing and Processing OPR Provider Transactions section.

### Recertifying OPR Provider Enrollment

OPR providers must maintain an active license to remain enrolled in the IHCP. Providers are not required to submit documentation to recertify their enrollment; the IHCP verifies licensing information on a monthly basis and may deactivate a provider’s enrollment based on license status.
**Disenrolling as an OPR Provider**

OPR providers may voluntarily disenroll from the IHCP at any time. Providers may disenroll via the Portal or, as follows, by mail:

1. Complete the *IHCP Ordering, Prescribing, Referring Provider Enrollment and Profile Maintenance Packet*. Detailed instructions are included in the packet. Complete only the following:
   - Fields 1 through 3 and 14 in Section II – Provider Information
   - Section VI – Provider Signature/Attestation
2. Submit the packet using the mailing instructions in the *Mailing and Processing OPR Provider Transactions* section.

After disenrolling as an OPR provider, providers may enroll as another provider type by submitting the appropriate enrollment packet. For more information about enrolling as another provider type, see the *Complete an IHCP Provider Packet* page at indianamedicaid.com.

**Mailing and Processing OPR Provider Transactions**

Before mailing the provider packet, providers should make a copy of the completed packet for their records. Mail the completed packet to Hewlett Packard Enterprise at the following address:

**Provider Enrollment**

P.O. Box 7263

Indianapolis, IN 46207-7263

Allow at least 20 business days for mailing and processing before checking the status of submission. After the transaction is processed, the Provider Enrollment Unit will notify the provider of the results.

- If the packet is incomplete, the Provider Enrollment Unit will contact the provider in an attempt to complete the packet. If the incomplete packet is not corrected, the application cannot be processed.
- If the packet is complete, the provider transaction will be processed.
- If the IHCP confirms the provider’s enrollment, the Provider Enrollment Unit will send a verification letter to the provider.
- If the IHCP denies enrollment, the provider will receive a notification letter explaining the denial reason. If a provider believes their enrollment was denied in error, the provider may appeal. See the *Appeal Process* section of this document for information.

**Opioid Treatment Programs Required to Enroll with IHCP**

Effective July 1, 2016, *Senate Enrolled Act (SEA) 297 (2016)* requires opioid treatment programs certified by the Indiana Family and Social Services Administration, Division of Mental Health and Addiction (FSSA/DMHA) to enroll as IHCP providers. SEA 297 amends *Indiana Code IC 12-23-18-0.5* to mandate that opioid treatment programs shall not operate in the state of Indiana unless they are enrolled with the IHCP prior to July 1, 2017.

Opioid treatment programs may enroll with the IHCP as billing providers or as ordering, prescribing, or referring (OPR) providers. Enrolled billing providers are eligible for IHCP reimbursement for covered services rendered. Enrolled OPR providers do not bill the IHCP for services but may order, prescribe, or refer services and supplies for patients that are IHCP members, and the rendering provider would be reimbursed. Note that practitioners working with opioid treatment programs who write orders, referrals, or prescriptions for individuals covered by Indiana’s Medicaid program must also individually enroll with the IHCP for those services to be covered and reimbursed.
Opioid treatment programs enrolling as billing providers should enroll under the appropriate provider type and specialty. The provider types eligible for IHCP enrollment are listed on the [Complete an IHCP Provider Packet](https://indianamedicaid.com) page at indianamedicaid.com. See the [IHCP Provider Enrollment Type and Specialty Matrix](https://indianamedicaid.com) to determine the appropriate provider type and specialty and to identify the documents that must be submitted for enrollment. Opioid treatment programs and individual practitioners enrolled as IHCP providers may contract with one or more IHCP managed care entities (MCEs) to serve members in managed care programs, including the Healthy Indiana Plan (HIP). See the [Managed Care](https://indianamedicaid.com) page at indianamedicaid.com for information about the managed care programs and the MCEs with which the State contracts.

Opioid treatment programs enrolling as OPRs are required by SEA 297 to maintain a memorandum of understanding with a community mental health center (CMHC) for the purpose of referring patients for services. Additionally, these opioid treatment programs are required to annually report information to the IHCP concerning members who receive services at their facilities. These reports must be filed by September 1 for the preceding fiscal year and must include:

- The number of Medicaid patients seen
- The services received by the program’s Medicaid patients, including any drugs prescribed
- The number of Medicaid patients referred to other providers
- The other provider types to which the Medicaid patients were referred

**Provider Information Maintenance**

To maintain the accuracy of the provider enrollment file, providers must notify Hewlett Packard Enterprise within 10 business days of any changes in the following information:

- Provider address, including changes to a mail-to, pay-to, service location (practice site), or home office (legal) address
- Licensure or certification
- Clinical Laboratory Improvement Amendments (CLIA) certification
- Medicare provider number
- Addition to or removal of a rendering provider from the group
- Specialty
- Taxpayer identification number (TIN)
- Legal name or doing business as (DBA) name
- Ownership
- Electronic funds transfer (EFT) account information
- Enrollment status ( disenrollment requests)

Delays in submitting this information to Provider Enrollment may result in erroneous payments or denials.

**Submitting Provider Information Updates**

Requests for changes to provider information can be updated electronically on the Portal or submitted by mail, using the appropriate maintenance form located on the [Update Your Provider Profile](https://indianamedicaid.com) page at indianamedicaid.com. Providers can also submit an IHCP provider packet with updates.
Changes to current provider file data must be authorized by written request from the provider or by direction from the FSSA.

Indicate the NPI and appropriate provider name on all correspondence. Delays in submitting this information to Provider Enrollment may result in erroneous payments or denials

**Submitting Updates by Mail**

IHCP provider packets and profile maintenance forms are available for making changes to the provider information on file with the IHCP. Updates submitted by mail using anything other than the appropriate forms are not accepted and are returned to the provider. An authorized owner or officer of the company must sign the form.

The provider profile maintenance (update) forms enable providers to request very specific changes to their current information on file. The following maintenance forms are available on the [Update Your Provider Profile](indianamedicaid.com) page:

- **IHCP Provider Disenrollment Form** is used to voluntarily disenroll from the IHCP.
- **IHCP Provider Enrollment Recertification of Licenses and Certifications Form** is used for providers that are required to recertify their enrollment credentials to continue to be enrolled with the IHCP. Providers receive written notification when it is time to recertify. The recertification form must be accompanied by supporting documentation as indicated on the [IHCP Provider Enrollment Type and Specialty Matrix](indianamedicaid.com).
- **IHCP Provider CLIA Certification Maintenance Form** is only used when there is a change to the level of CLIA certification a provider has been granted.
- **IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form** is used to request electronic funds transfer (EFT) instead of paper checks.
- **IHCP Provider Medicare Number Maintenance Form** is used to update Medicare numbers.
- **IHCP Provider Name and Address Maintenance Form** is used to update any of the four address types (home/legal office, mail-to, pay-to, or service location).
- **IHCP Provider Specialty Maintenance Form** is used to request a change to the specialty.
- **IHCP Provider Taxpayer Identification Number Maintenance Form** is used to make a change to TIN when it is not related to a change in ownership or transfer of assets.
- **IHCP Provider Delegated Administrator Addendum/Maintenance Form** is used to grant, change, or revoke authority for a specific individual to sign and submit certain documents on behalf of the provider. The form contains a list of the documents for which authority may be delegated.
- **IHCP Psychiatric Hospital Bed Addendum/Maintenance Form** is used to determine if your facility qualifies for reimbursement as a 16-bed or less psychiatric facility. This form applies only to provider type 01 – Hospital, specialty 011 – Psychiatric.
- **IHCP PRTF Attestation Letter/Maintenance Form** is used for the “Psych Under 21 Rule” that requires PRTF facilities to provide attestations of compliance each year by July 21 (or by the next business day if July 21 falls on a weekend or holiday). This form applies only to provider type 03 – Extended Care Facility, specialty 034 – Psychiatric Residential Treatment Facility. Use this form when submitting the annual attestation.
Provider Enrollment

- **Internal Revenue Service (IRS) Form W-9**, referred to as W-9, is used with the submitted enrollment packet or update form. Please follow [IRS instructions for completing the W-9](#). IRS states the following for disregarded entities: For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a “disregarded entity.” See [Regulations section 301.7701-2(c)(2)(iii)](#).
  - Enter the owner’s name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign limited liability corporation (LLC) that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner’s name is required to be provided on line 1.
  - If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity’s name on line 2, “Business name/disregarded entity name.”
  - If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a W-9, even if the foreign person has a U.S. taxpayer identification number (TIN).

To make multiple updates in one submission, use the **IHCP Provider Enrollment and Profile Maintenance Packet**. For example, a provider would use the packet specified by his or her provider type and classification to report an address change, a new EFT account, and Medicare numbers at the same time.

Send all IHCP provider packets and profile maintenance forms to Hewlett Packard Enterprise at the following address:

**Provider Enrollment Unit**
P.O. Box 7263
Indianapolis, IN 46207-7263

### Submitting Updates via the Provider Healthcare Portal

The Portal allows providers to view their information on file with the IHCP. Groups are also able to view all the rendering providers associated with their practice.

Portal users with appropriate administrative privileges also have the ability to update provider information online, rather than by sending a paper form. The following options are available from the Provider Maintenance page of the Portal:

- **Address Changes** – Change legal, mail-to, pay-to, and service location addresses. Dental providers can use this option to indicate whether they are accepting new patients or patients with special needs.
- **Specialty Changes** – Add additional specialties to an existing profile, unless restricted by type/specialty; for example, transportation and waiver providers may not change specialty, and no high- or moderate-risk specialty can be added or changed (cannot change primary specialty).
- **EFT Changes** – Enroll in EFT or change existing EFT information.
- **Presumptive Eligibility Changes** – Enroll as a qualified provider for the Presumptive Eligibility (PE), Presumptive Eligibility for Pregnant Women (PEPW), or Hospital Presumptive Eligibility (Hospital PE) processes. Only certain specialties can enroll as qualified providers; for a complete list of provider types, see the [Presumptive Eligibility](#), [Presumptive Eligibility for Pregnant Women](#), and [Hospital Presumptive Eligibility](#) modules.
- **Other Information Changes** – Enroll in IHCP programs such as Medical Review Team (MRT), the 590 Program, and Preadmission Screening and Resident Review (PASRR), if appropriate based on provider type/specialty.
- **Other Identification Changes** – Perform a variety of updates, including changes to legal name, organizational structure, NPI, taxonomy information, certificate/license information, Medicare participation, and patient population.
Tax ID Changes – Update TIN and SSN information. (Submission of a W-9 required.)

Contact and Delegated Administrator Information Changes – Make changes to delegated administrators for paper submissions.

Language Changes – Add languages for which the provider is able to interpret.

ERA Changes – Sign up to receive claim payment information using electronic remittance advice (ERA) 835 transactions.

Rendering Provider Changes – Add or remove rendering providers linked to the group provider.

Disclosure Changes – Report any new owners or managers and maintain address information for all disclosed entities.

The following additional update options are available from the My Home page of the Portal:

- Link to MAPIR – Register for the Electronic Health Records (EHR) incentive program. (This option appears only for eligible provider types.)
- Disenroll – Voluntarily disenroll from the IHCP.

Check with the Portal administrator in your organization for permissions to make provider maintenance updates. Additional information about becoming an administrator can be found in the FAQs at the top each page of the Portal, or in the Provider Healthcare Portal module.

**Provider Maintenance Details**

The following sections describe different types of provider information updates.

**Address Change**

It is extremely important that address information is current, because out-of-date address information can affect provider payment and receipt of program-related correspondence. Hewlett Packard Enterprise maintains four addresses in the provider master file (PMF) for each billing provider or group provider service location. The four addresses and their uses are listed in Table 1. All addresses must be current to avoid returned mail.

<table>
<thead>
<tr>
<th>Address Name</th>
<th>Correspondence</th>
</tr>
</thead>
</table>
| Home office (legal) address (corporate office or headquarters) | • 1099s  
• IRS information |
| Mail-to address | • Provider update and enrollment confirmation letters  
• Recertification Notice  
• Revalidation Notice  
• Special correspondence |
| Pay-to address | • IHCP payments  
• PMP disenrollment letters |
| Service location address | Physical location where services are rendered or claim documentation can be reviewed |

Address information can be regularly maintained by making updates via the Portal’s Provider Maintenance page or by submitting an IHCP Provider Name and Address Maintenance Form.
• Providers that fail to maintain their address information are subject to termination if mail is returned to Hewlett Packard Enterprise without a forwarding address.

• Forwarding addresses are used by Provider Enrollment to request an address update from providers, not to update information in CoreMMIS.

• If an existing provider moves his or her home office, the provider must separately update the home office (legal) address for each affected enrolled service location.

• Any changes to the home office (legal) address reported to the IHCP must be supported by a copy of a W-9 showing the same change was reported to the IRS, using the version of the W-9 currently posted on the IRS website.

If a provider is experiencing an interruption in normal mail from the IHCP, the provider may call Customer Assistance at 1-800-457-4584 or submit the appropriate provider maintenance form or Portal update.

Add a Service Location (Practice Site)

To add a new service location, billing providers must complete a new provider enrollment application. Providers must complete a separate provider packet or online application to enroll each new service location. For provider types considered at moderate or high risk for fraud, an unannounced site visit must be successful before a new service location can be added.

Close a Service Location

To disenroll a service location, providers must use the Disenroll link on the Portal’s My Home page or submit an IHCP Provider Disenrollment Form. Providers should indicate on the form which service location they want to deactivate. An authorized official listed in section C.1 or C.3 of Schedule C must sign the form to ensure processing. Failure to indicate the request type or to include an authorized official’s signature will result in the return of the document.

Provider Recertification

Providers that are required to recertify must submit the appropriate updates via the Provider Maintenance page of the Portal or using the IHCP Provider Enrollment Recertification of Licenses and Certifications Form. The appropriate certificate, approval letter or notice, proof of insurance, or license to extend their eligibility must be submitted along with the update.

Use the IHCP Provider CLIA Certification Maintenance Form to report a change to the level of CLIA certification a provider has been granted

Rendering Provider Updates

Group practices must submit enrollment applications and updates for their rendering providers. Groups report changes to their rendering providers’ status in addition to requests to enroll new rendering members. A current and active license is required for all rendering providers. The group must submit documentation that shows participation in either program for their rendering providers that apply for enrollment in the IHCP.
The IHCP policy requires rendering providers to be linked to each specific group service location where they render services. Hewlett Packard Enterprise links new rendering providers to the appropriate service locations (practice sites) or terminates linkage when requested.

Add Linkage

The group provider must submit all rendering provider enrollment and linkage requests to the Provider Enrollment Unit using the IHCP Rendering Provider Enrollment and Profile Maintenance Packet or the Rendering Provider Changes option on the Provider Maintenance page of the Portal. (New rendering providers must first enroll before they can be linked to a group on the Portal.) Group entities may add a newly enrolling or currently enrolled rendering provider to their service locations. When adding new rendering providers to a group, the rendering provider’s start date at the service location is indicated on Schedule B of the packet. Requests to enroll group members must be signed by an individual identified in section C.1 or C.3 of Schedule C in the group’s packet.

Deactivate Linkage

When rendering providers leave a group, the group or rendering provider must request a linkage deactivation to the group using the Rendering Provider Changes option on the Provider Maintenance page of the Portal, or on an IHCP Rendering Provider Enrollment and Profile Maintenance Packet or, for multiple deactivations, an IHCP Provider Disenrollment Form. The deactivation request should give the date the member left the group. The form must be signed.

Specialty Change

Changes to a specialty can be updated by using the Specialty Changes option on the Provider Maintenance page of the Portal, or by submitting an IHCP Provider Specialty Maintenance Form.

Taxpayer Identification Number Change

TIN changes occur when a provider submits an IHCP Provider Taxpayer Identification Number Maintenance Form or uses the Tax ID Changes option on the Provider Maintenance page of the Portal. A W-9 that contains the new TIN is required when making this change. A copy of the IRS TIN registration confirmation letter is required to support the new number.

TIN changes resulting from a change of ownership require completion of an IHCP provider packet or Portal enrollment application. See the Provider Reorganization and Change of Ownership section.

Name Change

For a change of legal name or doing business as (DBA) name not resulting from a change of ownership, providers can use the Provider Identification Changes option on the Provider Maintenance page of the Portal, or submit an IHCP Provider Name and Address Maintenance Form. In addition, providers must submit a W-9 that shows the new provider name.

Provider Reorganization and Change of Ownership

Providers are encouraged to use the Portal to perform change of ownership (CHOW) enrollments. The Portal provides step-by-step instructions for enrolling as a CHOW. All providers must report any CHOW, including, but not limited to, any change in direct or indirect ownership or control interest, merger, corporate reorganization, change in legal or DBA name, or change in federal TIN.
The new ownership entity must submit the following:

- A Portal enrollment application with CHOW selected as the provider classification

  Or

- A completed *IHCP Provider Enrollment and Profile Maintenance Packet*, including a signed *IHCP Provider Agreement* and an *IHCP Provider Change of Ownership Addendum*

- A W-9

- A copy of the purchase agreement or bill of sale

- Appropriate licensure, where applicable

- Any other appropriate forms or attachments necessary for enrollment

Additionally, *405 IAC 1-20* requires long-term care (LTC) providers to notify OMPP or the fiscal agent no less than 45 business days *before* the anticipated effective date of sale or lease agreement that a change of ownership may take place. Notification must be submitted in writing, and must include the following information:

- A copy of the agreement of sale or transfer

- The expected date of the sale or transfer

- If applicable, the name of any individual who:
  - Has an ownership or control interest,
  - Is a managing employee, or
  - Is an agent of the transferor (selling provider) who will also hold an ownership or control interest, be a managing employee, or be an agent of the transferee (purchasing provider)

LTC providers must mail the documentation to the following address:

**Provider Enrollment**  
P.O. Box 7263  
Indianapolis, IN 46207-7263

The transferee must submit an IHCP provider packet for amendment to the transferor’s provider agreement no less than 45 days before the effective date of the transfer, or receive a waiver from the FSSA if the transferee is unable to comply with the 45-day notice provision.

**Electronic Funds Transfer Change**

Changes that affect a provider’s account and routing number must be reported to avoid a failed electronic funds transfer of claim payments. To ensure the accuracy of EFT information in CoreMMIS, billing providers initiating or changing EFT information must submit a completed *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form* or submit the information via the EFT Changes option on the *Provider Maintenance* page of the Portal. Submitting an *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form* requires a voided check or a letter from your bank as verification of account and American Banking Association (ABA) routing numbers. The NPI or the billing provider number and service location must be included on the EFT form. The EFT form is available on the *Update Your Provider Profile* page at indianamedicaid.com.

See the *Financial Transactions and Remittance Advice* module for additional information about EFT.
Medicare Number

Use the IHCP Provider Medicare Number Maintenance Form to update Medicare numbers, or submit the update via the Portal using the Other Identification Changes option on the Provider Maintenance page.

Disenrollment Request

Requests for disenrollment from the IHCP ensure that the provider’s profile history is accurately maintained. The IHCP Provider Disenrollment Form can be used to disenroll a billing, group, rendering, or OPR provider from the Medicaid program. Disenrollment can also be completed using the Disenrollment link on the Portal.

Note: Providers enrolled as a PMP with an MCE must contact the MCE first to begin the disenrollment process.

If enrolled as a waiver provider, the provider must contact the State waiver agency first to begin the disenrollment process.

Licensure and IHCP Eligibility

All providers are required to be duly licensed, registered, or certified (405 IAC 5-4-1) to participate in the IHCP. Provider Enrollment uses a license verification process that includes all states’ licensing board data to enhance provider information on file. Additionally, the IPLA submits monthly electronic provider license status reports to Hewlett Packard Enterprise. The status reports permit the Provider Enrollment Unit to deactivate providers that no longer have active or unrestricted licensure. Out-of-state licensing board websites are used to validate licensure and to ensure licensing information is current and in good standing for providers that render services in other states. Any provider that is not appropriately licensed in the state where services are rendered is not eligible for enrollment in the IHCP for payment of services.

Nonrenewed licenses are reported as expired or inactive on the IPLA reports. Providers listed on the reports are subject to deactivation. When a provider does not intend to renew its license, it is important to report the nonrenewal to the Provider Enrollment Unit as a disenrollment. The information must be reported on an IHCP Provider Disenrollment Form, available at indianamedicaid.com, or by using the Disenrollment link on the Portal.

If a provider is required to recertify, a notification is mailed to the provider 60 business days prior to the end date for program participation. Providers that fail to renew their program eligibility within two weeks after the recertification end date must submit a new IHCP enrollment application along with the new license information and all required supportive documentation. Enrollment packets are available on the IHCP Provider Enrollment Transactions page at indianamedicaid.com, or providers can submit an application online through the Portal. If a provider recertifies prior to the program eligibility end date, a recertification form (or update via the Provider Maintenance page of the Portal) and any required documentation are all that is required to extend the program eligibility. All transportation providers are required to recertify based on either their insurance end date or the motor carrier’s certificate end date. If a provider is required to have a surety bond, proof of surety bond is also required.

The following license statuses provided by State licensing agencies are the basis for deactivation of a provider’s IHCP participation:

- Closed facility
- Deceased
- Expired
- Expired more than three years
• Inactive
• Null and void or error
• Retired
• Voluntary surrender
• Probationary licenses, which are subject to review for eligibility purposes

Lack of appropriate licensure affects a provider’s ability to gain payment for services rendered after their license termination date. The IHCP end date is the same as the licensing board’s termination or suspension date. The IHCP pursues collection of payments made to providers that bill for dates of service after their licensing board’s termination or suspension date. Such notification does not negate the IHCP’s ability to collect for dates of service paid to a provider whose license is not valid at the time services were rendered.

**Provider Deactivation and Disenrollment**

Providers may voluntarily end their IHCP enrollment at any time. To complete a voluntary deactivation request, providers must use the Disenroll link on the My Home page of the Portal or submit an IHCP Provider Disenrollment Form. If “Other” is selected as the reason for deactivation, providers must clearly state the reason for the deactivation request. The deactivation date is the date the disenrollment form is signed, unless otherwise requested.

It is recommended that providers update their mailing information if an address changes upon disenrollment – for example, if the provider is disenrolling due to a move to another state. The change ensures that payments, resulting from claim adjustments after the provider terminates, go to the appropriate address. Address updates are submitted on the Provider Maintenance page of the Portal or by mail, using the IHCP Provider Name and Address Maintenance Form.

**Managed Care Disenrollment**

Deactivation or termination from the IHCP, whether voluntary or involuntary, results in the provider’s immediate disenrollment from HIP, Hoosier Care Connect, and Hoosier Healthwise.

Providers that want to disenroll from only the HIP, Hoosier Care Connect, or Hoosier Healthwise components of the IHCP must contact the contracting MCE. If the Provider Enrollment Unit receives the request before the PMP disenrollment, Provider Enrollment employees coordinate with the MCEs. Providers can contact their MCE for additional details about disenrollment from a health plan program.

**Involuntary Termination or Deactivation**

The FSSA or its fiscal agent may deactivate or terminate a provider’s IHCP enrollment for the following reasons:
• License or certification expiration, suspension, or revocation
• Conviction of Medicaid or Medicare fraud
• Violation of federal or state statutes or regulations
• Name matched against the following:
  – System for Award Management (SAM), formerly Excluded Parties List System (EPLS), exclusion list
  – TIBCO MFT (Managed File Transfer), which replaced CHIP State Information Sharing System (MCSIS) sanction list
• Breach of any provisions in the IHCP Provider Agreement
• Returned mail
• No claim activity for more than 18 months

Payment for Services after Deactivation or Termination

Providers have up to one year from a date of service to file claims for service dates that fall within their eligibility period.

Under IC 12-15-22-4, following their deactivation or termination of participation in the IHCP, providers are no longer eligible for payment for services rendered for dates of service after the date of deactivation or termination.

Appeal Process

Under IC 4-21.5-3-7 and 405 IAC 1-1.5-2, providers have the right to appeal deactivation or termination action. To preserve an appeal, providers must specify the reason for the appeal in writing and file the appeal with the ultimate authority for the agency within 15 calendar days of receipt of a notification letter.

Send the appeal to the following address:

    MS07
    Gwen Killmer
    FSSA Secretary
    Indiana Family and Social Services Administration
    402 West Washington Street, Room W382
    Indianapolis, IN 46204

Providers that elect to appeal a determination must also file a statement of issues within 45 calendar days after receipt of notice of the determination. The statement of issues must conform to 405 IAC 1-1.5-2(e) and IC 4-21.5-3 and be sent to the same address as the appeal request.

Retroactive Eligibility

The normal effective date of IHCP provider enrollment is the date the Provider Enrollment Unit receives the enrollment packet. A retroactive enrollment date of no more than one year may be considered for approval by the FSSA in the following cases:

• A provider has proof of service rendered to an IHCP member within 12 months prior to the application received date, and both of the following apply:
  – All screening activities can support that the provider was compliant as of the requested date.
  – The provider is enrolled with Medicare on the requested date.
• An out-of-state provider provided services for an IHCP member in need of care while traveling.

A rendering provider’s effective date cannot be earlier than the effective date of the group to which the provider is linked.

Requests to backdate enrollment for other reasons will be reviewed for approval by the FSSA.
Note: The provider’s certification or license must be active for the entire retroactive period being requested. For providers that are surveyed by the ISDH and require certification for enrollment (Type 01 – Hospital, Type 02 – ASC, Type 03 – LTC, Type 05 – Home Health, and Type 06 – Hospice), the effective program start date cannot be earlier than the survey date or effective date provided by ISDH.

Claim Filing

Providers can bill for covered services rendered to IHCP members starting on their enrollment effective date, subject to the claim filing limit of one year. For a claim to be considered for reimbursement, the dates of service must be on or after the enrollment start dates. For group and clinic provider entities, the dates of service being billed must be on or after the rendering practitioner linkage effective date.

If the service was rendered more than one year ago, the provider must submit a paper claim and the appropriate documentation to request a filing limit waiver. See the Claim Submission and Processing module for details on how to submit a claim with filing limit waiver documentation.

Prior Authorization

Prior authorization (PA) for medically necessary covered services, if applicable, can be requested for a period beginning from the effective date of the provider’s enrollment. If PA is required for a covered service that had already occurred, it can be requested retroactively up to one year from the date the provider was enrolled. The provider must indicate on the PA request that the reason for the untimely request is “retroactive enrollment.” Authorization is determined solely on the basis of medical necessity. See the Prior Authorization module for details about PA.

Out-of-State Provider Provisions

Out-of-state healthcare providers may enroll in the IHCP and receive reimbursement for certain services provided to IHCP members. See the Out-of-State Providers module for more information about out-of-state providers and the IHCP.

Substitute Physicians and Locum Tenens

Substitute physicians and locum tenens may fill in for a member’s regular physician. The regular physician may be the member’s primary care physician or primary medical provider (PMP), or a specialist that a member sees on a regular basis. The substitute physician or locum tenens must be the same discipline as the regular physician.

Substitute Physicians

A substitute physician is a physician who is asked by the regular physician to see a member in a reciprocal agreement when the regular physician is unavailable to see the member. A substitute physician may be asked to see a member if the regular physician is not available or on call. The substitute arrangement does not apply to physicians in the same medical group with claims submitted in the name of the medical group. In addition, a substitute physician arrangement should not exceed 14 days.
In a substitute physician arrangement, the regular physician reimburses the substitute physician by paying the substitute the amount received for the service rendered or reciprocates by providing the same service in return. In a substitute physician arrangement, the regular physician and the substitute physician must be enrolled as an IHCP provider. In field 24D of the CMS-1500 claim form, enter the modifier Q5 to indicate that a substitute physician rendered the services.

**Locum Tenens Physicians**

Providers can create a *locum tenens* arrangement when the regular physician must leave his or her practice due to illness, vacation, or medical education opportunity and does not want to leave his or her patients without service during this period. Providers use the *locum tenens* arrangement in a single or a group practice, but the *locum tenens* physician cannot be a member of the group in which the regular physician is a member. The *locum tenens* physician usually has no practice of his or her own and moves from area to area as needed. The physician is usually paid a fixed *per diem* amount with the status of an independent contractor, not an employee.

The *locum tenens* physician must meet all the requirements for practice in Indiana, as well as all the hospital or other institutional credentialing requirements before providing services to IHCP members. The practitioner providing *locum tenens* services is not required to be an IHCP provider. The regular physician’s office must maintain documentation of the *locum tenens* arrangement, including what services were rendered and when they were provided.

The regular physician’s office personnel submit claims for the *locum tenens* services using the regular physician’s NPI and modifier Q6 in form field 24D of the CMS-1500 claim form.

*Locum tenens* arrangements should not exceed 90 consecutive days. If the physician is away from his or her practice for more than 90 days, a new *locum tenens* would be necessary. If a *locum tenens* provider remains in the same practice for more than 90 days, he or she must enroll as an IHCP provider.

**Charging Members for Noncovered Services**

Federal and state regulations prohibit providers from charging any IHCP member, or the family of a member, for any amount not paid for covered services following a reimbursement determination by the IHCP. See Code of Federal Regulations, Title 42, Part 447, Subpart A, Section 447.15; Indiana Administrative Code, Title 405, Article 1, Rule 1, Sections 3(i).

Furthermore, the *IHCP Provider Agreement* contains the following provision:

>To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with the federal and state statutes and regulations as the appropriate payment for Indiana Health Coverage Program covered services provided to Indiana Health Coverage Program members (recipients). Provider agrees not to bill members, or any member of a recipient’s family, for any additional charge for Indiana Health Coverage Program covered services, excluding any co-payment permitted by law.

The clear intent of this provision is to ensure that no member or family of a member is billed in excess of the amount paid by the IHCP for covered services.

As a condition of the provider’s participation in the IHCP, the provider must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If the provider disagrees with the Medicaid determination of payment, the provider’s right of recourse is limited to an adjustment request, administrative review, and appeal as provided in 405 IAC 1-1-3. Violation of this section constitutes grounds for the termination of the provider agreement and decertification of the provider, at the option of the FSSA.
Charging for Missed Appointments

IHCP providers may not charge IHCP members for missed appointments. The HHS based this policy on the reasoning that a missed appointment is not a distinct reimbursable service, but a part of the provider’s overall costs of doing business. Furthermore, the Medicaid rate covers the cost of doing business, and providers may not impose separate charges on members. In addition, according to 405 IAC 5-25-2, the IHCP will not reimburse a physician for missed appointments.

Charging for Copies or Transfers of Medical Records

IHCP providers are not permitted to charge for copies or transfers of medical records, including mailing costs. Federal regulation 42 CFR 447.15 states that providers participating in Medicaid must accept the State’s reimbursement as payment in full (except that providers may charge for applicable deductibles, coinsurances, or copayments). The reimbursement for services is intended to cover the costs of medical record duplications or medical record transfers. Providers do not receive additional reimbursement from the State, or authorized agents for the State, for any cost associated with medical record duplications or medical record transfers. The IHCP considers a physician who charges Medicaid patients for copying or transferring medical records to be in violation of this federal regulation and his or her IHCP Provider Agreement. Providers identified as showing a pattern of noncompliance with federal regulations and IHCP policy are subject to a Surveillance and Utilization Review (SUR) audit.

Member Billing Exceptions

An IHCP provider can bill an IHCP member for covered and noncovered services only when the following conditions are met:

- The IHCP member must understand, before receiving the service, that the service is not covered under the IHCP and that the member is responsible for the service charges. The provider must maintain documentation in the member’s file that clearly demonstrates that the member voluntarily chose to receive the service, knowing it was not covered by the IHCP. A provider may use a “waiver” form to document such notification; however, a “waiver” form is not required.

  Note: If a waiver form is used to document that a member has been informed that a service is noncovered, the waiver must not include conditional language such as “if the service is not covered by the IHCP, or not authorized by the member’s PMP, the member is responsible for payment.” This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or PA as needed.

- The covered or noncovered status of embellishments or enhancements to basic services can be considered separately from the basic service only if a separate procedure, revenue, or National Drug Code (NDC) exists:
  - Only if separate codes exist can a noncovered embellishment be billed to the member and the basic charge billed to the IHCP. Otherwise, the service, in its entirety, is considered covered or noncovered.
  - Example: Because no separate procedure exists for embellishments to a standard pair of eyeglass frames, it is not allowable for the IHCP to be billed for the basic frames and for the member to be billed for additional charges. The entire charge for fancy frames is noncovered by the IHCP in accordance with the Covered Services Rule.

- A provider can bill the member in situations where the provider took appropriate action to ascertain and identify a responsible payer for a service.
• A provider can bill the member if the member failed to advise the provider of Medicaid eligibility. If the provider is notified of the member’s Medicaid eligibility within the one-year filing limit, the IHCP must be billed for the covered service. Any monies that were collected by the IHCP provider from the member must be reimbursed in full to the IHCP member.

• Documentation must be maintained in the file to establish that the member was billed or information requested within the one-year filing limit.

• Providers can bill the member the amount credited to the member’s waiver liability as identified on the Remittance Advice following the final adjudication of the claim.

• Providers may bill a member if the service is not covered by the member’s benefit plan, such as services not related to family planning for Family Planning Eligibility Program members, and nonemergency services for to Package E (Emergency Services Only) members.

• Providers may bill a member when a service required prior authorization but the authorization was denied by the IHCP.

• Providers may bill a member for services that exceed a benefit limit when prior authorization is not available to receive additional services.

  Note: Obtaining a signed waiver will not prevent IHCP from investigating the facts alleged in the waiver.

• A hospital can bill a member for services if the hospital’s utilization review (UR) committee established under 42 CFR 482.30 makes a determination that a continued stay is not medically necessary. The determination must comply with the requirements of 42 CFR 482.30(d), which states the following:

  The determination that a continued stay is not medically necessary:

  I. May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12 (c), concur with the determination or fail to present their views when afforded the opportunity; and

  II. Must be made by at least two members of the UR committee in all other cases. Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.

• If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than two business days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c).
  – Before billing the patient, the provider must notify the patient or his or her healthcare representative in writing that the patient will be responsible for the cost of services provided after the date of the notice.
  – Providers should consult with their attorneys or other advisors about any questions concerning their responsibilities in the UR process.

These guidelines apply to all members, regardless of their eligibility category or program.
Refusing or Restricting Services to Members

A provider can make a business decision not to provide a service to a member as long as the reason for doing so is not a violation of civil rights laws or the Americans with Disabilities Act. Providers can restrict the number of IHCP patients by any means, as long as their standards for limiting patients do not violate any statutes or regulations.

For example, 405 IAC 5-1-2 prohibits discrimination on the basis of “age, race, creed, color, national origin, sex, or handicap.” If the provider’s specialty is limited to patients of a certain age or sex, such as gynecology or pediatrics, that is permissible. If individual providers are unsure whether their standards or methods violate civil rights laws or any other laws, they must verify with their attorneys.

A copy of the Civil Rights Compliance Policy Statement from the CMS is included in the Introduction to the IHCP module. It addresses civil rights and prohibits discrimination when providing IHCP-covered services.