INDIANA HEALTH COVERAGE PROGRAMS

Introduction to the IHCP

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	Scheduled update	FSSA and HPE

2.0	Policies and procedures as of June 1, 2017
	Published: January 23, 2018
		Scheduled update:
		• Reorganized and edited text as needed for clarity
		• Changed Hewlett Packard Enterprise references to DXC Technology
		• Clarified fees schedules as professional and outpatient
		• Added IVR system as an option to check member eligibility in the *Managed Care* section
		• Updated the *Managed Care Service Carve-Outs* section
		• In the *Provider Reimbursement Methodologies* section:
		  – Added explanation of the Outpatient Fee Schedule
		  – Clarified that managed care provider contracts may include negotiated rates
		• Added PASSR to the *Division of Aging* section
		• Added note in the *Division of Mental Health and Addiction* section that PRTF Transition Waiver was discontinued
		• Updated the *Contractors* section, including adding CareSource
		• Clarified what types of information are available to providers and updated hours in the *Customer Assistance* section
			FSSA and DXC

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Version	Date	Reason for Revisions	Completed By
		• Updated contact-related information in the *Provider Relations* section • Added bulletins and banner pages and clarified provider reference module information in *Table 1 – Provider Resources* • Updated the *Civil Rights Requirements* section and included a sample nondiscrimination posting	

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Overview

Indiana's Medicaid program, collectively referred to as the Indiana Health Coverage Programs (IHCP), provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant, or meet other eligibility requirements. The IHCP receives federal and State funds to operate the program and reimburse providers for reasonable and necessary medical care for eligible members. Each state administers its own Medicaid program within the provisions of federal legislation and broad federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). The Indiana Family and Social Services Administration (FSSA) administers the IHCP.

Information on IHCP services is available in the *Indiana Code* (IC) and *Indiana Administrative Code* (IAC), which are published online at in.gov. The administrative rules for the IHCP, including but not limited to member eligibility, provider types, and covered services, are published in Titles 405 and 407 of the IAC.

The *IHCP Provider Reference Modules* are the primary reference for billing and reimbursement guidance for providers conducting business with the IHCP. Modules include instructions for submitting IHCP claims and prior authorization (PA) requests, as well as other related topics. All modules can be accessed on the *Provider Reference Materials* page of the IHCP provider website at indianamedicaid.com.

IHCP medical coverage and reimbursement policy is defined in the *Medical Policy Manual,* which is also available at indianamedicaid.com.

Additional resources on the website include:

- *IHCP Banner Pages*

- *IHCP Bulletins*

- News and announcements

- Fee schedules (professional and outpatient)

- Code tables

- Provider enrollment and profile maintenance packets

- Program descriptions

- Contact information

- Provider education opportunities

- Forms, including prior authorization request forms

- IHCP Provider Healthcare Portal (Portal)

- Electronic data interchange (EDI) information, including *IHCP Companion Guides* for *Health Insurance Portability and Accountability Act* (HIPAA) version 5010

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Delivery Systems

The following sections describe the delivery systems the IHCP uses for administering Medicaid benefits and healthcare. For information on specific IHCP programs and associated benefit packages, see the *Member Eligibility and Benefit Coverage* module.

Fee-for-Service

The fee-for-service (FFS) delivery system reimburses providers on a per-service basis. Providers bill the appropriate IHCP claim-processing contractor for services rendered to members under the FFS delivery system:

- OptumRx for pharmacy services

- DXC Technology for all other services

Managed Care

The State has mandated a managed care delivery system for members enrolled in the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. Under the managed care system, members are enrolled with a managed care entity (MCE), which is responsible for the members' healthcare services. Each MCE maintains its own provider network, provider services unit, and member services unit.

The MCE pays claims, performs PA, and is responsible for subrogation activities. The MCE with which the member is enrolled should be contacted for specific billing, PA, and reimbursement policies and guidelines as the MCE may have different requirements. Providers can find a member's assigned MCE by checking the member's eligibility in the IHCP Portal or through the Interactive Voice Response (IVR) system. For MCE contact information, see the *IHCP Quick Reference Guide*, available at indianamedicaid.com.

All providers wanting to offer services to HIP, Hoosier Care Connect, or Hoosier Healthwise members must first enroll with the IHCP prior to contracting with the MCEs. Providers rendering services to a member enrolled with an MCE must be contracted with the MCE assigned to the member. This provision also includes out-of-state providers. See the *Provider Enrollment* module for details.

Managed Care Service Carve-Outs

The MCE is responsible for the delivery and payment of most care for its members; however, certain services are not paid by the MCE. These services, referred to as *carved-out services*, are billed for reimbursement as FFS claims. PA for these services would also be requested through the FFS PA process. See the *Claim Submission and Processing* module and the individual service-specific modules for more information about carved-out services. MCEs must provide care coordination and associated services related to carved-out services, including, but not limited to, transportation.

Self-Referral Services

Most services in managed care require referral from a primary medical provider (PMP). Self-referral services are an exception. The MCE reimburses any IHCP-enrolled providers for the following self-referral services unless other parameters are indicated. Self-referral services must be covered under the member's benefit plan and established benefit limits and prior authorization (PA) requirements apply:

- Chiropractic services rendered by a licensed chiropractor within chiropractic scope of practice

- Podiatry services rendered by a licensed podiatrist or physician

- Eye care services (except surgical services) rendered by a licensed optometrist or physician

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- Routine dental services rendered by a licensed dental provider *(Note: The provider must be within the MCE's network)*

- Diabetes self-management training (DSMT) services

- Immunizations

- Family planning services

- Emergency services, as defined in *IC 12-15-12-0.3* and *IC 12-15-12-0.5 (Note: Services may be rendered by any emergency services provider; requires IHCP enrollment to facilitate payment)*

- Urgent care services

- Psychiatric services rendered by physicians (including psychiatrists)

- Behavioral health services, such as mental health, substance abuse treatment, and chemical dependency services rendered by any of the following providers *(Note: The provider must be within the MCE's network)*:
  – Outpatient mental health clinics
  – Community mental health centers (CMHCs)
  – Psychologists
  – Certified psychologists
  – Health service providers in psychology (HSPPs)
  – Certified social workers
  – Certified clinical social workers
  – Psychiatric nurses
  – Independent practice school psychologists
  – Advanced practice nurses, under *IC 25-23-1-1(b)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
  – Persons holding a master's degree in social work, marital and family therapy, or mental health counseling (for outpatient mental health services as defined under *405 IAC 5-20-8*)

> *Note:* *PMP referral is not the same as prior authorization. Contact the member's MCE to determine whether the service or procedure requires prior authorization. Self-referral services may be subject to benefit limitations; providers should contact the MCE for additional guidance.*

Provider Reimbursement Methodologies

The FFS claim-pricing process calculates the IHCP-allowed amount for claims based on claim type and defined pricing methodologies for each provider type. These pricing methodologies include some of the following:

- Cost-based and case-mix reimbursement

- Diagnosis-related group (DRG)

- Fee Schedule

- Manually priced

- Medicare and Medicare Replacement Plan, and IHCP crossover coinsurance and deductible

- Outpatient ambulatory surgical center (ASC) flat rate

- Resource-based relative value scale (RBRVS)

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Details about these reimbursement methodologies are found in *405 IAC 1-8* through *405 IAC 1-11.5*. For reimbursement information related to specific provider types and services, see the appropriate provider reference module.

Two fee schedules are available from the [IHCP Fee Schedules](#) page at indianamedicaid.com:

- The Professional Fee Schedule contains a list of IHCP-covered Current Procedural Terminology (CPT®[1]) codes, Healthcare Common Procedure Coding System (HCPCS), and Current Dental Terminology (CDT®[2]) codes and includes indicators specific to each code, such as program coverage, reimbursement, and prior authorization. The Professional Fee Schedule is searchable by keyword or code and can also be downloaded free of charge. The IHCP automatically updates the Professional Fee Schedule each month or on demand.

- The Outpatient Fee Schedule reflects coverage, pricing, and reimbursement methodology for HCPCS and CPT codes billed by outpatient hospitals and ASCs. The Outpatient Fee Schedule is posted as a Microsoft Excel document (compatible with versions 97 or later) so providers can search and sort as needed. It is updated at least quarterly to reflect any change in policies.

> *Note:*   *Under managed care, the MCEs reimburse in-network providers as stated in their provider contracts, which may include negotiated rates. In the absence of another arrangement, MCEs reimburse out-of-network providers according to FFS pricing methodologies. Providers should contact the MCE for managed care program reimbursement rates.*
>
> *For additional information about managed care reimbursement, contact the member's MCE. See the [IHCP Quick Reference Guide](#), available at indianamedicaid.com, for contact information.*

State, Regional, and Contractor Responsibilities

This section outlines the responsibilities of the entities involved in administering the IHCP.

Family and Social Services Administration

The FSSA is the State agency responsible for administration of the IHCP, which requires coordination with a number of entities. This section outlines the primary agencies involved in program administration.

Office of Medicaid Policy and Planning

The FSSA Office of Medicaid Policy and Planning (OMPP) is responsible for the general planning and oversight of the IHCP, including coordination with program partners and contractors. The OMPP oversees the Medicaid State Plan, Medicaid waivers, and federal reporting. In addition, the OMPP establishes IHCP policy and manages IHCP contractor relationships.

Division of Family Resources

The FSSA Division of Family Resources (DFR) is responsible for determining eligibility for IHCP members, enrolling members in the appropriate program, and maintaining the eligibility files for the IHCP member population. A complete [directory of local DFR offices](#) is available on the FSSA website at in.gov/fssa.

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[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*
[2] *CDT copyright 2016 American Dental Association. All rights reserved.*

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Division of Aging

The FSSA Division of Aging is responsible for overseeing two 1915(c) home and community-based services (HCBS) waiver programs: the Aged and Disabled (A&D) Waiver and the Traumatic Brain Injury (TBI) Waiver. The Division of Aging is also responsible for administering the Money Follows the Person (MFP) demonstration grant and processing PASRR requests.

Division of Disability and Rehabilitative Services

The FSSA Division of Disability and Rehabilitative Services (DDRS) manages the delivery of services to children and adults with intellectual and developmental disabilities. The DDRS administers two 1915(c) HCBS waiver programs: Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) Waiver.

Division of Mental Health and Addiction

The FSSA Division of Mental Health and Addiction (DMHA) administers one 1915(c) waiver program, the Psychiatric Residential Treatment Facility (PRTF) Transition Waiver (discontinued September 30, 2017), and three 1915(i) State Plan HCBS programs: Adult Mental Health and Habilitation (AMHH), Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW).

Contractors

The FSSA contracts with a fiscal agent and other entities to perform the day-to-day program functions associated with administration of the IHCP. The current contractors and responsibilities include the following:

- DXC Technology – Fiscal agent
  - Fee-for-service (FFS) nonpharmacy claim processing
  - Member and provider customer service
  - Provider enrollment
  - Provider relations
  - Managed care entity and enrollment broker support
  - Third-party liability
  - IHCP Provider Healthcare Portal

- OptumRx – Pharmacy benefit manager (PBM), FFS pharmacy benefits
  - FFS pharmacy claim processing
  - FFS pharmacy-related prior authorizations
  - FFS pharmacy-related member and provider services
  - FFS pharmacy-related claim audit functions
  - Drug rebate services
  - Pharmacy rate setting

- Cooperative Managed Care Services (CMCS) – FFS PA administrator
  - FFS nonpharmacy utilization management and prior authorizations

- MAXIMUS – Enrollment broker
  - HIP, Hoosier Care Connect, and Hoosier Healthwise member and provider helplines
  - Potential member program education
  - Counseling for health plan selection
  - MCE assignment for members who do not self-select an MCE

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- Myers and Stauffer LC – Rate-setting contractor
  - Nonpharmacy rate setting
  - Long-term care audits

- Anthem, CareSource, Managed Health Services (MHS), and MDwise – MCEs for one or more IHCP managed care program (HIP, Hoosier Care Connect, and Hoosier Healthwise)
  - Utilization management and prior authorizations*
  - Establishing a provider network
  - Care management
  - Claim processing*
  - Member and provider support
  - Community outreach
  - Provider education

    * Note that, for certain services (such as dental or pharmacy), these functions may be handled by a subcontractor of the MCE.

Indiana State Department of Health

The Indiana State Department of Health (ISDH) is responsible for certifying the following provider types:

- Long-term care (LTC) facilities

- Intermediate care facilities for individuals with intellectual disability (ICFs/IID)

- Pediatric nursing facilities

- Residential care facilities

- Rehabilitation facilities

- Home health agencies

- Hospitals

- Rural health clinics (RHCs)

- Ambulatory surgical centers (ASCs)

- Laboratories

- Radiology centers (portable x-ray facilities)

- End-stage renal disease (ESRD) clinics

- Hospice facilities

- Outpatient physical therapy and speech language pathology (OPT/SP) facilities

- Comprehensive outpatient rehabilitation facilities (CORF)

Providers may contact the ISDH at the following address or telephone number:

Indiana State Department of Health
2 N. Meridian St.
Indianapolis, IN 46204

(317) 233-1325

Provider Services

Being responsive to the needs of IHCP providers is a primary emphasis for the IHCP. Entities contracted with the FSSA perform parallel provider services functions for providers in their respective networks.

MCE Provider Services

Each MCE contracted for HIP, Hoosier Care Connect, or Hoosier Healthwise maintains a provider services unit to address the concerns and questions of providers serving members in their health plans. The *IHCP Quick Reference Guide* at indianamedicaid.com includes contact information for these provider services units.

OptumRx Provider Services

OptumRx, the FFS pharmacy benefit manager (PBM), serves as the liaison between pharmacy providers and IHCP members for FFS programs and carved-out services. OptumRx maintains a provider services unit to address the concerns and questions of pharmacy providers rendering services to members in FFS programs, including the resolution of pharmacy-claim-processing issues. The *IHCP Quick Reference Guide* at indianamedicaid.com includes contact information for the OptumRx Clinical and Technical Help Desk where member and provider telephone inquiries should be directed.

DXC Provider Services

DXC, the IHCP fiscal agent, serves as the overall liaison between the provider and member communities for the IHCP. DXC performs provider services to address concerns and questions for providers conducting business with the IHCP, including the resolution of FFS nonpharmacy claim-processing issues. The following DXC business units perform provider services:

- Provider Enrollment Unit is responsible for provider enrollment, revalidation, and provider profile maintenance activities.

- Customer Assistance Unit is responsible for answering telephone inquiries.

- Written Correspondence Unit responds to inquiries submitted by mail or through the Portal and performs administrative reviews as directed by the FSSA.

- Provider Relations Unit functions as the educational arm of the IHCP.

Provider Enrollment

The Provider Enrollment Unit performs the following key functions:

- Assesses provider eligibility through verification of licensure, certification, and insurance and approves documents required for enrollment. Enrollment requirements are based on provider type and specialty, and adhere to guidelines and rules set by federal and State regulations.

- Ensures that no enrolled provider is excluded from participation by the Office of the Inspector General (OIG), the CMS, or other federal or State agencies.

- Processes provider enrollment packets and profile maintenance forms.

- Deactivates enrolled providers that no longer meet State requirements for participation in the IHCP.

- Maintains provider files for all enrolled, denied, and terminated providers.

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Enrollment analysts monitor enrollment activities from initial receipt of an enrollment application or provider profile update through final disposition.

IHCP enrollment applications and provider profile updates may be completed online using the *Provider Healthcare Portal*. Printable enrollment packets and profile maintenance forms are available on the *Become a Provider* page at indianamedicaid.com. For additional information about provider enrollment and profile maintenance, see the *Provider Enrollment* module or call Customer Assistance.

Customer Assistance

As the front line of communications with providers, Customer Assistance representatives quickly detect the impact of program policy and procedural changes through provider inquiries. Customer Assistance can be contacted toll-free at **1-800-457-4584**.

Live assistance is available 8 a.m. to 6 p.m. Eastern Time, Monday through Friday, excluding holidays. To maintain compliance with the HIPAA Provider Rule, Customer Assistance representatives cannot verify member eligibility.

Automated responses to provider inquiries are available 24 hours per day through the Interactive Voice Response (IVR) system. Automated IVR responses are available for such functions as verifying member eligibility, member benefit limits, and claim status.

> *Note:* *Providers can access pertinent member eligibility and claim status information online via the Portal or through the IVR system using a touch-tone telephone. Both systems provide access 24 hours a day, seven days a week. Instructions for accessing these features are included in the Interactive Voice Response System and Provider Healthcare Portal modules.*
>
> *The 270/271 member eligibility and 276/277 claim status transactions are standardized, electronic data interchange (EDI) transactions. Data is sent and received in the same format for all providers. Additional information is available in the Electronic Data Interchange module and the IHCP Companion Guides at indianamedicaid.com.*

To assist with timely processing of inquiries, providers should consider the following guidelines when contacting the Customer Assistance Unit:

- To verify member eligibility (for both FFS and managed care members), providers can inquire through the IVR system, Portal, or 270/271 health care eligibility benefit inquiry and response transaction.

- For general claim status inquiries of FFS claims, providers can check the weekly Remittance Advice (RA) or inquire through the IVR system, Portal, or 276/277 claim status request and response transaction.

- Providers should not inquire about the status of a specific claim until at least 30 business days after submission. This length of time is generally considered reasonable to process a claim.

- When contacting Customer Assistance to request information about an FFS claim, providers should be prepared with the following information:
    - Billing provider's 10-digit National Provider Identifier (NPI) or IHCP Provider ID
    - Full 9-digit ZIP Code (ZIP Code + 4) of the service location address
    - Facility name or practice name
    - Last four digits of the taxpayer identification number (TIN)
    - Member's name
    - Member's date of birth, Claim ID, or dates of service (including specification of the claim type, such as inpatient, outpatient, medical, dental, and so forth)
    - Amount billed

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- If a provider speaks to a Customer Assistance representative, the provider should make a note of the date of the telephone call, the name of the representative who handled the call, and the contact tracking number (CTN). This information is helpful when a follow-up inquiry is necessary.

- Providers should contact the MCE with which the member is enrolled for inquiries about managed care claims.

Written Correspondence

The Written Correspondence Unit is another link between the provider community and the IHCP. Providers should contact the Written Correspondence Unit for assistance with researching complex FFS claim denials or when the provider experiences difficulty receiving claim payment. Additionally, providers can contact the Written Correspondence Unit to obtain other information, including member benefit limit information and clarification of the IHCP rules and regulations.

Providers are encouraged to provide comprehensive information in their correspondence, including a clearly stated reason for the inquiry. Providers should also include any of the following items that are applicable:

- Copies of submitted claim forms (or printouts of Portal claims) and any documentation that was attached

- PA numbers or a copy of PA decision forms

- Copies of RA statements

This information provides necessary details and is helpful in formulating an accurate and complete response to the provider. The more information provided about the history of a particular issue, the more easily an analyst can reach the resolution.

Inquiries and supporting documentation can be submitted electronically through the Portal using the Secure Correspondence feature. Each message is assigned a CTN, which can be used to track the status of the correspondence. When the Written Correspondence analyst resolves the inquiry, a notification email is sent to the provider with a link to the page on the Portal where the response can be reviewed. See the *Provider Healthcare Portal* module for details.

Written inquiries can also be submitted by mail using the *Indiana Health Coverage Programs Written Inquiry* form, available on the *Forms* page at indianamedicaid.com. Using the inquiry form ensures that the Written Correspondence analyst has all the information necessary to conduct thorough research. Written inquiries should be sent to the following address:

> **DXC – Written Correspondence**
> **P.O. Box 7263**
> **Indianapolis, IN 46207-7263**

Written Correspondence analysts will respond in writing to the provider within 10 business days of receiving the written inquiry. Responses are assigned a CTN that is important for tracking and should be referred to in subsequent correspondence with the IHCP about the issue.

Providers should not use Written Correspondence to check claim status. Claim status can be determined by checking RA statements or inquiring through the Portal, IVR system, or 276/277 claim status request and response transaction.

Providers should not use the Written Correspondence Unit for claim submission, unless specifically directed to do so.

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Requests for Paper Remittance Advice

Providers should access the Portal to view or download a Remittance Advice. However, providers can request a paper RA from the Written Correspondence Unit in the following ways:

- Submit the request as a secure correspondence message through the Portal.

- Email the request to inxixwrittencorr@hpe.com.

- Mail the request either on provider letterhead or using the *Indiana Health Coverage Programs Written Inquiry* form, available on the *Forms* page at indianamedicaid.com

Requests for Administrative Review

The Written Correspondence Unit handles provider requests for administrative review of claim adjudication of all FFS nonpharmacy claims. See the *Claim Administrative Review and Appeals* module for more information.

Provider Relations

The Provider Relations Unit includes a team of regional field consultants that can assist providers via the telephone, emails, and on-site visits. Consultants also offer on-site training to encourage the provider community to use the Portal and *Health Insurance Portability and Accountability Act* (HIPAA)-compliant electronic transactions, and to recruit new providers for the IHCP. Specific region assignments and contact information are available on the *Provider Relations Field Consultants* page at indianamedicaid.com or by calling Customer Assistance.

Provider Relations field consultants have the following key responsibilities:

- Work directly with the provider community to provide education and ensure program and claim-processing understanding.

- Create a stable, interpersonal relationship with the providers in their assigned geographical territory.

- Work closely with the financial managers, administrators, and business leaders of the provider community to educate about IHCP policies and objectives, assist with resolving provider issues, and conduct training seminars. To ensure a successful training seminar or on-site visit, it is recommended that the following information is provided to assist the field consultant in structuring the meeting or presentation to best meet the needs of the audience:
  – Provider community segment attending the seminar
  – Number of attendees
  – Time and location of the event
  – Issues to be addressed
  – Point of contact, in case additional information is needed prior to the event

The Provider Relations Unit also coordinates the broader provider education component of the IHCP. In conjunction with other program contractors, the unit works to develop and present educational sessions about all aspects of the IHCP. Scheduled workshops are offered each quarter throughout the year, as well as at an annual seminar. Workshops are announced in IHCP provider bulletins and banner pages, provider association newsletters, and on the *Provider Education* page at indianamedicaid.com. Providers may register for workshops using the Workshop Registration link on the *Provider Education* page.

When contacting the Provider Relations field consultant, allow 24 hours for a response to the email or voicemail.

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Provider Resources and Contact Information

Table 1 is designed to provide a quick reference for providers with questions about claims or programs, or in need of clarification on a specific topic.

Table 1 – Provider Resources

Provider Resource	How to Access Resource	When to Use Resource
IHCP Bulletins and Banner Pages	View or download from the *News, Bulletins, and Banner Pages* page at indianamedicaid.com	*Bulletins* provide official notice of new and revised policies, program changes, and information about special initiatives. *Banner pages* provide official notice of changes to claim processing, billing guidance, as well as details about provider education opportunities and program reminders. Providers are required to stay abreast of IHCP notices. IHCP publications are archived on the website for historical purposes. Providers are cautioned not to rely on dated publications. The most current information about a topic can be found in the posted provider reference module and in publications issued after the effective date of the module.
Medical Policy Manual	View or download from the *Provider Reference Materials* page at indianamedicaid.com	Providers can refer to the *Medical Policy Manual* as the primary resource for IHCP coverage and reimbursement policies. Policy updates are announced in IHCP provider bulletins and added to the published manual at regular intervals.
IHCP Provider Reference Modules	View or download from the *Provider Reference Materials* page at indianamedicaid.com	Providers can refer to the *IHCP Provider Reference Modules* as a primary resource for billing guidance, claim submission and processing information, prior authorization request procedures, and other related topics. These modules include links to billing-related code tables and answers to billing and other procedural questions. Updates to billing guidance and procedures are announced in IHCP banner pages and bulletins and added to the published reference modules at regular intervals. The most current information about a topic can be found in the posted provider reference module and in publications issued after the effective date of the module.

Provider Resource	How to Access Resource	When to Use Resource
IHCP website	indianamedicaid.com	Providers can access the website to obtain program information, such as the following: • *IHCP Banner Pages* • *IHCP Bulletins* • News and announcements • *IHCP Provider Reference Modules* • *Medical Policy Manual* • Fee schedules (professional and outpatient) • Code tables • Provider enrollment and profile maintenance packet • Program descriptions • Contact information • Provider education opportunities • Forms, including prior authorization request forms • Provider Healthcare Portal • EDI information, including *IHCP Companion Guides* for HIPAA version 5010
Customer Assistance	**1-800-457-4584** Live assistance available 8 a.m. – 6 p.m. Eastern Time Monday through Friday, excluding holidays	Providers can contact the Customer Assistance Unit with telephone inquiries about IHCP claim processing, policy, covered services, provider enrollment, and updates to the provider file.
Written Correspondence	**DXC – Written Correspondence** **P.O. Box 7263** **Indianapolis, IN 46207-7263** Or via secure correspondence on the Provider Healthcare Portal	Providers can contact the Written Correspondence Unit to address specific questions about the IHCP, for research on complex claims, to get claim-specific assistance, to request a paper RA, or to request administrative review of a claim.
Provider Relations	Field consultant assignments and voice mail extensions are available on the *Provider Relations Field Consultants* page at indianamedicaid.com or from Customer Assistance	Providers can contact field consultants for explanations of IHCP policies and objectives, assistance in resolving issues, and setting up training seminars and on-site visits.
IHCP Quick Reference Guide	View or download from indianamedicaid.com	Refer to this guide for telephone numbers, addresses, and online resources for various entities that support the IHCP.

Avenues of Resolution

The following tools are available to assist providers in resolving concerns related to various issues.

Coverage or Policy

For concerns related to IHCP coverage or policy, submit a *Request for Policy Consideration* form by email to Policyconsideration@fssa.in.gov. The form is available on the *Forms* page at indianamedicaid.com.

Reimbursement

To resolve problems or disagreements related to the denial or payment of FFS claims, see the *Claim Administrative Review and Appeals* module.

To resolve problems or disagreements related to managed care claims, see the grievance procedures established by the individual MCE.

Prior Authorization

To resolve problems associated with FFS prior authorizations, see the *Prior Authorization* module.

To resolve problems associated with managed care prior authorization, see the grievance procedures established by the individual MCE.

Provider or Member Fraud

To report Medicaid fraud or abuse, see the *IHCP Quick Reference Guide* at indianamedicaid.com for contact information. More information about provider or member fraud and abuse is available in the *Provider and Member Utilization Review* module.

Division of Family Resources

To resolve member eligibility problems involving caseworkers or supervisors, contact the FSSA call center or the local DFR office. See the directory of local DFR offices on the FSSA website at in.gov/fssa. The telephone number for the FSSA call center is 1-800-403-0864. This number also serves as the fax number for the Document Center. The address for the Document Center is:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

If a director does not respond to the complaint to the provider's satisfaction, the provider can write a letter providing facts to the DFR deputy director at the following address:

MS03
Deputy Director
Division of Family Resources
Family and Social Services Administration
402 W. Washington St., Room W392
Indianapolis, IN 46204

Providers should specify in the letter their attempts made to resolve the problem.

Civil Rights Requirements

The IHCP does not discriminate on the basis of race, color, national origin, sex, age, or disability in compliance with federal requirements set forth in:

- *Section 1557 of the Affordable Care Act*

- *Title VI of the Civil Rights Act of 1964*

- *Section 504 of the Rehabilitation Act of 1973*

- *Age Discrimination Act of 1975*

- *Omnibus Budget Reconciliation Act (OBRA) of 1981, where applicable*

If a provider receives a complaint of an alleged violation of the *Civil Rights Act*, the provider must advise the FSSA of the complaint. Within 10 working days from the date the provider receives notification of a civil rights violation complaint, the provider must send a copy of the complaint to the following address:

> **MS15**
> **Attn: Kelly Flynn**
> **Civil Rights Plan Coordinator**
> **Office of Medicaid Policy and Planning**
> **402 W. Washington St., Room W374**
> **Indianapolis, IN 46204**

Federal laws and regulations require similar compliance from all recipients of federal funds. Federal rules require such entities, including IHCP providers, to demonstrate such compliance by taking the following actions:

- All IHCP providers must prominently post notices that specify the following information:
  - The provider complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability
  - The provider makes available free aids and services to people with disabilities to communicate effectively with the provider, including qualified interpreters, written information in other formats and free language services to people whose primary language is not English
  - How to obtain the aids and services referenced previously
  - The name and contact information of the provider's civil rights coordinator who handles grievances (if the provider employs 15 or more individuals)
  - The availability of a grievance procedure as well as how to file a grievance
  - How to file an Office for Civil Rights (OCR) complaint

  A sample posting is available at the Department of Health and Human Services (HHS) website at hhs.gov for your reference. The IHCP has developed a sample posting specific to the state of Indiana, as shown on page 1 of Figure 1.

- All IHCP providers must include taglines in published materials to alert individuals with limited English proficiency (LEP) to the availability of language assistance services. Major patient publications are required to include taglines translated into at least the top 15 languages spoken by individuals with LEP in the state. Lesser patient publications are required to include taglines for the top two languages spoken. Translated resources for nondiscrimination notices and taglines are available in these and many languages at the HHS website at hhs.gov. The sample nondiscrimination posting includes taglines with the top 16 languages spoken in Indiana, as shown on page 2 of Figure 1.

Providers must comply with federal law with regard to the *Patient Self-Determination Act* contained in the *OBRA of 1990*. This law requires that providers advise adult patients about the patient's right to determine treatment before they can no longer make healthcare decisions for themselves. The patient can express their choice in an *advance directive*.

Figure 1 – Sample Nondiscrimination Posting (Page 1 of 2)

Discrimination is Against the Law

[Paste provider identifier label here]

- ➢ Complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- ➢ Does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
- ➢ Provides free aids and services to people with disabilities to communicate effectively with us.
- ➢ Provides free language services to people whose primary language is not English.

If you need these services, help is available. [Paste contact label here]

If you believe we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email. [Paste contact label here]

If you need help filing a grievance help is available. [Paste contact label here]

You can also file a civil rights complaint with the Indiana Civil Rights Commission (ICRC) by calling **1-800-628-2909 or filing electronically at** in.gov/icrc/.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or telephone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019; 1-800-537-7697 (TDD)

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Figure 1 – Sample Nondiscrimination Posting (Page 2 of 2)

Discrimination is Against the Law

[Paste provider identifier label here]

English (English) … complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): … cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

繁體中文 (Chinese): … 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Deutsch (German): … erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Deitsch (Pennsylvania Dutch): … iss willich, die Gsetze (federal civil rights) vun die Owwerichkeet zu folliche un duht alle Leit behandle in der seem Weg. Es macht nix aus, vun wellem Schtamm ebber beikummt, aus wellem Land die Voreldre kumme sinn, was fer en Elt ebber hot, eb ebber en Mann iss odder en Fraa, verkrippelt iss odder net.

ကကျာ်ပှၤ (Burmese): … မှာ ပတိုဒ်ဆၢရ်ၢ နှင့် သက်ဆိုင်သော အများပြည်သူ ရပိုင်ခွင့် ဥပဒေ နှင့် လက်တွေ့
အကျိုးဝင်သည့် သာမက လူမျိုး၊ အသားရောင်၊ မွေးဖွားသည့်နိုင်ငံ၊ အသက်၊ မသန်စွမ်းဖြစ်မှု၊ သို့မဟုတ် လိင် နှင့် ပတ်သက်၍လည်း ခွဲခြားဆက်ဆံမှု အပြုင်းမရှိပါ။

العربية (Arabic): … يلتزم بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

□□□ (Korean): … 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Tiếng Việt (Vietnamese): … tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Français (French): … respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

日本語 (Japanese): … は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Nederlands (Dutch): … voldoet aan de geldende wettelijke bepalingen over burgerrechten en discrimineert niet op basis van ras, huidskleur, afkomst, leeftijd, handicap of geslacht.

Tagalog (Tagalog – Filipino): … Sumusunod ang sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Русский (Russian): … соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

ਪੰਜਾਬੀ (Punjabi): … ਲਾਗੂ ਸੰਘੀ ਨਾਗਰਿਕ ਹੱਕਾਂ ਦੇ ਕਾਨੂੰਨਾਂ ਦੀ ਪਾਲਣਾ ਕਰਦੀ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਸਮਰਥਤਾ, ਜਾਂ ਲਿੰਗ 'ਤੇ ਆਧਾਰ 'ਤੇ ਵਿਤਕਰਾ ਨਹੀਂ ਕਰਦੀ ਹੈ।

हिंदी (Hindi): … लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

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