



ABA Beyond the Basics

Indiana Health Coverage Programs (IHCP)

Gainwell Technologies

2026 IHCP Works Annual Seminar October

Agenda

- Eligibility and Applied Behavior Analysis (ABA) Coverage Criteria
- Prior Authorization & Limit Updates
- ABA Provider Requirements and Reimbursement
- Common Claim Denials
- Important Updates at a Glance
- Helpful Tools
- Questions





Eligibility and ABA Coverage Criteria

Verifying Eligibility



- Members may have a change of coverage due to varying circumstances; therefore, always check eligibility **prior** to rendering services for **every** date of service.
- You can check online on the [IHCP Provider Healthcare Portal](#), with the virtual assistant GABBY at 800-457-4584, option 2, or through an approved vendor software for the 270/271 eligibility benefit transactions.
- Eligibility **cannot** be verified for future dates.
- Use one of the following: the Member's ID; Social Security Number (SSN) and Birth Date; or Last Name, First Name and Birth Date.

My Home | Eligibility | Claims | Care Management | Resources

Eligibility Thursday 07/09/2026 11:39 PM

Eligibility Verification Request

* Indicates a required field.
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID		Last Name		First Name	
SSN *		Birth Date *			
*Effective From		Effective To			

Member Is Eligible



Benefit Details 			
Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	07/09/2026	07/09/2026
Family Supports HCBS Waiver	Authorized Family Supports HCBS Waiver services found in the Notice of Action (NOA)	07/09/2026	07/09/2026

Benefit Details lists the member's coverage, including benefit plan name and description. For ABA therapy, the member must have a benefit plan that includes Full Medicaid Coverage. As articulated in IHCP Bulletin [BT202627](#), ABA Therapy is covered exclusively via Early Periodic Screening Diagnostic and Treatment (EPSDT) services for members under 21 years of age.

Limited-benefit plans such as Emergency Services Only or Family Planning Eligibility Program would not include coverage for ABA therapy.

Some searches may have more than one coverage type listed.

Eligibility Limits, Managed Care Assignment and Other Insurance Details



Limit Details		
The Dollar Limits and Service Limits may not reflect recent claims.		
Service Limits	Limit	Remaining
6209 FULL MOUTH OR PANORAMIC X-RAYS LIMIT ONCE /3	1	-
6211 PERIODIC/LIMITED ORAL EVAL LIMIT 1 EVERY 6MON	1	-
6212 FLUORIDE TREATMENT LIMITED TO 1 EVERY 6 MONTH	1	-
6225 ONE SEALANT PER TOOTH PER LIFETIME - Sealant applied	3, 4, 5, 12, 13, 14, 15, 19, 20, 21, 28, 29, 31	-
6297 ROUTINE VISION EXAM LIMIT TO 1/12 MONTHS AGE	1	-
6380 ABA services limited to 4000 hours (16,000 un	16000	15473

Managed Care Assignment Details			
Managed Care Program		Primary Medical Provider	Provider Phone
Fee for Service + NEMT			
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
07/09/2026	07/09/2026	VERIDA, INC	

Other Insurance Details						
Carrier Name (Carrier ID)	Address	Phone Number	Policy ID	Group ID	Policy Holder	Coverage Type
UNITED HEALTHCARE	PO BOX 740800 ATLANTA, GA 30374	1-877-842-3210				HOSPITALIZATION, MEDICAL AND MAJOR MEDICAL

Limit Details: Definitive count of what has paid. Can be slightly behind given claims lag but once depleted, it's depleted.

Managed Care Assignment Details: Advises who manages the care for the member on this date of service.

Other Insurance Details: Lists any other insurance on file that would be considered primary, if applicable.



ABA Therapy Coverage Criteria

For IHCP coverage of ABA therapy services, all the following criteria must be met:

- The member is **under 21 years** of age.
- The member has been **diagnosed with autism spectrum disorder (ASD)** by a qualified healthcare provider (defined on following slide).
- A qualified healthcare provider has completed a **comprehensive diagnostic evaluation (CDE)** of the member using the most recent version.
- A qualified healthcare provider has made a **treatment referral** recommending ABA therapy.

Note: A copy of the CDE must be included with the referral. If the CDE is more than one year old, the referral must also include an updated statement of need as well as an up-to-date behavior assessment completed by the ABA therapy provider.



Who is a Qualified Healthcare Provider to Complete the CDE?

- Defined as a practitioner who has specialized training in the application of the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM) autism criteria and holds one of the following credentials:

Licensed Advanced Practice
Registered Nurses (APRNs)

Licensed physician (including
psychiatrists and pediatricians)

Doctoral-level licensed clinical
psychologist, endorsed as a health
service provider in psychology
(HSPP)

Licensed Physician Assistants

Comprehensive Diagnostic Evaluation (CDE) Requirements



The CDE must include all the following components:

- Interview with a caregiver who is familiar with the individual's history and current functioning level
- Structured observation of the individual's current social communication skills and behaviors
- Review of available external evaluations or screenings (such as First Steps, school or therapy evaluations)
- Documentation of a completed screening/diagnostic evaluation using the most recent version of the DSM
- Documentation that the individual cannot adequately participate in home, school or community activities or that the individual presents a safety risk to self or others
- A referral from a physician for autism-specific services

Behavior Assessment Requirements



A behavior assessment must be conducted prior to the initiation of ABA therapy, with reassessments performed at least every six months thereafter, for continuation of service.

The behavior assessment must include three core standardized behavior instruments:

- Vineland Adaptive Behavior Scales
- Behavior Assessment System for Children (BASC), specifically version 4 after 10/1/26 (see IHCP Bulletin [BT2026123](#))
- An age-appropriate, objective direct skills assessment

The behavior assessments may be performed by any of the following practitioners:

- Psychologist
- Board Certified Behavior Analyst-Doctoral (BCBA-D)
- Master's-level Board Certified Behavior Analyst (BCBA)

The behavior assessment must be signed by the lead analyst and parent or guardian.

The complete scoring report, including outcome measure scores and graphs, must be submitted with prior authorization requests.

Provider changes should be managed by the new provider.

Treatment Plan Requirements for ABA Therapy



Individualized

- Identify the behavioral, psychological and medical concerns of the member.
- Individualized intervention strategies to eliminate and replace the problematic behavior.

Specific

- Identify short-, medium- and long-term goals and their timeline, updated after each assessment.
- Tie those goals to the requested hours, including a clear schedule of planned services & interventions.

Collaborative

- Document how parents, guardians and/or caregivers will participate, including training and school transition.
- Plan is co-signed by lead analyst and guardian.



Prior Authorization and Limit Updates



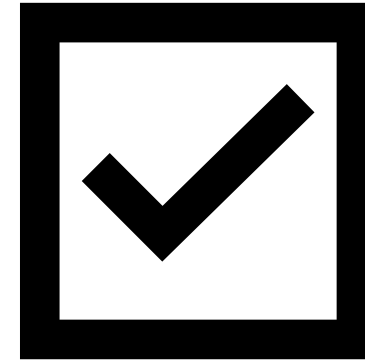
ABA Prior Authorization

- All ABA therapy services require prior authorization (PA).
- PA requests must include:
 - Individual treatment plan and supporting documentation
 - Number of hours requested with supporting documentation
- Requests are limited to six months; PA requests for longer periods will not be approved.
- The requested hours and treatment plan should be individualized to the child's needs, up to 40 hours per week.
- ABA therapy PA requests will include caregiver coaching and training when required and appropriate.

ABA Prior Authorization Checklist

Providers can use the IHCP [Applied Behavior Analysis \(ABA\) Prior Authorization Checklist](#) to prepare comprehensive PA requests for ABA therapy, which should reduce suspensions for requests for additional information.

This checklist is available on the [Forms](#) page of the provider website (in.gov/medicaid/providers), under *Miscellaneous PA-Related Forms*.





Prior Authorization Contact Information

The Indiana Health Coverage Programs (IHCP) fee-for-service prior authorization and utilization management (PA-UM) contractor is Acentra Health.

PA submission can be done by Acentra's Atrezzo portal, fax, phone or mail. Contact information:

[Atrezzo Portal](#)

Email: INPriorAuthIssues@acentra.com

Phone: 866-725-9991

Fax: 800-261-2774

Acentra Health – Prior Authorization

6802 Paragon Place, Suite 440

Richmond, VA 23230

Reminders:

- **PA is not a guarantee of payment.**
- **If a member has other non-Medicare primary coverage and the service requires PA, the provider must obtain PA from both sources before rendering and billing for services.**

Comprehensive Versus Targeted ABA Therapy Services



Comprehensive

Comprehensive ABA therapy services give a high level of support and usually take 16 or more hours each week. They are often used with young children. The services work on many skills at the same time, such as learning, behavior, communication, and daily living skills. The goal is to help the child do better in everyday life and reduce challenges related to ASD.

Targeted

Targeted ABA therapy helps individuals work on a few important skills at a time. These may include acclimating to new environments, social skills, transitioning between tasks, or specific challenges like sleep disruptions or aggression. Services may be provided for up to 15 hours each week. This support can help people of many ages, especially when they are working on certain challenges or moving from more intensive services to a lesser amount of support.



Comprehensive Therapy Services

Billing & PA

Providers must include the UA modifier on both the PA request and the associated claim for proper processing of comprehensive ABA therapy services. The claim must include the relevant U1, U2 or U3 modifier to indicate the level of the provider specialty. The PA Request does not include the provider specialty modifier.

See Table 4 in [BT202627](#) for more information on billing comprehensive therapy.

Limitations

Eligible individuals may receive up to 4,000 hours (16,000 units) of comprehensive ABA therapy services over their lifetimes based on medical necessity, with up to 15 hours of medically necessary targeted ABA therapy services weekly following the utilization of 4,000 hours. If further comprehensive ABA therapy is found to be medically necessary, as determined through subsequent review by FSSA, the member's MCO, or a delegated entity of FSSA, it will be covered under EPSDT services.



Caregiver Training and Exceptions

- Comprehensive ABA therapy PA requests must include caregiver coaching and training:
 - **Comprehensive:** Minimum 12 hours of caregiver coaching per six-month authorization period, prorated when shorter.
 - **Targeted:** Based on medical necessity, not establishing a fixed monthly or six-month floor requirement.
- Minimum may be reduced via PA request when qualifying barriers are present. **Documentation must support the barrier on PA request.**
- Qualifying barriers occurring mid-PA period must be documented and communicated per IHCP Bulletin [BT2026136](#).

Qualifying barrier examples include but are not limited to:

- Caregiver Availability and Custody Issues
 - Serious Medical Circumstances
- Competing Caregiving Responsibilities
 - Emergency Events
 - Legal Circumstances

Targeted Therapy Services

Billing & PA Request

Targeted ABA therapy services are billed much like in the past, with U1, U2 or U3 modifiers for the provider type and specialty level, but no UA modifier. No modifiers should be included on the PA Request.

Limitations

Targeted ABA therapy services are excluded from the 4,000-hour lifetime comprehensive ABA therapy services allocation and remain available, when medically necessary, to eligible members.



Caregiver Coaching and Training

Requirement

Caregiver coaching is required for comprehensive therapy services. There is a minimum of two hours per month or twelve hours per six-month authorization unless barriers are identified on the PA Request.

There is no fixed minimum for targeted therapy services, rather the appropriate minimum will be determined based on medical necessity.

Billing

Requires a U2 or U3 modifier on the claim. 97155 and 97156 may not be submitted as comprehensive, thus no UA modifier on claim nor PA request. If 97157 will be billed as comprehensive, it must include the UA on both the claim and PA request.

Limitations

The IHCP allows up to 18-hours of caregiver coaching and training per standard six-month period. More may be granted if determined to be medically necessary.



Modifiers on Claims vs. PA Requests – A Summary

PA Requests only include a modifier when the service is for a member receiving comprehensive ABA.

ABA claims require modifiers to indicate the provider specialty (U1, U2, U3). The UA modifier is required when the member is receiving comprehensive ABA. U4, U6, U8 may be used to indicate group size during shared sessions.





ABA Provider Requirements and Reimbursement

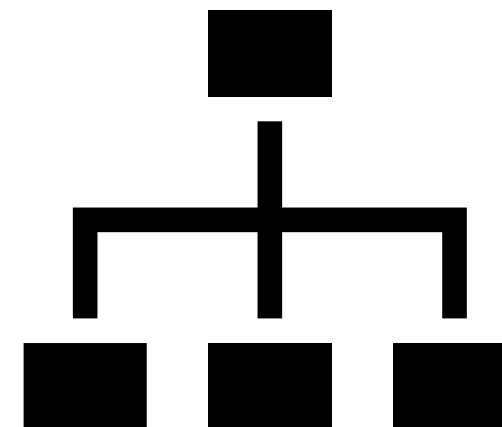


Supervision Requirements

Every rendering provider must practice within scope.

- The IHCP requires a minimum of one hour of supervision by a BCBA or other IHCP-approved qualifying supervising clinician for every eight hours of RBT-delivered ABA therapy services.
- ABA therapy services performed by a BCaBA or a credentialed RBT, must be under the direct supervision of a BCBA, BCBA-D or HSPP.

For more information about supervision requirements, please see *IHCP Bulletin* [BT202662](#).





Required Modifiers for Rendering Providers

For IHCP reimbursement, ABA therapy services must be rendered by an appropriate practitioner and billed with the correct modifiers:

- U1 modifier: Credentialed Registered Behavioral Technician (RBT)
- U2 modifier: Bachelor-level Board Certified Assistant Behavior Analyst (BCaBA)
- U3 modifier: Master's-level Board Certified Behavior Analyst (BCBA), Doctoral-level Board Certified Behavior Analyst (BCBA-D), or Health service provider in psychology (HSPP)

See Table 5 of the IHCP [Behavioral Health Services Codes](#) for a breakdown of which services a given level may provide.

Modifiers U1, U2 and U3 are for billing purposes only and should not be included on PA requests for these services.



Rendering Provider Type and Specialties

Except in the case of ABA therapy services billed by school corporations, practitioners who render ABA therapy services must be enrolled in the IHCP under one of the following specialties:

- Provider type 11, specialty 615 – ABA Therapist (Masters/Doctoral or HSPP)
- Provider type 11, specialty 624 – ABA Therapist (Bachelors)
- Provider type 11, specialty 625 – ABA Therapist (RBT)

Note: For school corporation claims, the school corporation's NPI must be listed for both the billing and the rendering provider. The individual practitioner who rendered the ABA therapy service for the school corporation does not need to be enrolled in the IHCP but must still meet the required qualifications for the service.

Group Therapy Codes and Modifiers



Group ABA therapy service procedure codes have new rate tiers assigned for group sizes of two, three, and four to eight participants. For billing purposes, group size must be indicated using the appropriate modifier:

Procedure Codes

- 97154
- 97157
- 97158

Modifiers

- U4: Services delivered to a group size of 2
- U6: Services delivered to a group size of 3
- U8: Services delivered to a group size of 4-8
- Note: U1-U3 are required in addition.



Modifiers U4, U6 and U8 are for billing purposes only and should *not* be included on PA requests for these services.

Reimbursement

Reimbursement is based on the
[IHCP Professional Fee Schedule](#)

Choose the View the Professional Fee Schedule menu, click Accept on the IHCP Fee Schedules Copyright Agreement and search or download the applicable fee schedule you require.

IHCP Fee Schedules

The Indiana Health Coverage Programs (IHCP) publishes reimbursement information regarding all Common Procedural Terminology (CPT^{®1}), Healthcare Common Procedure Coding System (HCPCS), and Current Dental Terminology (CDT^{®2}) codes, as well as NUBC Official UB-04 Specifications³, recognized by the IHCP through the following fee schedules.

[Go to Outpatient Fee Schedule](#)

Professional Fee Schedule – Last Updated August 11, 2026 (reflects changes completed as of 7/28/2026)

The Professional Fee Schedule is intended for use by providers that bill services to the IHCP using professional claims (CMS-1500 claim form or electronic equivalent) or dental claims (ADA 2012 claim form or electronic equivalent). The rates indicated apply to Medicaid-covered services reimbursed under the fee-for-service (FFS) delivery system, and also serve as minimum reimbursement rates for all IHCP managed care programs. Managed care entities (MCEs) may have additional or different prior authorization (PA) requirements or criteria for some services.

The Professional Fee Schedule is published on the second Tuesday of each month, after 4 p.m., with information current as of the previous Sunday. Therefore, it is highly recommended that you access the schedule online for the most current information regarding procedure codes recognized by the IHCP.

The current IHCP Professional Fee Schedule can be accessed in the following ways:

- [Search](#) the Professional Fee Schedule – Search for a particular procedure code, code range or code description.
- [View a text file](#) of the Professional Fee Schedule.
- [View \(and download\) an Excel file](#) of the Professional Fee Schedule.
- [Download and convert](#) the Professional Fee Schedule – Includes instructions for importing the file into other popular applications.



Updating to a New Specialty

1. In Provider Maintenance, under the rendering provider, choose the Specialty Changes link

Provider Maintenance: Ins

Instructions

[Tax ID Changes](#)

[Contact and Delegated Administrator Information Changes](#)

[Specialty Changes](#)

[Language, Gender and Ethnicity Changes](#)

[Other Information Changes](#)

[Provider Identification Changes](#)

[Check Status](#)

2. Remove the current Specialty by selecting Remove Link

* Indicates a required field.
✓ Indicates a primary specialty.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

	Specialty	Action
+	✓ 625 : ABA Therapist (RBT)	Remove
+	Click to add specialty.	

Submit

Cancel



Updating to a New Specialty, continued

3. Select the appropriate Specialty from the drop-down menu and click Add

* Indicates a required field.
✓ Indicates a primary specialty.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Specialty	Action
Click to collapse.	
Provider Type 11 : Behavioral Health Provider Primary ☒	*Specialty
Add Reset	

4. Click Submit

* Indicates a required field.
✓ Indicates a primary specialty.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click "Remove" link to remove the entire row.

Specialty	Action
☒ 624 : ABA Therapist (Bachelors)	Remove
☐ Click to add specialty.	





Common Claim Denials

Denial Example: Prior Authorization Units Exceeded



Denial EOB Code 3006 and Claim Adjustment Reason Code 198

Claim EOB Information			
Claim / Service #	Disposition	EOB Code	Description
Svc # 1	Deny	3006	PAYMENT FOR THIS SERVICE HAS BEEN DENIED OR CUTBACK DUE TO DOLLARS BILLED EXCEEDING THE DOLLARS PRIOR AUTHORIZED.

Claim Adjustment Reason Code Information				
Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	198		System	Precertification/notification/authorization/pre-treatment exceeded.

The claim denied due to the number of units billed for an authorized service/procedure
or

The claim pays up to the remaining number of units.

Denial Example Resolution: Prior Authorization Units Exceeded



Resolution: Please review your PA via Acentra Health's [Atrezzo](#) portal. Verify what you were approved for versus what you billed, including dates, units and modifiers.

If the member needs additional authorization, please reach out to Acentra.

See the [Prior Authorization](#) provider reference module for additional details.



Denial Example: Prior Authorization Not Found

Denial EOB Code 3001 and Claim Adjustment Reason Code 197

Claim EOB Information					
Claim / Service #	Disposition	EOB Code	Description		
Svc # 1	Deny	3001	DATES OF SERVICE NOT ON THE P.A. MASTER FILE.		

Claim Adjustment Reason Code Information						
Claim / Service #	ARC Code	Adjustment Amount	System	Description		
Svc # 1	197	\$300.00	System	Precertification/authorization/notification/pre-treatment absent.		

This denial indicates the code billed requires PA for that program, and the dates of service indicated on the claim do not fall within the start/stop dates prior authorized for the service rendered.

or

If the **modifier usage** on the claim does not match the usage on the PA.



Denial Example Resolution: Prior Authorization Not Found

Resolution: Contact the PA contractor Acentra Health via their [Atrezzo](#) portal to follow up on the status of the request and review your claim dates and **modifier usage** versus authorization approved.

If there is no PA on file, the claim will remain denied unless you are able to obtain retro authorization. Medical records cannot bypass this requirement.



Denial Example: Modifier Used is Not Compatible

Denial EOB Code 4033 and Claim Adjustment Reason Code 4

Claim EOB Information				
Claim / Service #	Disposition	EOB Code	Description	
Svc # 1	Deny	4033	THE MODIFIER USED IS NOT COMPATIBLE WITH THE PROCEDURE CODE BILLED. PLEASE VERIFY AND RESUBMIT.	
Claim Adjustment Reason Code Information				
Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	4	\$1,040.00	System	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

The modifier billed must match the rendering provider's level of certification.

U1 modifier: RBT
U2 modifier: BCaBA
U3 modifier: BCBA, BCBA-D and HSPP

Recommend [BT202627](#)
Tables 4 & 5 for a
crosswalk of modifier to
provider specialty +
service combinations.

Denial Example Resolution: Modifier Used is Not Compatible



Service Details							
#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Copay Amount	Units
<u>1</u>	04/20/2026	04/20/2026	11-Office	97153-ADAPTIVE BEHAVIOR TX BY TECH	\$1,040.00		32.00 Unit
From Date 04/20/2026 To Date 04/20/2026 Place of Service 11-Office Procedure Code 97153-ADAPTIVE BEHAVIOR TX BY TECH Diagnosis Pointers 1 - - - Modifiers JA-M/CAID CARE LEV 10 STATE DEF Charge Amount \$1,040.00 Units 32.00 Unit Type Unit EPSDT ☐ Family Plan ☐ EMG ☐ Rendering Provider ID ID Type NPI Rendering Taxonomy Line Item - Control#							

Resolution: Please review the service details of the claim. Verify the rendering provider and enter the correct modifier U1, U2 or U3 to reflect the rendering provider's certification level for each service detail.

Denial Example: Rendering Provider Is Not an Eligible Member of Billing Group



Denial EOB Code 1010 and Claim Adjustment Reason Code B7

Claim EOB Information			
Claim / Service #	Disposition	EOB Code	Description
Svc # 1	Deny	1010	RENDERING PROVIDER IS NOT AN ELIGIBLE MEMBER OF BILLING GROUP OR THE GROUP PROVIDER NUMBER IS REPORTED AS THE RENDERING PROVIDER. PLEASE VERIFY PROVIDER NUMBER AND RESUBMIT.

Claim Adjustment Reason Code Information				
Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	B7	\$2,700.00	System	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

The claim denied because the rendering provider is not linked to the billing group or the group provider NPI is being used in error.

Denial Example Resolution: Rendering Provider is Not An Eligible Member of Billing Group

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	05/14/2026	05/14/2026	11-Office	97153-ADAPTIVE BEHAVIOR TX BY TECH	\$2,700.00	24.00 Unit	Remove

***From Date** 05/14/2026 **To Date** 05/14/2026 ***Place of Service** 11-Office

***Procedure Code** 97153-ADAPTIVE BEHAVIOR TX BY TECH ***Diagnosis Pointers** 1

Modifiers U1-M/CAID CARE LEV 1 STATE DEF UA-M/CAID CARE LEV 10 STATE DEF

Charge Amount \$2,700.00 ***Units** 24.00 ***Unit Type** Unit **EPSDT** ☐ **Family Plan** ☐ **EMG** ☐

Rendering Provider ID **ID Type** NPI **Rendering Taxonomy**

Line Item Control#

Resolution: Review the NPI submitted.
Confirm it is the **rendering provider's NPI**.
Confirm the rendering provider is linked to the group.
Confirm the rendering is appropriate on the header and each detail.





Important Updates at a Glance



Telehealth Restrictions per [BT202627](#)

Telehealth restrictions

Effective April 1, 2026, the IHCP will no longer allow CPT codes 97151, 97152, 97153, 97154 or 0373T to be billed with modifier 95 – *Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system* for telehealth service delivery. These codes represent assessment, protocol development and adaptive behavior treatment services that require direct, in-person interaction and real-time behavior observation to ensure treatment fidelity, member safety and clinically valid outcomes. This change supports higher treatment quality and aligns with evidence-based expectations for accurate functional assessment and effective behavior-change implementation.

Group Enrollment Moratorium

The IHCP announced a temporary moratorium on ABA provider agency enrollments, effective as of June 6, 2026, for an initial period of six months in IHCP Bulletin [BT202692](#).

The IHCP may continue to extend the moratorium in six-month increments. The moratorium applies to new ABA group enrollments and changes of ownership for existing ABA therapy agencies. It does not apply to rendering provider enrollment requests for individuals providing ABA therapy services.

The IHCP will consider limited exceptions to the moratorium to ensure sufficient member access to ABA therapy services to areas in need. Provider agencies seeking an exception to the moratorium must be accredited per the requirements described in *IHCP Bulletin* [BT202646](#).

Providers may submit their request for an exception by emailing
OMPPPProviderRelations@fssa.in.gov.





ABA Accreditation Requirement

Beginning Oct. 1, 2027, the IHCP will require all newly enrolled and existing applied behavior analysis (ABA) group enrollments to be accredited [BT202646/BT2026118](#).

All providers **must have completed the accreditation process and remain actively accredited** by Oct. 1, 2027, to remain IHCP-enrolled.

The IHCP will recognize accreditations from the following organizations:

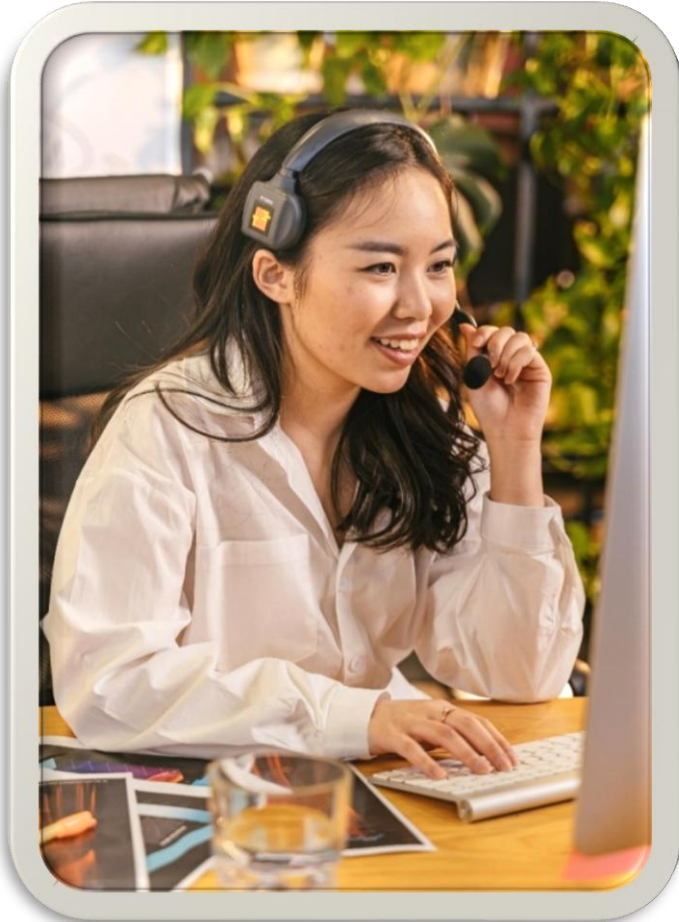
- The Autism Commission on Quality (ACQ)
- The Behavioral Health Center of Excellence (BHCOE)*

*Note: Any previous accreditation issued from BHCOE will be accepted until an agency's reaccreditation with ACQ.



Helpful Tools

Useful Information



[Indiana Medicaid for Providers website](#)

[IHCP Provider Reference Modules](#)

[IHCP Bulletins](#)

Sign up for [email notifications](#) to receive weekly summaries of new and updated bulletins, modules and other publications.

Customer Assistance

800-457-4584

8 a.m. - 5 p.m. Eastern Time Monday – Friday

[Provider Relations Consultants](#) by region

Secure Correspondence via the [IHCP Provider Healthcare Portal](#)
(After logging in to the [IHCP Provider Healthcare Portal](#), click the
Secure Correspondence link to submit a request.)

Provider Relations Consultants



Areas Covered	Consultant	Email	Telephone
Region 1 plus Chicago/Watseka, IL, and Sturgis, MI	Michelle Walls	INXIXRegion1@gainwelltechnologies.com	317-488-5071
Region 2 plus Danville, IL	Jill Harris	INXIXRegion2@gainwelltechnologies.com	317-488-5080
Region 3	Open	INXIXRegion3@gainwelltechnologies.com	317-488-5324
Region 4 plus Cincinnati/Harrison and Hamilton/Oxford, OH	Kassandra Johnson	INXIXRegion4@gainwelltechnologies.com	317-488-5153
Region 5	Virginia Hudson	INXIXRegion5@gainwelltechnologies.com	317-488-5186
Region 6	Open	INXIXRegion6@gainwelltechnologies.com	317-210-2618
Region 7 plus Louisville and Owensboro, KY	Tami Lott	INXIXRegion7@gainwelltechnologies.com	317-286-6894
All out-of-state providers except those in the previously listed cities	Judy Green	INXIX_OOS@gainwelltechnologies.com	317-488-5026



Questions

Thank you for attending!

By taking a few moments to complete the event and session evaluations, you help us understand your experience and shape the future of our programs.

