INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Introduction to the IHCP

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Revision History

Version	Date	Reason for Revisions	Completed By
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1.1	Policies and procedures as of Aug. 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: Feb. 13, 2017	Scheduled update	FSSA and HPE
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6.0	Policies and procedures as of Sept. 1, 2021 Published: Dec. 14, 2021	Scheduled update: • Edited text as needed for clarity • Changed DXC references to Gainwell • Changed ISDH references to IDOH • Updated *Table 1 – Fee-for-Service PA and Claim Submission* • Updated information in the *Provider Reimbursement Methodologies* section • Added UnitedHealthcare in the *Contractors* section • Updated the *Southeastrans Provider Services* section • Updated the *Provider Relations* section • Updated the *Provider Resources and Contact Information* section, including adding *Table 3 – Office of Medicaid Policy and Planning Email Inboxes for Providers*	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Updated the *Civil Rights Requirements* section to add a reference to the *American Disabilities Act* and to update *Figure 1 – 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* can be used as a reference for medical coverage, billing guidance and reimbursement policy 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 *IHCP Provider Reference Modules* page of the IHCP provider website at in.gov/medicaid/providers.

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 PA 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

Delivery Systems

The following sections describe the delivery systems the IHCP uses for administering Medicaid benefits and healthcare. For information about specific IHCP programs and associated benefit plans, 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. For services rendered under the FFS delivery system, providers should submit claims and, if required, PA requests to the appropriate IHCP FFS contractor, as listed in Table 1. The table also lists the provider reference modules that contain FFS billing and PA procedures for each type of service.

Table 1 – Fee-for-Service PA and Claim Submission

Type of Service	Submit PA Requests and Claims To	Modules With More Information
Pharmacy	OptumRx	*Pharmacy Services*
Nonemergency medical transportation (NEMT) services *(except services exempt from brokerage)*	Southeastrans	*Transportation Services*
All others	Gainwell Technologies	*Claim Submission and Processing* *Prior Authorization*

Managed Care

The state of Indiana has mandated a managed care delivery system for members enrolled in the following programs:

- Healthy Indiana Plan (HIP)
- Hoosier Care Connect
- 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.

Per the IHCP contract, the MCE is responsible for performing claim processing, PA authorization and subrogation activities for its particular subcontractor network. 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 in.gov/medicaid/providers.

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.

> *Note: The IHCP also provides the Program of All-Inclusive Care for the Elderly (PACE) for individuals 55 years old or older who are certified by the state of Indiana to need a nursing facility level of care, are able to live safely in the community at the time of enrollment, and reside in a PACE service area. Designated PACE organizations serve as MCEs for PACE members. For more information, see the Member Eligibility and Benefit Coverage module and the Program of All-Inclusive Care for the Elderly page at in.gov/fssa.*

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 carved-out services, when required, also follows the FFS process. MCEs must provide care coordination and associated services related to carved-out services, including but not limited to transportation.

See the *Member Eligibility and Benefit Coverage* module for more information, including a list of carved-out services.

Self-Referral Services

Most services in managed care require referral from a primary medical provider (PMP). Self-referral services are an exception. For services designated as *self-referral*, MCEs reimburse IHCP-enrolled providers without a PMP referral. Self-referral services must be covered under the member's benefit plan and established benefit limits, and PA requirements apply.

For more information, including a list of self-referral services, see the *Member Eligibility and Benefit Coverage* module.

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)
- Maximum fee
- Manually priced
- Medicare and Medicare Advantage Plan, and IHCP crossover coinsurance and deductible
- Outpatient ambulatory surgical center (ASC) flat rate
- Percentage of billed charges
- Resource-based relative value scale (RBRVS)

Details about these reimbursement methodologies are found in *405 IAC 1-8*, *405 IAC 1-10.5* and *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 in.gov/medicaid/providers:

- The **Professional Fee Schedule** contains a list of IHCP-covered Current Procedural Terminology (CPT®[1]), Healthcare Common Procedure Coding System (HCPCS) and Current Dental Terminology (CDT®[2]) procedure codes and includes indicators specific to each code, such as program coverage, reimbursement and PA. The entire Professional Fee Schedule can be viewed online, or a search tool is available to view only results for a specific procedure code, code range or code description. This fee schedule can also be downloaded as a Microsoft Excel document or as a text file that can be imported into popular applications such as Microsoft Access. The IHCP automatically updates the Professional Fee Schedule each week.
- The **Outpatient Fee Schedule** reflects coverage, pricing and reimbursement methodology for HCPCS and CPT procedure codes and revenue codes billed by outpatient hospitals and ASCs. The Outpatient Fee Schedule is posted as a Microsoft Excel document so that providers can search and sort as needed. It is updated monthly 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 contact information, see the IHCP Quick Reference Guide, available at in.gov/medicaid/providers.*

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.

Division of Aging

The FSSA Division of Aging is responsible for overseeing two 1915(c) Home- and Community-Based Services (HCBS) waiver programs:

- Aged and Disabled (A&D) Waiver
- Traumatic Brain Injury (TBI) Waiver

The Division of Aging is also responsible for administering the Money Follows the Person (MFP) demonstration grant for A&D and TBI and for processing Preadmission Screening and Resident Review (PASRR) requests, including level-of-care (LOC) assessments, for long-term care.

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)
- Community Integration and Habilitation (CIH) Waiver

The DDRS is also responsible for administering the MFP demonstration grant for CIH.

Division of Mental Health and Addiction

The FSSA Division of Mental Health and Addiction (DMHA) administers three 1915(i) State Plan HCBS programs:

- Adult Mental Health and Habilitation (AMHH)
- Behavioral and Primary Healthcare Coordination (BPHC)
- 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. Current contractors and responsibilities include the following:

- Gainwell Technologies – Fiscal agent
  - Fee-for-service (FFS) claim processing for services other than pharmacy and brokered NEMT
  - FFS nonpharmacy PA and utilization review
  - Member and provider customer service
  - Provider enrollment
  - Provider relations
  - Managed care entity and enrollment broker support
  - Third-party liability
  - IHCP Provider Healthcare Portal
- OptumRx – FFS pharmacy benefit manager
  - FFS pharmacy claim processing
  - FFS pharmacy-related PA
  - FFS pharmacy-related member and provider support
  - FFS pharmacy-related claim audit functions
  - Drug rebate services
  - Pharmacy rate setting

- Southeastrans – FFS nonemergency medical transportation (NEMT) broker
  - FFS NEMT provider network development
  - FFS NEMT member and provider support
  - FFS NEMT claim processing*
  - FFS NEMT transportation scheduling*

  ** Except for NEMT services that are exempt from the brokerage requirement.*
- MAXIMUS – Enrollment broker
  - HIP, Hoosier Care Connect and Hoosier Healthwise member and provider support
  - Member program education
  - Member counseling for selection of MCE (also known as health plan)
  - MCE assignment for members who do not self-select an MCE
- Myers and Stauffer LC – Rate-setting contractor
  - Nonpharmacy rate setting
  - Long-term care audits
- Anthem, CareSource, Managed Health Services (MHS), MDwise and UnitedHealthcare – IHCP-contracted managed care entities for the HIP, Hoosier Care Connect and Hoosier Healthwise programs
  - Utilization management and PA**
  - Provider network development
  - 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.*

Contact information for these contractors is available in the *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers.

Indiana Department of Health

The Indiana Department of Health (IDOH) is responsible for certifying, credentialing and/or licensing certain provider types and specialties – including, in conjunction with the CMS, certifying providers for Clinical Laboratory Improvement Amendments (CLIA). For applicable specialties, see the *IHCP Provider Enrollment Type and Specialty Matrix*, available at in.gov/medicaid/providers.

For questions about the IDOH certification, credentialing or licensure process, providers may contact the IDOH at the following address or telephone number:

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

317-233-1325 or **800-382-9480**

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*, available at in.gov/medicaid/providers, includes contact information for these provider services units.

OptumRx Provider Services

OptumRx, the FFS pharmacy benefit manager, maintains a provider services unit to address the questions and concerns of pharmacy providers rendering services under the IHCP FFS delivery system – including the resolution of pharmacy-claim-processing issues. The *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers includes contact information for the OptumRx Clinical and Technical Help Desk, where member and provider telephone inquiries should be directed.

Southeastrans Provider Services

Southeastrans is responsible for brokering nonemergency medical transportation (NEMT) services for IHCP members served through the FFS delivery system.

Contact information for Southeastrans, including reservation and facility dispatch lines and links for members, transportation providers and facilities, is included in the *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers. Information about contracting with Southeastrans and other guidance for transportation providers can be found on the *Southeastrans Indiana Transportation Providers* page at southeastrans.com.

Gainwell Provider Services

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

- The Provider Enrollment Unit is responsible for provider enrollment, revalidation and provider profile maintenance activities.
- The Prior Authorization and Utilization Management Unit is responsible for FFS nonpharmacy PA and utilization management services.
- The Customer Assistance Unit is responsible for answering telephone inquiries.
- The Written Correspondence Unit responds to inquiries submitted through the Portal and performs administrative reviews as directed by the FSSA.
- The 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 transactions, including applications and profile maintenance updates.
- Deactivates enrolled providers that no longer meet state requirements for participation in the IHCP.
- Maintains provider files for all enrolled, denied and terminated providers.

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, accessible from the home page at in.gov/medicaid/providers. Printable enrollment packets and profile maintenance forms are available on the *Complete an IHCP Provider Enrollment Application* page at in.gov/medicaid/providers. 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 **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 Privacy 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 24 hours a day, seven days a week, using automated online, telephone and electronic transaction systems as described in the Member Eligibility and Benefit Coverage and Claim Submission and Processing modules.

- *Instructions for accessing information online via the Portal are included in the Provider Healthcare Portal module.*
- *Instructions for accessing information via the IVR system using a touch-tone telephone are included in the Interactive Voice Response System module.*
- *Instructions for accessing information via the 270/271 and 276/277 electronic data interchange (EDI) transactions are available in the Electronic Data Interchange module and the IHCP companion guides at in.gov/medicaid/providers.*

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 nine-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)
  - Claim ID or other information needed to identify the claim, including:
    - Member information (Member ID or name and date of birth)
    - Service information (dates of service and claim type [inpatient, outpatient, medical, dental and so forth])
    - Amount billed
- 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

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 electronic claims) and any documentation that was attached
- 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 and should be referred to in subsequent correspondence with the IHCP about the issue. When the Written Correspondence analyst resolves the inquiry, an automated 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 Correspondence analysts will respond in writing to the provider within 10 business days of receiving the inquiry.

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.

Requests for Paper Remittance Advice

Providers are encouraged to use the Portal to view or download a Remittance Advice. However, if needed, providers can request a paper RA from the Written Correspondence Unit as described in the *Financial Transactions and Remittance Advice* module.

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 organizes its team of consultants into regions to minimize wait times when providers contact the unit for assistance. Every region has a *field consultant* and an *internal consultant* working in conjunction to meet the needs of the provider community. A dedicated email address and voicemail number for each region enables both the field and internal consultants for that region to access, research and respond to provider inquiries. Consultants also offer on-site training to encourage the provider community to use the Portal and HIPAA-compliant electronic transactions, and to recruit new providers for the IHCP. Specific region assignments and contact information are available on the *Provider Relations Consultants* page at in.gov/medicaid/providers or by calling Customer Assistance at 800-457-4584.

Provider Relations 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 providers about IHCP policies and objectives, assist with resolving provider issues, and conduct training.

When scheduling an on-site visit from a Provider Relations consultant, providers should convey the following information to assist the consultant in structuring the meeting or presentation to best meet the needs of the audience:

- Provider community segment attending the visit
- Number of attendees
- Preferred time and location of the visit
- Issues to be addressed
- Point of contact, in case additional information is needed prior to the visit

The Provider Relations Unit also coordinates the broader provider education component of the IHCP. In conjunction with other IHCP contractors, the unit develops and presents educational sessions about all aspects of the IHCP, through a set of scheduled workshops (IHCP Roadshow) and an annual seminar (IHCP Works). See the *Provider Education Opportunities* page at in.gov/medicaid/providers for links to information about upcoming workshops or seminars (including registration instructions), as well as additional training resources, such as archived presentations from past workshops and seminars, periodic online webinars (IHCP Live), and various training documents for self-paced learning. Workshops and webinars are announced in IHCP provider bulletins and banner pages, provider association newsletters, and on the IHCP provider website at in.gov/medicaid/providers.

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

> *Note: The "IHCP Listens" email account (IHCPListens@fssa.in.gov) allows providers to give feedback on current or past trainings and to suggest topics for future trainings. The FSSA conveys relevant information received at this account to the Provider Relations Unit.*

Provider Resources and Contact Information

Providers can sign up for email of Medicaid and other FSSA news, reminders and other important information at the *IHCP Email Notifications* page or by entering their email address in the green sign-up box at the bottom of any page on in.gov/medicaid/providers. After submitting an email address, select the **IHCP Providers** subscription topic to receive notices when news items, bulletins, banner pages, and updates to provider reference modules, code tables and other important reference documents are published to the website.

Table 2 serves as a quick reference for providers with questions about claims or programs, or in need of clarification on a specific topic.

Table 2 – 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 in.gov/medicaid/providers	*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. These 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 either in the posted provider reference module or in publications issued after the effective date of the module.
IHCP provider reference modules	View or download from the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers	Providers can refer to the IHCP provider reference modules as a resource for medical coverage, PA procedures, billing guidance, claim submission and processing information, reimbursement policy, and other related topics. These modules include links to billing-related code tables and answers to billing and other procedural questions. Updates to policies and procedures are announced in IHCP banner pages and bulletins and added to the published reference modules at regular intervals.
IHCP provider website	in.gov/medicaid/providers	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 • Fee schedules (professional and outpatient) • Code tables • Provider enrollment and profile maintenance packets • Program descriptions • Contact information • Provider education opportunities • Forms, including PA request forms • Provider Healthcare Portal • EDI information, including IHCP companion guides for HIPAA version 5010

Provider Resource	How to Access Resource	When to Use Resource
Provider Healthcare Portal	portal.indianamedicaid.com, accessible from the home page at in.gov/medicaid/providers	New providers can enroll in the IHCP through the Portal. Enrolled providers can become registered Portal users to access functions such as the following: • Update provider information on file • Verify member eligibility and check benefit limits • File claims and check claim status (FFS, nonpharmacy claims only) • Submit PA requests and check PA status (FFS, nonpharmacy PA only)
Customer Assistance telephone line	Toll-free at **800-457-4584** Automated assistance is available 24 hours a day through the Interactive Voice Response (IVR) system. Live assistance available 8 a.m. – 6 p.m. Eastern Time Monday through Friday, excluding holidays	The Customer Assistance line represents the primary access point for telephone inquiries about IHCP provider enrollment, third-party liability, claim submission and processing, EDI trading partner and Provider Healthcare Portal technical assistance, policy, and covered services. The following functions are available through the IVR system: • Verify member eligibility and check benefit limits • Check claim status (FFS, nonpharmacy claims only) • Check PA status (FFS, nonpharmacy PA only)
Written Correspondence	Contact Gainwell via secure correspondence on the Provider Healthcare Portal	Providers can contact the Written Correspondence Unit to address specific questions about the IHCP, to get claim-specific assistance (such as researching complex claim denials, member benefit limits or issues receiving payment), to request a paper RA, or to request administrative review of a claim. Providers should not submit claims for processing to the Written Correspondence Unit unless specifically directed to do so. The Written Correspondence Unit forwards medical policy inquiries to the OMPP.
Provider Relations consultants	Regional consultant assignments, with email and voicemail information, are available on the *Provider Relations Consultants* page at in.gov/medicaid/providers or from Customer Assistance	Providers can contact provider relations 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 the *IHCP Quick Reference Guide* at in.gov/medicaid/providers	Refer to this guide for telephone numbers, addresses and online resources for various entities that support the IHCP.

Table 3 provides email addresses to OMPP business units for providers' questions, feedback and requests for guidance.

> *Note: The IHCP encourages providers to check with their IHCP Provider Relations consultants for initial questions. A complete list of the consultants is available on the Provider Relations Consultants page at in.gov/medicaid/providers.*

Table 3 – Office of Medicaid Policy and Planning Email Inboxes for Providers

OMPP Business Unit	Email Address	When To Use Email Inbox
Provider Enrollment	OMPPProviderEnrollment@fssa.IN.gov	To ask questions and request clarifications about any aspect of IHCP provider enrollment, including: • Enrollment policy • Initial enrollment and application process • IHCP-requested changes to a submitted application
Provider Relations	OMPPProviderRelations@fssa.IN.gov	To ask questions, general or specific, about the following: • Announcements, including bulletins, banner pages and news items • Claim appeals • Claim processing and reimbursement • Clarification of policies and deadlines • Prior authorization
	IHCPListens@fssa.IN.gov	To allow providers to give input about the following: • Feedback on past IHCP workshops, webinars and other presentations • Ideas for future workshops or presentations • Requests for clarification of policies and programs (in future workshops or written communication)
Reimbursement	FSSA.IHCPReimbursement@fssa.in.gov	For questions or issues regarding reimbursement of services, including the following: • Payment rates for claims • Requests for changes to reimbursement rates

OMPP Business Unit	Email Address	When To Use Email Inbox
Policy Consideration	PolicyConsideration@fssa.in.gov	For technical issues with using the online *OMPP Policy Consideration Request Submission Form* or to inquire about a previously submitted request or update the email address submitted with a request *Note: Do not submit policy consideration requests via email; instead, use the online submission form. More information about the policy consideration process is available on the Policy Consideration Requests page at in.gov/medicaid/providers.*
FSSA SUD (Substance Use Disorder) services	SUD.Services@fssa.in.gov	To email questions or concerns about SUD treatment services *Note: Additional information is available on the Substance Use Disorder Treatment page at in.gov/medicaid/providers.*

Avenues of Resolution

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

IHCP Coverage and Medical Coverage Policy

To request a change to IHCP coverage parameters or medical policies, submit a policy consideration request. Instructions for submitting a policy consideration request can be found on the *Policy Consideration Requests* page at in.gov/medicaid/providers.

Reimbursement

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

To resolve issues or disagreements related to managed care claims, providers should contact the MCE with which the member is enrolled.

Prior Authorization

To resolve issues associated with FFS PA, see the *Prior Authorization* module.

To resolve issues associated with managed care PA, providers should contact the MCE with which the member is enrolled.

Provider or Member Fraud

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

Member Eligibility Determination

To resolve member eligibility issues, call the DFR toll-free telephone number at **800-403-0864** or contact the local DFR office. See the directory of local DFR offices on the FSSA website at in.gov/fssa.

The telephone number for the DFR also serves as the fax number for the FSSA 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 issue.

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*
- *Title II of the Americans with Disabilities Act (ADA)*
- *Omnibus Budget Reconciliation Act (OBRA) of 1981, where applicable*

If a provider receives a complaint of an alleged civil rights violation, 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
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

[Name of provider (individual or group entity)] complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
[Name of provider (individual or group entity)] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of provider (individual or group entity)]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact [name of civil rights coordinator (or other contact, if fewer than 15 employees)].

If you believe that [name of provider entity] 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 with:

[Name and title of civil rights coordinator (or other contact, if fewer than 15 employees)]
[Mailing address]
[Telephone number]; [TTY number, if entity has one]
[Fax]
[Email]

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [name and title of civil rights coordinator (or other contact, if fewer than 15 employees)] is available to help you.

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)

Complaint forms are available at https://www.hhs.gov/ocr/complaints.

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.

ကရင်ဘာသာစကား (Burmese): … မှာ ဗဟိုအစိုးရ နှင့် သက်ဆိုင်သော အများပြည်သူ ရပိုင်ခွင့် ဥပဒေ နှင့် လက်တွေ့ အကျင့်ဝင်သည် သာမက လူမျိုး၊ အသားရောင်၊ မွေးဖွားသည့်နိုင်ငံ၊ အသက်၊ မသန်စွမ်းဖြစ်မှု၊ သို့မဟုတ် လိင် နှင့် ပတ်သက်၍လည်း ခွဲခြားဆက်ဆံမှု အလျင်းမရှိပါ။

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 ਨਾਗਿਰਕ ਹੱਕ□ ਦੇ ਕਾਨੂੰਨ□ ਦੀ ਪਾਲਣਾ ਕਰਦੀ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਸਮਰਥਤਾ, ਜ□ ਿਲੰਗ 'ਤੇ ਅਧਾਰ 'ਤੇ ਿਵਤਕਰਾ ਨਹ□ 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।