INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Provider Enrollment

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of Oct. 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: Feb. 13, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of September 1, 2017 Published: March 22, 2018	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of April 1, 2018 Published: July 26, 2018	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of March 1, 2019 Published: Oct. 15, 2019	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of Nov. 1, 2020 Published: April 8, 2021	Scheduled update	FSSA and Gainwell
6.0	Policies and procedures as of Sept. 1, 2023 Published: March 8, 2024	Scheduled update: • Edited text as needed for clarity • Updated web links • Changed ISDH references to Indiana Department of Health (IDOH) • Removed "criminal" from the background check references • Updated the MCS information in the *IHCP Provider Enrollment Partner Agencies* section • Added a note box in the *Provider Classifications* section explaining provider terminology for enrollment versus claim submission • Updated the *Application Fee* section • Updated the *Hardship Exception* section to include evidence and validation must be provided • Updated the *Fingerprint Background Check* section	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Added the *W-9 Form Requirements* section and *Disregarded Entities* subsection • Updated the *National Provider Identifier Requirements* section • Clarified information in the *Hospital (Type 01)* section regarding the Medicare enrollment requirement • Updated the *Hospice (Type 06)* section • Updated the *Behavioral Health Provider (Type 11)* section and subsections • Added the *Donor Milk Bank (Type 25, Specialty 252)* section • Updated the *Transportation (Type 26)* section and subsection • Added the *Medicare-Only Provider (Type 37)* section • Updated the *Retroactive Provider Enrollment* section • Updated the *Prior Authorization* section • Updated the *General Enrollment Instructions* section • Updated steps and figures in the *Enrolling Online Using the Provider Healthcare Portal* section • Updated the *Enrollment Application Details* section, including removing references to the *IHCP Psychiatric Hospital Bed Addendum/Maintenance Form* • Updated the *Enrollment Packet Tips – Avoiding Common Errors* section • Update the *Disclosure Information* section and subsections • Updated the *Required and Nonrequired Provider Documents* section • Updated the *Enrollment Confirmation* section • Updated the *Enrolling as a Primary Medical Provider* section • Removed the *Preadmission Screening and Resident Review Level II Provider Enrollment* section • Updated field names to match the Portal and paper enrollment packets in the *Section 4: Provider Profile Maintenance and Other Enrollment Updates* introduction. • Updated the *View Provider Profile Information* section	

Version	Date	Reason for Revisions	Completed By
		• Updated *Table 1 – Provider Maintenance Options* • Updated the *Submitting Provider Profile Updates by Mail* section • Updated the *Taxpayer Identification Changes* section • Updated the *Address Changes* section • Updated the *Other Information Changes* section • Updated the *Provider Identification Changes* section • Updated the *Revalidation* section • Updated the *Provider Disenrollment* section • Updated the *Involuntary Termination or Deactivation* section • Updated the *Maintaining Records* section • Updated the *Opioid Treatment Programs Enrolled as OPRs* section • Updated the *Locum Tenens Healthcare Providers* section • Updated the *Charging Members for Noncovered Services* section • Updated the *Charging for Copies or Transfers of Medical Records* section • Updated the *Member Billing Exceptions* section	

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Section 1: Introduction

> *Note: For updates to information in this module, see the IHCP Bulletins at in.gov/medicaid/providers.*

To receive reimbursement for services covered under the Indiana Health Coverage Programs (IHCP), including Medicaid services, a provider must be eligible for enrollment and actively enrolled in the IHCP (*Indiana Administrative Code 405 IAC 1-1.4-3*). This module contains information about IHCP provider eligibility requirements as well as provider enrollment, profile maintenance and revalidation procedures.

For information about IHCP-enrolled providers charging members for services *not* covered by the IHCP, see the *Charging Members for Noncovered Services* section.

IHCP Provider Enrollment Partner Agencies

The IHCP provider enrollment procedures are designed to ensure timely, efficient and accurate processing of provider enrollment applications and updates to provider profiles (information on file with the IHCP for existing providers).

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

- Gainwell Technologies, in its role as the IHCP Provider Enrollment Unit, performs the following functions:
  - Enrollment of all providers
  - Maintaining the provider profile with changes as reported and authorized by the Indiana Department of Health (IDOH)
  - Processing enrollment and provider profile update requests
  - Verifying licensure and certification requirements
  - Assigning IHCP Provider IDs
  - Storing National Provider Identifier (NPI) and taxonomy information submitted by providers
  - Maintaining active, terminated and denied provider files
  - Disenrolling providers at the direction of the Indiana Family and Social Services Administration (FSSA), IDOH, Indiana Professional Licensing Agency (IPLA), Centers for Medicare & Medicaid Services (CMS), Office of the Inspector General (OIG) or Attorney General (AG) when such action is warranted
  - Maintaining provider-specific rate information as supplied by the rate-setting contractor
- The Indiana Division of Mental Health and Addiction (DMHA) certifies the following entities:
  - Community mental health centers (CMHCs)
  - Freestanding psychiatric facilities
  - Psychiatric residential treatment facilities (PRTFs)
  - Adult Mental Health Habilitation (AMHH), Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW) service providers
  - Opioid treatment programs (OTPs)
  - Substance use disorder (SUD) residential addiction treatment facilities
  - Medicaid Rehabilitation Option (MRO) clubhouse

- The IPLA issues licenses and certifications for physicians, nurses, dentists, mobile dentists, podiatrists, chiropractors, therapists (speech, language, physical and occupational), hearing aid dealers, optometrists, audiologists, pharmacies, home medical equipment providers and health service providers in psychology. Licensed providers in state and out of state are subject to licensure requirements (see *405 IAC 5-1.4-3* for enrollment requirements).
- Motor Carrier Services (MCS) of the Indiana Department of Revenue certifies for-profit intrastate transportation providers including common carrier (ambulatory and nonambulatory) and broker fleets. The U.S. Department of Transportation (USDOT) certifies interstate common carriers. These providers must have Indiana MCS certification and/or USDOT authority to be enrolled in the IHCP.
- Indiana Emergency Medical Service (IEMS) certifies ambulance and air ambulance carriers.
- The IDOH provides survey information for certain providers required to be licensed by and/or registered with the IDOH. These providers include hospitals, ambulatory surgery centers, long-term care facilities, home health agencies, rehabilitation facilities and agencies, hospices, rural health centers, laboratories and end-stage renal disease (ESRD) clinics.
- The IDOH and the CMS certify providers for Clinical Laboratory Improvement Amendments (CLIAs); CLIA certificates are updated by the CMS electronically on an ongoing basis.
- Myers and Stauffer serves as the rate-setting contractor for the state of Indiana.

Provider Classifications

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

- **Billing** – A practitioner operating as an individual or sole practitioner, or an organization operating as a business entity, billing for services at a distinct location, with no rendering providers linked to the practice or entity.
- **Group** – A practice or business entity operating at a distinct service location with one or more practitioners (rendering providers) linked to a common taxpayer identification number (TIN) for billing. Group providers must ensure that rendering providers are linked to each service location where they render services for the group practice.
- **Rendering** – A practitioner or other provider performing services for a group practice and linked to a common TIN. A provider enrolled as a *rendering* provider under one or more groups at one or more service locations may also enroll as a *billing* provider at a different service location.
- **Ordering, Prescribing or Referring (OPR)** – Practitioners who do not bill the IHCP for services rendered but may order, prescribe, or refer services or medical supplies for IHCP members. These nonbilling providers are required by the *Affordable Care Act* (*42 CFR Parts 405, 447, 455, 457* and *498*) to enroll in the Medicaid program to participate as an OPR provider.

Note: The preceding classifications refer to the way a particular provider is enrolled with the IHCP. These terms mean something different in the context of billing claims:

- *The "billing provider" on the claim could be enrolled under either the billing **or** group classification.*
- *The "rendering provider" on the claim could be enrolled under either the rendering **or** billing classification.*
- *The "OPR provider" on the claim could be enrolled under the OPR, rendering **or** billing classification.*

Successful claim processing depends on accurate input of information about all applicable providers. See the Claim Submission and Processing module for more information about claim submission procedures.

Section 2: Provider Eligibility and Enrollment Requirements

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

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

Conditions for Provider Enrollment

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

- The provider is licensed, registered or certified by the appropriate professional regulatory agency pursuant to state or federal law, or otherwise authorized by the Indiana Family and Social Services Administration (FSSA) or the Indiana Department of Health (IDOH). See the *Maintaining Licensure and Certification* section for more information.

> *Note: Out-of-state providers are certified, licensed, registered or authorized as required by the state in which the provider is located and must fulfill the same conditions as an in-state provider. The IHCP Provider Enrollment Type and Specialty Matrix at in.gov/medicaid/providers lists out-of-state provider document requirements for eligible providers and indicates which provider types and specialties are ineligible for out-of-state enrollment. For more information, see the Out-of-State Providers module.*

- The provider has obtained a National Provider Identifier (NPI), as described in the *National Provider Identifier Requirements* section (applicable for all healthcare providers; not required for atypical providers).
- The provider has completed and submitted either an electronic or paper version of the provider agreement and all other applicable sections of the enrollment application, including dated signatures, where applicable, as required by the FSSA. The *IHCP Provider Enrollment Transactions* page at in.gov/medicaid/providers includes enrollment information and a link to the IHCP Provider Healthcare Portal (IHCP Portal) for online enrollment. Online transactions are preferred, but, for providers not using the IHCP Portal, the *Complete an IHCP Provider Enrollment Application* page includes *Indiana Health Coverage Programs Enrollment and Profile Maintenance Packets* (IHCP provider packets) that can be completed, printed and submitted via mail.
- Provider types identified as needing to pay an application fee have paid the application fee for each service location they wish to enroll. A list of providers subject to the application fee can be found in the *IHCP Provider Enrollment Risk Category and Application Fee Matrix*, available at in.gov/medicaid/providers. See the *Application Fee* section for more information.
- Providers categorized as high-risk providers in the Medicaid program are required to obtain a fingerprint-based national background check of any person who:
  - Holds at least a 5% ownership or controlling interest in a facility or entity
  - Is a member of the board of directors of a nonprofit facility or entity

  For more information on the fingerprint-based background check for high-risk providers, see the *Fingerprint Background Check* section.

- The outcome of unannounced site visits, performed pre- and post-enrollment for provider types considered at moderate or high risk for fraud, is successful.
- Participation in the Medicare program or the appropriate state's Medicaid program has been confirmed for out-of-state providers and designated provider types. See the *IHCP Provider Enrollment Type and Specialty Matrix* for a detailed listing, as some provider types require proof of participation in Medicare or the appropriate state's Medicaid program, and some may require both.
- The provider is eligible to participate in all applicable federal or state programs. Eligibility is verified by searching databases that include the TIBCO Managed File Transfer (MFT) sanction list, System for Award Management (SAM), Social Security Death Master File, and the List of Excluded Individuals and Entities (LEIE).

Application Fee

Designated providers are required to pay an application fee. The application fee is used for program integrity efforts. The *IHCP Provider Enrollment Risk Category and Application Fee Matrix* indicates which IHCP provider types and specialties are subject to an application fee.

IHCP providers subject to the application fee will be required to pay an application fee for each service location upon initial enrollment, changes of ownership and enrollment revalidations. See the *Provider Enrollment Application Fee* page at in.gov/medicaid/providers for the correct application fee amount. The amount is set by the Centers for Medicare & Medicaid Services (CMS) and is subject to change annually.

The application fee must be paid electronically – either online or by telephone:

- To pay online, go to the *Provider Enrollment Application Fee* page at in.gov/medicaid/providers and click the **IHCP Bill Pay site** link to begin the payment process.
- To pay by telephone, call 800-457-4584, wait for the list of options and then press 2 to access provider services

Providers may pay the fee using a credit card, debit card or electronic funds transfer (EFT) from a checking account. Contact Customer Assistance toll-free at 800-457-4584 for assistance with the online payment system.

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

Application Fee Exemptions

Physicians, nonphysician practitioners, and some medical groups and clinics **are not required to pay an application fee.** See the *IHCP Provider Enrollment Risk Category and Application Fee Matrix* to confirm whether an application fee is required for a specific provider type and specialty.

Providers that are enrolled in Medicare **are not required to pay an application fee** to Medicaid. If the Medicare enrollment is pending, the application fee will be required.

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

Hardship Exception

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

Any providers that believe they should be entitled to a hardship exception from the application fee should enclose, with their enrollment packet, a letter explaining and validating the nature of the hardship, as well as copies of documentation validating the hardship and providing evidence of all steps taken to try to raise the required fee from other sources, such as loans, grants and so forth. Evidence of financial hardship can be demonstrated through documents such as the following:

- Cost reports
- Balance sheets
- Bank statements
- Income statements
- Cash flow statements
- Tax returns

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

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

Risk Category Requirements

All provider specialties are assigned a risk level: high, moderate or limited. See the *IHCP Provider Enrollment Risk Category and Application Fee Matrix* to identify the risk level for a given provider specialty.

> *Note: A provider's risk level can be modified to a higher risk level on an individual provider basis. Imposition of a payment suspension or an outstanding overpayment requires raising the provider's risk level to high.*

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

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

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

Screening for providers designated as **high risk** includes the "limited risk" and "moderate risk" screening requirements, *plus* submission of fingerprints for a national background check on individuals with at least 5% ownership or controlling interest in the business entity. See the *Fingerprint Background Check* section.

Site Visits

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

Fingerprint Background Check

Providers categorized as high risk must undergo a fingerprint-based background check through the Indiana state-authorized vendor. For any provider in this category, background checks are required for any person with a 5% or greater direct or indirect ownership or controlling interest in the business, including the board of directors if the business is a nonprofit entity.

When scheduling the fingerprinting, it is important to choose **Family & Social Services Administration** as the *agency type* and **FSSA Affordable Care Act** as the *applicant type*. Other choices will require repeating the process. The IHCP is unable to share the results of the background check with any other agency. The confirmation number that providers receive at the fingerprint collection center must be provided as proof of compliance. The IHCP provider enrollment packets and the IHCP Portal provider application include fields for fingerprint confirmation numbers.

All affected newly enrolling providers and providers revalidating their enrollments must comply with this requirement at the time their application is submitted. Instructions are provided on the *Provider Enrollment Risk Levels and Screening* page at in.gov/medicaid/providers. Provider specialties affected at enrollment and revalidation are identified on the *IHCP Provider Enrollment Risk Category and Application Fee Matrix*.

W-9 Form Requirements

Internal Revenue Service (IRS) Form W-9, available from irs.gov, is required with all billing and group enrollment applications (including for initial enrollments, revalidations and changes of ownership) and also with many provider maintenance update requests. Information submitted in an IHCP enrollment transaction must be consistent with the information reported on the *W-9* form.

Providers must use the current version of the *W-9*, as posted on the IRS website. Please complete the *W-9* following the instructions on the form.

Disregarded Entities

On the *W-9* form, the IRS defines disregarded entities as follows:

> *For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii).*

The IHCP requires that the name and taxpayer identification number (TIN) for a disregarded entity be reported as follows:

- Enter the owner's name on line 1 of the *W-9* – or, if the direct owner of the entity is also a disregarded entity, enter the name of the first owner that is not disregarded for federal tax purposes. The name of the entity entered on line 1 of the *W-9* should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign limited liability corporation (LLC) that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. The name entered in line 1 of the *W-9* must exactly match the provider name on the IHCP enrollment.

- The disregarded entity's name may be entered on line 2 of the *W-9*. If there is an additional doing-business-as (DBA) name, it can be entered along with the disregarded entity name. If a name is entered in line 2 of the *W-9*, it must exactly match the service location/DBA name on the IHCP enrollment. Payments can be made to the service location/DBA name, but the 1099 will be issued to the entity listed on line 1 of the *W-9*, according to IRS guidelines.
- The federal tax classification (organizational structure) and TIN (employer identification number [EIN] or Social Security number [SSN]) reported on the *W-9* and entered in the IHCP enrollment must be that of the owner listed in line 1, not that of the disregarded entity.
- If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate *Form W-8* instead of a *W-9*, even if the foreign person has a U.S. TIN.

National Provider Identifier Requirements

The NPI is a 10-digit numeric identifier that is required for all healthcare providers (both individuals and organizations) that want to enroll in the IHCP. This standard, unique identifier is assigned by the National Plan and Provider Enumerator System (NPPES). Applying for an NPI is a separate process from IHCP enrollment.

Healthcare providers without an existing NPI must obtain one from the NPPES before submitting their application with the IHCP. To obtain an NPI, apply online at the NPPES website at nppes.cms.hhs.gov. For more information about NPI enumeration, see the *Enumeration Reports* page at cms.gov.

> *Note: Waiver providers, transportation providers (other than ambulances and air ambulances) and Medical Review Team (MRT) copy centers are not considered healthcare providers. These providers, called* ***atypical providers****, are not required to have NPIs. When doing business with the IHCP, atypical providers use their IHCP Provider IDs (which all providers receive when they enroll in the IHCP) in place of an NPI.*

The IHCP requires healthcare providers to enroll or revalidate using the type of NPI that aligns with the organizational structure under which the provider will be doing business with the IHCP. There are two types of healthcare provider NPIs:

- **Type 1 (individual)** – A healthcare provider that is conducting business as an individual or as a sole proprietor must obtain a Type 1 NPI.
- **Type 2 (organizational)** – A healthcare provider that is conducting business as an organization or a distinct subpart of an organization, such as a group practice, a facility or a corporation (including an incorporated individual), must obtain a Type 2 NPI.

For providers enrolling or revalidating with the IHCP to bill for services (*billing provider* and *group provider* classifications), the organizational structure of the enrolling entity is determined by the information reported on the provider's IHCP enrollment application and on the Internal Revenue Service (IRS) *W-9* form submitted with the application.

Providers that do not bill the IHCP directly (*rendering provider* and *ordering, prescribing or referring [OPR] provider* classifications) are not required to submit a *W-9* form; the organizational structure associated with rendering providers is considered to be "individual" in all instances.

Alignment of the NPI type, organizational structure, provider name and taxpayer identification number (TIN) is required and will be verified as follows:

- An **individual healthcare practitioner** who is conducting business with the IHCP **as an individual** but who will **not be billing** the IHCP directly for services must enroll with the IHCP under the ***rendering*** provider classification (linked to one or more group providers) using the following information:
  - The practitioner's **Type 1 NPI**
  - The practitioner's **personal name** as the "provider name" on the enrollment
  - The practitioner's **Social Security number (SSN)** as the TIN associated with the IHCP enrollment

  The individual practitioner must provide proof of proper licensure or certification with the IHCP rendering provider enrollment application.

Example:	*Jane Doe, a nurse practitioner is employed by AA Medical Group. Ms. Doe's services are billed by and reimbursed to AA Medical Group. Ms. Doe enrolls with the IHCP as a rendering provider under the name "Jane Doe," using her personal Type 1 NPI. Her enrollment is linked to AA Medical Group, which is enrolled with the IHCP as a group provider using the business' Type 2 NPI.*

- An **individual healthcare practitioner** who is enrolling to **bill** the IHCP directly for services and who is conducting business with the IHCP **as an individual** may enroll using either a Type 1 or Type 2 NPI, depending on how the provider will be listed in the provider directory:
  - If the individual is enrolling using their **personal name**, the ***billing*** enrollment classification should be selected, and the following should be used:
    - The practitioner's **Type 1 NPI**
    - The practitioner's **SSN** as the TIN associated with the enrollment
  - If the individual is enrolling using a **business name**, the ***group*** enrollment classification should be selected, and the following should be used:
    - The provider's **Type 2 NPI** (representing the business)
    - The business' **employer identification number (EIN)** as the unique identifier associated with the IHCP enrollment application.

    The provider will also be required to enroll separately as a ***rendering*** enrollment classification using:
    - The practitioner's **Type 1 NPI**
    - The practitioner's **SSN** as the TIN associated with the enrollment

Note:	*If the provider is a disregarded entity, the **name of the owner** (individual or entity) should be used as the "provider name" and the **owner's EIN (or SSN, if the owner has one)** should be used as the TIN.*

The provider name, TIN and organizational structure on the *W-9* must match the same information reported on the IHCP enrollment application. The individual practitioner must provide proof of proper licensure or certification with the IHCP enrollment application. Billing providers do not bill the IHCP for services rendered by other providers and do not have providers enrolled with the IHCP as rendering providers linked to their enrollments.

Example:	*Dr. Smith is a sole proprietor, operating under the DBA Smith Medical Office. He bills and is reimbursed directly for services he personally renders. Dr. Smith enrolls with the IHCP as a billing provider under his personal name (listing Smith Medical Office as his service location/DBA designation) and using his personal Type 1 NPI.*

- An **individual healthcare practitioner** who is enrolling to **bill** for services and who is conducting business with the IHCP **as a business entity** (C Corporation, S Corporation, Partnership or LLC [including a single-member LLC electing to do business as a corporation]) must separately enroll both the business and the individual practitioner.

  The **business** must be enrolled under the *group* provider classification using the following:
  - The business entity's **Type 2 NPI**
  - The **business entity's name** (as shown on income tax returns) as the provider name on the enrollment
  - The business entity's **EIN** as the TIN associated with the enrollment

  In addition, the **practitioner** must enroll under the *rendering* provider classification (linked to the group) using the following information:
  - The practitioner's **Type 1 NPI**
  - The practitioner's **personal name** as the provider name on the enrollment
  - The practitioner's **SSN** as the TIN associated with the enrollment

  The business entity's name, TIN and organizational structure on its *W-9* must match the same information reported on the IHCP enrollment application. The individual practitioner must provide proof of proper licensure or certification with the IHCP rendering provider enrollment application.

Example:	*Dr. Jones is conducting business as a corporation, Jones Dental Services, LLC. She bills and is reimbursed for services she personally renders in the name of Jones Dental Services, LLC. Dr. Jones enrolls her business with the IHCP as a group provider under the name Jones Dental Services, LLC, using the business' Type 2 NPI. She also enrolls herself with the IHCP as a rendering provider under her own name, using her personal Type 1 NPI. Dr. Jones is linked as a rendering provider to the group Jones Dental Services. As a group provider, Jones Dental Services may have additional rendering providers linked to its IHCP enrollment.*

Note:	*If a dentist is enrolling under a business name, the dental broker will not contract with them unless they are enrolled as both a group and a rendering provider with the appropriate NPIs.*

- An **organization** that is enrolling to **bill** for services and that is **conducting business with the IHCP as a business entity** (including a C Corporation, S Corporation, LLC, Partnership and Trust/Estate) must enroll under either the ***billing* or *group*** provider classification, using the following:
  - The business entity's **Type 2 NPI**
  - The business entity's **name (as shown on income tax returns)** as the provider name on the enrollment
  - The business entity's **EIN** as the TIN associated with the enrollment

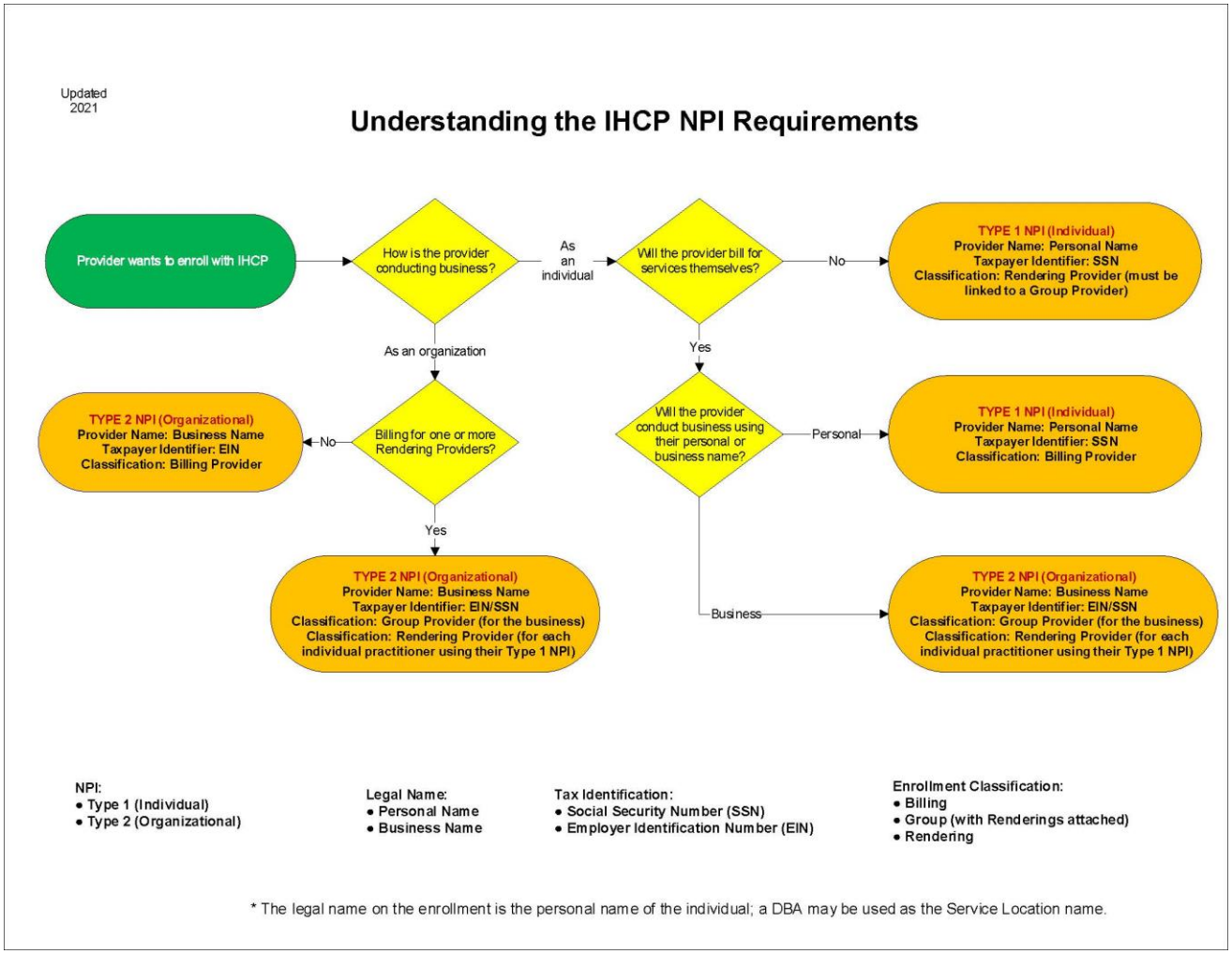
  The name, TIN and organizational structure on the *W-9* must match the same information reported on the IHCP enrollment application. An organization must enroll as a billing provider if it is not billing the IHCP for services rendered by individual rendering providers. An organization must enroll as a group provider if it is billing the IHCP for services rendered by one or more rendering providers. Any rendering providers linked to the organization's group enrollment must provide proof of proper licensure or certification with their IHCP rendering provider enrollment applications.

Example 1:	*ABC Medical Supply is a business entity conducting business as a C Corporation. The entity bills and is reimbursed for medical supplies in the name of ABC Medical Supply; there are no rendering providers (practitioners such as physicians, physician assistant and so on) associated with the business. The business enrolls with the IHCP as a billing provider under the name ABC Medical Supply using the business' Type 2 NPI.*

> *Example 2: Main Street Medical Group is a business entity conducting business as a partnership. The entity bills and is reimbursed for services rendered by employed physicians and nurse practitioners in the name of Main Street Medical Group. The business enrolls with the IHCP as a group provider using the business' Type 2 NPI. Each employed practitioner should be enrolled with the IHCP as a rendering provider under his or her personal name using his or her personal Type 1 NPI. The practitioners are linked as rendering providers to the group Main Street Medical Group.*

Figure 1 presents a schematic illustration of the NPI and enrollment data reporting requirements. The NPI reporting requirements and related guidance do not apply to atypical provider types (waiver providers, transportation providers [other than ambulances and air ambulances] and MRT copy centers), which are not required to have an NPI and do not use an NPI for billing the IHCP.

Figure 1 – NPI Reporting Requirements Process



Provider Type and Specialty Requirements

This section identifies the IHCP enrollment requirements by provider type and specialty. For requirements associated with the OPR provider type, see *Section 5: Ordering, Prescribing or Referring Providers (Type 50)*.

A provider can choose only one provider type per enrollment, but can choose any number of *specialties* under the selected provider type. If a provider requires **more than one** provider type, an additional application must be submitted and another IHCP Provider ID assigned.

The IHCP Portal allows rendering providers to enroll with more than one provider type using a single NPI, as long as the rendering provider meets the enrollment criteria for each additional provider type. To enroll under multiple provider types, the rendering provider must have a taxonomy associated with their provider profile.

For risk category and application fee information associated with each provider specialty, see the *IHCP Provider Enrollment Risk Category and Application Fee Matrix.* For a quick reference of documentation requirements for each specialty, see the *IHCP Provider Enrollment Type and Specialty Matrix*.

Hospital (Type 01)

All hospitals are enrolled as **billing** providers. Four specialties are associated with provider type 01 – *Hospital*:

- 010 – *Acute Care*
- 011 – *Psychiatric Facility*
- 012 – *Rehabilitation*
- 013 – *Long Term Acute Care*

All hospitals must be enrolled in Medicare as a hospital to qualify for Medicaid enrollment.

All in-state acute care, rehabilitation and long-term acute care (LTAC) hospitals (specialties 010, 012 and 013) are certified and licensed by the IDOH. The IDOH must forward certification documentation to the IHCP Provider Enrollment Unit before IHCP enrollment can be finalized.

All in-state psychiatric hospitals (specialty 011) are certified by the IDOH and licensed by the Division of Mental Health and Addiction (DMHA). Documentation of a license from the DMHA or certification from the IDOH is required for IHCP enrollment.

Out-of-state acute care, psychiatric and rehabilitation hospitals must submit a copy of their current license or accreditation certificate from the appropriate state. The rate-setting contractor furnishes the IHCP Provider Enrollment Unit with rate information on medical education rates and costs-to-charge ratio information, if applicable.

All in-state LTAC hospitals (specialty 013) are first enrolled as licensed acute care hospitals. To change the provider specialty from 010 – *Acute Care* to 013 – *Long Term Acute Care*, the provider must be designated by the CMS as a long-term hospital for the Medicare program, or have an average inpatient length of stay greater than 25 days, based on the same criteria used by the Medicare program. Providers should contact Myers and Stauffer (the rate-setting contractor) for purposes of establishing a facility-specific rate (see the *IHCP Quick Reference Guide* at in.gov/medicaid/providers for contact information). Out-of-state LTACs are not eligible for enrollment in the IHCP.

> *Note: Psychiatric hospitals with more than 16 beds may be enrolled in the IHCP as an institution of mental disease (IMD), following the definition in the Code of Federal Regulations 42 CFR 435.1010.*

Ambulatory Surgical Center (Type 02)

All ambulatory surgical centers (ASCs) are enrolled as **billing** providers. The only specialty associated with provider type 02 – *Ambulatory Surgical Center* is specialty 020 – *Ambulatory Surgical Center (ASC)*.

The IDOH certifies in-state ASCs and must forward documentation to the IHCP Provider Enrollment Unit before IHCP enrollment can be finalized. Out-of-state ASCs must submit a copy of their current license from the appropriate state.

Extended Care Facility (Type 03)

All extended care facilities are enrolled as **billing** providers. Five specialties are associated with provider type 03 – *Extended Care Facility*:

- 030 – *Nursing Facility*
- 031 – *Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)*
- 032 – *Pediatric Nursing Facility*
- 033 – *Residential Care Facility*
- 034 – *Psychiatric Residential Treatment Facility (PRTF)*

All type 03 specialties require IDOH certification, and that documentation must be forwarded to the IHCP Provider Enrollment Unit before enrollment is completed. Out-of-state extended care facilities are not eligible for enrollment in the IHCP.

The final rule published in the *Federal Register* modified *42 CFR 442.15* and eliminated the requirement for time-limited agreements for ICF/IID and residential care facility providers. As a result, provider specialties 031 and 033 no longer need to recertify each year by submitting a new provider agreement. These providers are still subject to enrollment revalidation requirements.

PRTFs (specialty 034) require the following:

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

  The *IHCP PRTF Attestation Letter/Maintenance Form* includes a model attestation letter for PRTFs. PRTFs are required to submit a new attestation letter to the IHCP Provider Enrollment Unit annually.

> *Note: The model PRTF Provider Attestation Letter includes a state survey number, so that the IDOH and the FSSA can track facilities. The IDOH issues a state survey number after reviewing the PRTF Attestation Form. Because the state survey number is used for internal purposes, providers should disregard this field.*

Rehabilitation Facility (Type 04)

Two specialties are associated with provider type 04 – *Rehabilitation Facility*:

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

All outpatient rehabilitation facilities with specialty 040 are enrolled as **billing** providers. All CORFs (specialty 041) are enrolled as **group** providers and must have a physician, a health service provider in psychology (HSPP) **and** a physical therapist linked to the group. CORFs must be enrolled in Medicare to qualify for Medicaid enrollment.

The IDOH certifies rehabilitation facilities and agencies, as well as CORFs. The IDOH must forward the documentation to the IHCP Provider Enrollment Unit before the IHCP enrollment is completed. Out-of-state outpatient rehabilitation facilities (specialties 040 and 041) are not eligible for enrollment in the IHCP.

Home Health Agency (Type 05)

All home health agencies are enrolled as **billing** providers. The only specialty associated with the provider type 05 – *Home Health Agency* is specialty 050 – *Home Health Agency*. The IDOH is the sanctioning body that licenses home health agencies. The IDOH must forward the documentation to the IHCP Provider Enrollment Unit before the enrollment can be finalized.

Out-of-state home health agencies are not eligible for enrollment in the IHCP.

Hospice (Type 06)

Hospice providers are enrolled as **billing** providers. The only specialty associated with provider type 06 – *Hospice* is specialty 060 – *Hospice*.

A hospice provider must be enrolled in Medicare to qualify for Medicaid enrollment.

Before IHCP enrollment can be finalized, the following documentation is required:

- A Certification and Transmittal (C&T) form for each hospice office location forwarded to the IHCP Provider Enrollment Unit by the IDOH
- A copy of a current hospice license

> *Note: For state-licensed hospitals, health facilities and home health agencies, an IDOH approval to operate a hospice program is acceptable in lieu of a hospice license.*

Out-of-state hospice facilities are not eligible for enrollment in the IHCP.

Clinic (Type 08)

Clinics are enrolled as **group** providers. The specialty of the rendering providers linked to the group is dependent on the specialty of the clinic. Provider type 08 – *Clinic* is used for freestanding clinics that have multiple provider types and specialties linked to the clinic.

Eight provider specialties are associated with provider type 08 – *Clinic*. The specific clinic provider specialties and the required documentation for each are as follows:

- 080 – *Federally Qualified Health Center (FQHC)* must have an advanced practice registered nurse (APRN) and a physician linked to the group. Before enrollment is finalized, a CMS approval letter is required *for each location*. A usual and customary charge (UCC) rate for encounter code T1015 is also required before the provider may submit encounter claims. The rate-setting contractor sends the IHCP Provider Enrollment Unit the UCC rate, and that rate is specific to the service location (practice site). Out-of-state FQHCs are not eligible for enrollment in the IHCP.
- 081 – *Rural Health Clinic (RHC)* must have an APRN and a physician linked to the group. Before the enrollment is finalized, a CMS approval letter is required *for each location*. A UCC rate for encounter code T1015 is required before the provider may submit encounter claims. The rate-setting contractor sends the IHCP Provider Enrollment Unit the UCC rate, and that rate is specific to the service location (practice site). Out-of-state RHCs are not eligible for enrollment in the IHCP.
- 082 – *Medical Clinic* has different rendering provider specialties – usually at different levels, such as nurses and doctors – linked to the clinic.
- 083 – *Family Planning Clinic* must have APRNs and/or physicians linked to the clinic.
- 084 – *Nurse Practitioner Clinic* must have one or more APRNs linked to the clinic.
- 086 – *Dental Clini*c must have one or more dentists (provider type 27 –*Dentist* with any dental specialty other than 276 – *Mobile Dentist*) linked to the clinic. The term "dental" can only be used in the name of a corporation if all shareholders are licensed dentists.
- 087 – *Therapy Clinic* must have a minimum of two physicians plus one or more therapists (such as specialties 170 – *Physical Therapist*, 171 – *Occupational Therapist*, 173 – *Speech/Hearing Therapist* or 615 – *Applied Behavior Analysis [ABA] Therapist*) linked to the clinic.
- 088 – *Birthing Center* must have certified nurse midwives or physicians linked to the clinic.

Advanced Practice Registered Nurse (Type 09)

For IHCP reimbursement, advanced practice registered nurses (APRNs) must be individually enrolled with the IHCP. APRNs may enroll as **billing** providers, **group** providers or **rendering** providers linked to a group. Six specialties are associated with provider type 09 – *Advanced Practice Registered Nurse*:

- 090 – *Pediatric Nurse Practitioner*
- 091 – *Obstetric Nurse Practitioner*
- 092 – *Family Nurse Practitioner*
- 093 – *Nurse Practitioner (Other, such as clinical nurse specialist)*
- 094 – *Certified Registered Nurse Anesthetist (CRNA)*
- 095 – *Certified Nurse Midwife*

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

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

Physician Assistant (Type 10)

For IHCP reimbursement, physician assistants must be individually enrolled with the IHCP. Physician assistants may enroll as a **billing** provider or as a **rendering** provider under a group practice. The only specialty associated with provider type 10 – *Physician Assistant* is specialty 100 – *Physician Assistant*.

Physician assistants must hold a current professional license from the appropriate state's licensing agency to enroll with the IHCP.

Physician assistants may enroll in one or more MCE networks and serve as a PMP. See the *Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise Provider Enrollment* section.

Behavioral Health Provider (Type 11)

The classification under which a behavioral health provider enrolls depends on the provider's specialty. Specific requirements for each specialty under provider type 11 – *Behavioral Health Provider* are as follows:

- 110 – *Outpatient Mental Health Clinic* must be enrolled as a **group** provider, and one or more of the following specialties must be linked to the group:
  - Psychiatrist or other physician specialty
  - HSPP
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Marriage and Family Therapist (LMFT)
  - Licensed Mental Health Counselor (LMHC)
  - Licensed Clinical Addiction Counselor (LCAC)

  A completed *IHCP Outpatient Mental Health Addendum* is required. Out-of-state outpatient mental health clinics are not eligible for enrollment in the IHCP.
- 111 – *Community Mental Health Center (CMHC)* must be enrolled as a **group** provider. Certification from the DMHA and a completed *IHCP Outpatient Mental Health Addendum* are required. Out-of-state CMHCs are not eligible for enrollment in the IHCP. In addition to behavioral healthcare, CMHCs may also provide primary care services to IHCP members; such services must be rendered by IHCP-enrolled providers authorized to provide primary healthcare.
- 114 – *Health Service Provider in Psychology (HSPP)* may be enrolled as a **billing** provider, a **group** provider or a **rendering** provider linked to a group. A copy of the provider's current license, with the HSPP endorsement, from the appropriate state's licensing agency is required.
- 613 – *Medicaid Rehabilitation Option (MRO) Clubhouse* must be enrolled as a **rendering** provider that can render psychosocial rehabilitation services when linked to the IHCP-enrolled CMHC group provider that has been approved by the DMHA. Certification from the DMHA is required. Out-of-state MRO clubhouse providers are not eligible for enrollment in the IHCP.
- 615 – *Applied Behavior Analysis (ABA) Therapist* may be enrolled as a **billing** provider, a **group** provider with ABA therapists linked to the group or a **rendering** provider linked to a group. ABA therapists enrolled as rendering providers can be linked to an outpatient mental health clinic, CMHC, HSPP, ABA therapist, medical clinic, therapy clinic or any physician group practice. A current professional license as an HSPP, as defined in *IC 25-33*, or a valid certification from the Behavior Analyst Certification Board (BACB) as a Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst-Doctoral (BCBA-D) is required.

- 616 – *Licensed Psychologist* may be enrolled as a **billing** provider, a **group** provider or a **rendering** provider linked to a group. A copy of the provider's current psychologist license from the appropriate state's licensing agency is required.
- 617 – *Licensed Independent Practice School Psychologist* may be enrolled as a **billing** provider, a **group** provider or a **rendering** provider linked to a group. A copy of the provider's current school services – school psychologist license, from the appropriate state's department of education is required. The individual must be recognized by the department of education as an Initial, Proficient or Accomplished Practitioner. Documentation that the individual maintains an Independent Practice Endorsement (IPE) is also required.
- 618 – *Licensed Clinical Social Worker (LCSW)* may be enrolled as a **billing** provider, a **group** provider or a **rendering** provider linked to a group. A copy of the provider's current clinical social worker license from the appropriate state's licensing agency is required.
- 619 – *Licensed Marriage and Family Therapist (LMFT)* may be enrolled as a **billing** provider, a **group** provider or a **rendering** provider linked to a group. A copy of the provider's current marriage and family therapist license from the appropriate state's licensing agency is required.
- 620 – *Licensed Mental Health Counselor (LMHC)* may be enrolled as a **billing** provider, a **group** provider or a **rendering** provider linked to a group. A copy of the provider's current mental health counselor license from the appropriate state's licensing agency is required.
- 621 – *Licensed Clinical Addiction Counselor (LCAC)* may be enrolled as a **billing** provider, a **group** provider or a **rendering** provider linked to a group. A copy of the provider's current clinical addiction counselor license from the appropriate state's licensing agency is required.
- 835 – *Opioid Treatment Program (OTP)* may be enrolled as a **billing** provider or a **group** provider. A Drug Enforcement Administration (DEA) license as well as certification from the Indiana DMHA are required. Out-of-state OTPs are not eligible for enrollment in the IHCP.
- 836 – *Substance Use Disorder (SUD) Residential Addiction Treatment Facility* must be enrolled as a **billing** provider. A facility must meet the following requirements and submit proof of both:
  - DMHA (or their own state's equivalent agency) certification as a sub-acute facility that includes an American Society of Addiction Medicine (ASAM) designation of offering either Level 3.1 or Level 3.5 residential services
  - Department of Child Services (DCS) licensing as a childcare institution or private secure care institution with a DMHA Addiction Services Provider, Regular Certification that includes ASAM designation of offering either Level 3.1 or Level 3.5 residential services

See the following subsections for additional information about OTPs and SUD residential addiction treatment facilities, as well as for additional behavioral health specialties enrolled under the 1915(i) Home- and Community-Based Services (HCBS) programs.

Opioid Treatment Programs

In accordance with *Senate Enrolled Act (SEA) 297 (2016), IC 12-23-18-0.5* mandates that OTPs shall not operate in the state of Indiana unless they are enrolled with the IHCP. The OTP may be enrolled with the IHCP either as a billing provider (under the billing or group classification) or it may be enrolled as an ordering, prescribing or referring (OPR) provider only (see the *Opioid Treatment Programs Enrolled as OPRs* section).

All OTP providers enrolling with the IHCP, whether as billing or OPR providers, are required to have a Drug Enforcement Administration (DEA) license as well as certification from the state's DMHA.

OTPs may enroll with the IHCP under the provider type and specialty that best identifies their practice. However, OTPs wanting to bill the IHCP for the administration of methadone and other related services exclusive to OTPs ***must*** be enrolled under provider type 11 – *Behavioral Health Provider*, with specialty 835 – *Opioid Treatment Program*.

A provider that is enrolled in the IHCP as provider type 11 with a **different specialty** can add specialty 835 to the existing enrollment if they meet all applicable requirements and submit appropriate documentation. A provider that is enrolled with the IHCP under a **different provider type**, such as type 08 – *Clinic*, is required to **submit a separate application** if they want to also enroll as provider type 11, specialty 835.

> *Note: Provider specialty 835 cannot be reimbursed for buprenorphine or naltrexone medication-assisted treatment. To be reimbursed for these services, qualified prescribers must be enrolled and bill under a different IHCP provider type and specialty appropriate for delivering these services.*

Counseling services in an OTP (specialty 835) must be provided by a clinician meeting certain credentialing requirements. See the *Behavioral Health Services* module for details.

Substance Use Disorder Residential Addiction Treatment Facilities

Reimbursement for SUD residential treatment will be made **only** to facilities that are enrolled as provider type 11 with specialty 836. Any facility enrolled with the IHCP under a different provider type will be required to submit a separate application if they want to also enroll as provider type 11, specialty 836 to receive reimbursement for residential SUD treatment services.

Providers that wish to be reimbursed by the IHCP for SUD residential services must complete the ASAM designation process. Information about the ASAM designation process can be found on the *American Society of Addiction Medicine (ASAM) Designation* page at in.gov/fssa/dmha.

SUD residential addiction treatment providers rendering services other than those included in the SUD per diem (as described in the *Behavioral Health Services* module) must bill for those additional services using another, appropriate IHCP-enrolled provider type and specialty.

Providers designated as ASAM patient placement criteria levels 3.1 or 3.5 are required to have protocols for the continuation of medication-assisted treatment (MAT). These protocols need to be established by a designated ASAM 3.1 or 3.5 SUD residential addiction treatment facility for qualified providers to:

- Provide access to buprenorphine or naltrexone.
- Connect members to methadone in an OTP setting.
- Arrange for and monitor pharmacotherapy for psychiatric medications.

> *Note: Providers enrolled as provider specialty 836 – SUD Residential Addiction Treatment Facility cannot be reimbursed for methadone under this provider specialty. To be reimbursed for methadone treatment, a facility must be enrolled with provider specialty 835 – Opioid Treatment Program.*
>
> *Additionally, providers enrolled as either specialty 835 or 836 cannot be reimbursed for buprenorphine or naltrexone MAT. To be reimbursed for these services, qualified prescribers must be enrolled and bill under another IHCP provider type and specialty appropriate for delivering these services.*

1915(i) Home- and Community-Based Services Specialties

Provider type 11 – *Behavioral Health Provider* also includes the following specialties, associated with the 1915(i) HCBS programs under the Indiana State Plan and administered by the DMHA:

- 115 – *Adult Mental Health and Habilitation (AMHH)* is a specialty that can only be added to an enrolled CMHC, as a secondary specialty. AMHH provider certification from the DMHA is required. Out-of-state providers are not eligible.
- 611 – *Child Mental Health Wraparound (CMHW)* may be enrolled as a **billing** provider, a **group** provider or a **rendering** provider linked to a group. CMHW provider certification from the DMHA is required. Out-of-state providers are not eligible.
- 612 – *Behavioral and Primary Healthcare Coordination (BPHC)* is a specialty that can only be added to an enrolled CMHC, as a secondary specialty. BPHC provider certification from the DMHA is required. Out-of-state providers are not eligible.

School Corporation (Type 12)

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

Public Health Agency (Type 13)

Public health agencies are enrolled as **billing** providers or **group** providers. The only specialty associated with provider type 13 – *Public Health Agency* is specialty 130 – *County Health Department*. Out-of-state public health agencies are not eligible for enrollment in the IHCP.

Podiatrist (Type 14)

Podiatrists may be enrolled as **billing** providers, **group** providers or **rendering** providers linked to a group. Individual providers must submit a copy of their current license from the appropriate state's licensing agency. The only specialty associated with provider type 14 – *Podiatrist* is specialty 140 – *Podiatrist*.

A locum tenens podiatrist can fill in for a member's regular podiatrist. For more information, see the *Locum Tenens Healthcare Providers* section.

Chiropractor (Type 15)

Chiropractors may be enrolled as **billing** providers, **group** providers or **rendering** providers linked to a group. Individual providers must submit a copy of their current license from the appropriate state's licensing agency. The only specialty associated with provider type 15 – *Chiropractor* is specialty 150 – *Chiropractor*.

A locum tenens chiropractor can fill in for a member's regular chiropractor. For more information, see the *Locum Tenens Healthcare Providers* section.

Therapist (Type 17)

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

- 170 – *Physical Therapist*
- 171 – *Occupational Therapist*
- 173 – *Speech/Hearing Therapist*

Optometrist (Type 18)

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

A locum tenens optometrist can fill in for a member's regular optometrist. For more information, see the *Locum Tenens Healthcare Providers* section.

Optician (Type 19)

Opticians are enrolled as **billing** providers or as **rendering** providers linked to an optometrist group. Opticians cannot enroll as a group provider. The only specialty associated with provider type 19 – *Optician* is specialty 190 – *Optician*.

Audiologist (Type 20)

Audiologists may be enrolled as **billing** providers, **group** providers or **rendering** providers linked to a group. A copy of a current license from the appropriate state's licensing agency is required. The only specialty associated with provider type 20 – *Audiologist* is specialty 200 – *Audiologist*.

Audiologists who are also hearing aid dealers do not need to enroll separately as a hearing aid dealer.

Hearing Aid Dealer (Type 22)

Hearing aid dealers can be enrolled as **billing** providers only. Hearing aid dealers cannot enroll as a group nor as a rendering provider linked to a group. A copy of a current hearing aid dealer license from the appropriate state's licensing agency is required. The only specialty associated with provider type 22 – *Hearing aid dealer* is specialty 220 – *Hearing aid dealer*.

Pharmacy (Type 24)

Pharmacies are enrolled as **billing** providers only. Provider type 24 – *Pharmacy* must enroll with a primary specialty of 240 – *Pharmacy*.

A copy of a current pharmacy license (or permit) from the applicable state's licensing agency must be submitted for enrollment in the IHCP. Out-of-state pharmacy providers that deliver drugs or devices to Indiana patients via the U.S. Postal Service or other delivery services, such as FedEx or DHL, are required to have an Indiana nonresident pharmacy license as well as a license issued by their home state.

Adding DME or HME Specialty to a Pharmacy Enrollment

Pharmacy providers can add specialty 250 – *DME/Medical Supply Dealer* and/or 251 – *HME/Home Medical Equipment* as secondary specialties, when applicable. One IHCP Provider ID is assigned to the provider for all the specialties. When a pharmacy chain is enrolled, each store receives an individual Provider ID, which can include one or all of the specialties.

To add the HME specialty to a pharmacy provider's enrollment, a copy of a current HME license from the Indiana State Board of Pharmacy is also required.

Because provider specialties 250 and 251 are considered high risk, pharmacies that wish to add one of these specialties to their enrollment will be required to complete a fingerprint-based background check for all individuals with 5% or more ownership or controlling interest in the provider, in addition to the unannounced site visit and other requirements associated with moderate- and low-risk specialties. See the *Risk Category Requirements* section for more information.

To determine if a pharmacy needs to have specialty 250 or 251 for reimbursement of a given procedure code, consult the Service Category field in the IHCP Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers:

- If the procedure code falls under service category MDSPY (Medical Supplies), the pharmacy does not require specialty 250 or 251.
- If the procedure code falls under service category DME (Durable Medical), the pharmacy must add specialty 250 or 251 to their enrollment. (To determine which of these two specialties would be required for a given procedure code in this service category, refer to the code set tables for each specialty within *Durable and Home Medical Equipment and Supplies Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.)

Durable Medical Equipment/Medical Supply Dealer (Type 25)

The following sections outline the specialties that can enroll under provider type 25 – *Durable Medical Equipment/Medical Supply Dealer*.

DME/Medical Supply Dealer (Type 25, Specialty 250)

DME providers can be enrolled as **billing** providers only. Stand-alone DME providers are enrolled under provider type 25 and are assigned specialty 250 – *DME/Medical Supply Dealer*. DME providers can add specialty 251 – *HME/Home Medical Equipment* to their enrollment when applicable. To add the HME specialty to a DME provider's enrollment, a copy of a current HME license from the Indiana State Board of Pharmacy must be submitted with the enrollment.

For out-of-state enrollment of a DME specialty from a state that licenses DME providers, a license from the state's licensing agency is required.

For DME providers located outside Indiana, prior authorization is required for **all** services, unless the provider has been granted "in-state status," which exempts them from the out-of-state PA requirement and allows them to follow normal PA guidelines as though they were located in Indiana. To enroll in the IHCP with an in-state status for PA purposes, the provider must be located in an out-of-state area that has been designated as in-state for PA purposes, **or** must submit documentation verifying that they meet all requirements for achieving in-state status, including that they maintain a business office in Indiana. See the *Out-of-State Suppliers of Medical Equipment* section of the *Out-of-State Providers* module for details.

HME/Home Medical Equipment (Type 25, Specialty 251)

HME providers can be enrolled as **billing** providers only. Stand-alone HME providers are enrolled under provider type 25 and are assigned specialty 251 – *HME/Home Medical Equipment*. HME providers can add specialty 250 – *DME/Medical Supply Dealer* to their enrollment when applicable.

All HME providers (including out-of-state providers) that render services to Indiana clients must have a current HME license from the Indiana State Board of Pharmacy and must present a copy of the license with their enrollment.

For HME providers located outside Indiana, prior authorization is required for **all** services, unless the provider has been granted "in-state status," which exempts them from the out-of-state PA requirement and allows them to follow normal PA guidelines as though they were located in Indiana. To enroll in the IHCP with an in-state status for PA purposes, the provider must be located in an out-of-state area that has been designated as in-state for PA purposes, **or** must submit documentation verifying that they meet all requirements for achieving in-state status, including that they maintain a business office in Indiana. See the *Out-of-State Suppliers of Medical Equipment* section of the *Out-of-State Providers* module for details.

Donor Milk Bank (Type 25, Specialty 252)

Effective Nov. 1, 2022, the IHCP allows accredited donor milk banks to enroll under provider type 25 with the specialty 252 – *Donor Milk Bank*. Donor milk banks may enroll only as **billing** providers. This provider specialty is considered a stand-alone specialty and may not be added to other enrollments.

To be eligible for IHCP enrollment under this specialty, providers must be accredited by the Human Milk Banking Association of North America (HMBANA).

Transportation Provider (Type 26)

Transportation providers can be enrolled as **billing** providers only and must be recertified annually or as required by permits, certificates and liability insurance coverage periods. A provider seeking to enroll transportation services must make transportation services available to the general public and demonstrate that its primary business function is the provision of transportation services. This requirement does not apply to transportation providers that provide only ambulance, family member or school corporation transportation services.

In addition to enrolling with the IHCP, transportation providers must also contract with Verida for nonemergency medical transportation (NEMT) provided to Traditional Medicaid FFS members and/or with the appropriate MCE transportation broker for transportation services provided to managed care members.

> *Note: Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP) transportation services provided in accordance with 405 IAC 5-30-11 must conform to the requirements set out in IC 20-27 and are exempt from the transportation provider agreement requirements.*

Nine specialties are associated with provider type 26 – *Transportation Provider*. Each specialty has specific IHCP enrollment requirements as follows:

- 260 – *Ambulance*

  Ambulance providers must submit a copy of their emergency medical services (EMS) commission certificate for IHCP enrollment and revalidation, and for recertification, based on certificate end date.

- 261 – *Air Ambulance*

  Air ambulance providers must submit a copy of their EMS commission certificate for IHCP enrollment and revalidation, and for recertification, based on certificate end date.

- 262 – *Bus*

  Bus providers must submit the following for IHCP enrollment and revalidation, and for recertification, based on certificate end date:
  - Copy of appropriate and valid driver's licenses for all drivers
  - Proof of insurance coverage as required by the Indiana motor carrier authority

- 263 – *Taxi*

  Taxi providers must submit the following for IHCP enrollment and revalidation, and for recertification, based on certificate end date:
  - A document showing operating authority from a local governing body (city taxi or livery license for in-state enrollments; for out-of-state, a document showing taxi operating authority from the local governing body as a common carrier)
  - Copy of retail merchant's certificate (or, if applicable, proof of nonprofit status from the IRS)
  - Copy of appropriate and valid driver's licenses for all drivers associated with the provider
  - Name, Social Security number and date of birth for each driver working for the transportation provider, as well as provider attestation statements as described in the *Driver Information and Attestation Requirements* section
  - Proof of surety bond as described in the *Surety Bond Requirements* section
  - Proof of insurance, as indicated by local ordinances (or, if unspecified by local ordinance, a minimum of $25,000/$50,000 of public livery insurance covering all vehicles used in the business)

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

- 264 – *Common Carrier (Ambulatory)* and 265 – *Common Carrier (Nonambulatory)*

  Common carrier providers are categorized as for-profit and not-for-profit businesses. Each category has specific certification and supporting documentation requirements for IHCP enrollment and revalidation, and for recertification, based on certificate end date:
  - **For-profit** common carriers must submit the following:
    - Copy of their MCS certificate from the Indiana Department of Revenue (or, for out-of-state providers, the appropriate state's certification for common carriers **and** MCS certificate showing interstate authority, if the provider crosses state lines)
    - Name, Social Security number and date of birth for each driver working for the transportation provider, as well as provider attestation statements as described in the *Driver Information and Attestation Requirements* section
    - Copy of appropriate and valid driver's licenses for all drivers associated with the provider
    - Proof of surety bond as described in the *Surety Bond Requirements* section
    - Proof of insurance coverage showing the amount of coverage
  - **Not-for-profit** common carriers must submit the following:
    - Proof of nonprofit status from the IRS
    - The appropriate state's certification for common carriers
    - Name, Social Security number and date of birth for each driver working for the transportation provider, as well as provider attestation statements as described in the *Driver Information and Attestation Requirements* section
    - Copy of appropriate and valid driver's licenses for all drivers associated with the provider
    - Proof of surety bond as described in the *Surety Bond Requirements* section
    - Proof of insurance (the minimum requirement is $500,000 of combined single-limit commercial automobile liability insurance)

In addition, interstate carriers must submit their U.S. Department of Transportation (USDOT) number for verification.

> *Note: The IHCP provides reimbursement for transportation of ambulatory members (individuals who are able to walk or can transfer from a wheelchair without assistance) to or from an IHCP-covered service. Commercial or common ambulatory service (CAS) transportation may be provided in any type of vehicle. The IHCP reimburses for nonambulatory services (NAS) or wheelchair services when a member must travel* ***in a wheelchair*** *to or from an IHCP-covered service.*

- 266 – *Family Member*

  Family members or close associates of IHCP members, or able-bodied members themselves, may enroll in the IHCP as drivers so that their mileage for the member's nonemergency medical transportation can be reimbursed. This option is appropriate for members who must make frequent trips for medical services, and who have a person willing and able to transport them (or who are able to transport themselves), but doing so presents a financial burden.

  Family members or close associates of IHCP members may enroll in the IHCP as drivers so that their mileage for the member's nonemergency medical transportation can be reimbursed. This option is appropriate for members who must make frequent trips for medical services, and who have a person willing and able to transport them, but doing so presents a financial burden.

  When a family member or associate is enrolled as a transportation provider, that individual may provide services only to the designated member(s), and those services are subject to prior authorization.

  As described on the *Family Member/Associate Transportation Providers* page at in.gov/medicaid/providers, the family member or associate driver may enroll with the IHCP online using the online IHCP Portal or by mail using the *IHCP Family Member/Associate Transportation Provider Enrollment and Profile Maintenance Packet*, completed and signed by the enrolling driver. The driver must also submit the following documents for IHCP enrollment and revalidation, and for recertification, based on certificate end date:
  - *Medicaid Family Member or Associate Transportation Services Form*, completed and signed by the IHCP member being transported
  - Copy of valid driver's license
  - Copy of current auto insurance for the vehicle being used (must be minimum state required limits)
  - Copy of current auto registration for the vehicle being used
  - A *W-9* tax form

  Out-of-state family member transportation providers are not eligible for enrollment in the IHCP.

  > *Note: Common carrier and taxi providers that transport their family members must have a separate enrollment as a family member transportation provider to be reimbursed.*

- 267 – *Transportation Network Company (TNC)*

  TNC providers must submit the following documentation for IHCP enrollment and revalidation, and for recertification, based on certificate end date:
  - Copy of a TNC permit from the Indiana Department of Revenue
  - Proof of surety bond as described in the *Surety Bond Requirements* section
  - Proof of insurance coverage

  Out-of-state providers are not eligible for enrollment in the IHCP under provider specialty 267.

- 269 – *Broker Fleet*
  - Copy of their MCS certificate from the Indiana Department of Revenue
  - Name, Social Security number and date of birth for each driver working for the transportation provider, as well as provider attestation statements as described in the *Driver Information and Attestation Requirements* section
  - Copy of appropriate and valid driver's licenses for all drivers associated with the provider
  - Proof of insurance coverage

  Preapproval by the FSSA is required for enrollment under this specialty.

  Out-of-state providers are not eligible for enrollment in the IHCP under provider specialty 269.

Transportation providers that are required to provide proof of insurance (specialties 262–267 and 269) can enter this information during the enrollment or revalidation process, or as a provider maintenance update.

Surety Bond Requirements

The IHCP requires an Indiana surety bond from entities applying to enroll as provider type 26 – *Transportation* with any of the following provider specialties:

- 263 – *Taxi*
- 264 – *Common Carrier (Ambulatory)*
- 265 – *Common Carrier (Nonambulatory)*
- 267 – *Transportation Network Company (TNC)*

The surety bond must be in the amount of at least $50,000 and must last a minimum of three years.

The following are exceptions to the surety bond requirement:

- Not-for-profit status − a 501(c)(3) organization only
- Owned or controlled by a hospital licensed by the IDOH
- Owned or controlled by a pharmacy with a permit issued by the Indiana Board of Pharmacy
- Owned or controlled by a person that is licensed or certified by the IPLA
- Granted a waiver of the requirement at the discretion of the Secretary of FSSA:
  - If transportation services are to be provided in a federal or state designated underserved area
  - If it has been determined the provider does not pose a significant risk of submitting fraudulent or false Medicaid claims

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

> *Note: If a waiver is requested, the provider's application will not be processed until a decision is made to grant or deny the waiver.*
>
> *If the waiver is not granted, the provider has 30 days from the date on the notice of rejection to submit the required bond.*

The required surety bond can be obtained by contacting a licensed insurance broker who will find a company to underwrite the bond. It is important that the broker be given the specific surety bond requirements to ensure that the bond is compliant with the new regulation. The *Indiana Medicaid Surety Bond Requirements* document at in.gov/medicaid/providers outlines the requirements and can be copied for reference by the insurance broker. The document includes a link to *Indiana's Medicaid Transportation Provider Surety Bond* form (*State Form 55382*).

Driver Information and Attestation Requirements

Effective Sept. 1, 2023, the IHCP requires certain driver information and provider attestations be completed for initial enrollment, revalidation and recertification of the following specialties:

- 263 – *Taxi*
- 264 – *Common Carrier (Ambulatory)*
- 265 – *Common Carrier (Nonambulatory)*
- 267 – *Transportation Network Company (TNC)*
- 269 – *Broker Fleet*

In addition to attaching copies of driver's licenses for each driver, these providers are now also required to do the following:

- Disclose the name, Social Security number and birth date for each driver working for them
- Attest to the following statements:
  - "I attest to having a process necessary for addressing any violation of a state drug law."
  - "I attest to having a process to disclose to the Indiana Health Coverage Programs (IHCP) the driving history, including any traffic violations, of each individual driver employed by this provider upon request by the IHCP."
  - "I attest that all individuals who currently provide transportation for this provider have been reported and that I will be responsible for updating this enrollment with additional drivers as needed."

Providers may enter this driver information and complete the attestations on the IHCP Portal or using the Transportation provider packet.

Dentist (Type 27)

Dentists may be enrolled in the IHCP as **billing** providers, **group** providers or **rendering** providers linked to a group. Dental practices must be owned by licensed dentists. Indiana law prohibits a non-dentist owner in any dental practice. Provider type 27 – *Dentist* includes the following specialties, all of which require submission of a copy of a current license issued by the appropriate state's licensing agency:

- 270 – *Endodontist*
- 271 – *General Dentistry Practitioner*
- 272 – *Oral Surgeon*
- 273 – *Orthodontist*
- 274 – *Pediatric Dentist*
- 275 – *Periodontist*
- 276 – *Mobile Dental Van*
- 277 – *Prosthesis*

Provider specialty 276 – *Mobile Dental Van* must be enrolled as a **group** and must submit a copy of their current mobile dental license issued by the IPLA. This specialty is not eligible for out-of-state enrollment.

> *Note: If a dentist enrolls in the IHCP under a business name, the dental broker will not contract with them unless they are enrolled as both a group and rendering provider with the appropriate NPIs: a Type 2 NPI for the group enrollment and a Type 1 NPI for the rendering enrollment. See the National Provider Identifier Requirements section for more information about enrolling as an individual healthcare practitioner conducting business with the IHCP as a business entity.*

A locum tenens dentist can fill in for a member's regular dentist. For more information, see the *Locum Tenens Healthcare Providers* section.

Laboratory (Type 28)

Four specialties are associated with provider type 28 – *Laboratory*:

- 280 – *Independent Lab*
- 281 – *Mobile Lab*
- 282 – *Independent Diagnostic Testing Facility (IDTF)*
- 283 – *Mobile Independent Diagnostic Testing Facility (IDTF)*

The provider specialties can enroll as follows:

- 280 and 281 – **Billing** provider only
- 282 – **Group** provider only
- 283 – Either a **billing** provider or a **group** provider

A Clinical Laboratory Improvement Amendment (CLIA) certificate is required for independent labs and mobile labs for the location where services are rendered. IDTFs and mobile IDTFs (specialties 282 and 283) do not require a CLIA certificate.

IDTFs and mobile IDTFs must have a physician linked to the group. For mobile IDTFs, a physician must be on staff, and a valid driver's license is required for all drivers.

Radiology (Type 29)

Radiology clinics can be enrolled as **billing** providers or **group** providers. A radiology group's rendering providers are enrolled with provider type *31 – Physician* with provider specialty 341 – *Radiologist*.

Two specialties are associated with provider type 29 – *Radiology*:

- 290 – *Freestanding X-Ray Clinic*
- 291 – *Mobile X-Ray Clinic*

Radiology providers are required to submit a copy of their IDOH Notice of Compliance, unless they perform only positron emission tomography (PET) and/or magnetic resonance imaging (MRI) services.

> *Note: PET and MRI services do not require a Notice of Compliance.*

Operator certificates are required for all employee operators except PET and/or computer tomography (CT) scanner operators.

Mobile X-ray clinics (specialty 291) must submit a valid driver's license. Out-of-state mobile X-ray clinics that will be performing services (other than PET or MRI) *in Indiana* must possess a Notice of Compliance in Indiana, from the IDOH.

End-Stage Renal Disease Clinic (Type 30)

End-stage renal disease (ESRD) clinics must be enrolled as **billing** providers. They cannot be enrolled as group providers. The only specialty associated with provider Type 30 – *End-Stage Renal Disease (ESRD) Clinic* is specialty 300 – *Free-Standing Renal Dialysis Clinic*. Out-of-state ESRD clinics are not eligible for enrollment in the IHCP.

The IDOH sends certification information to the IHCP Provider Enrollment Unit. ESRD clinics are required to have a valid CLIA certificate on file with the IHCP. This CLIA certificate can be for the lab that the ESRD clinic provider contracts with to perform lab services. It is the provider's responsibility to update CLIA certifications if there are changes to the CLIA certification level or if the CLIA number changes. The CMS regularly notifies the IHCP Provider Enrollment Unit of updates to the end date for the CLIA number on file, but providers must still report as an update any change to the CLIA number on file.

Physician (Type 31)

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

The following specialties are associated with provider type 31 – *Physician*:

- 310 – *Allergist*
- 311 – *Anesthesiologist*
- 312 – *Cardiologist*
- 313 – *Cardiovascular Surgeon*
- 314 – *Dermatologist*
- 315 – *Emergency Medicine Practitioner*
- 316 – *Family Practitioner*
- 317 – *Gastroenterologist*
- 318 – *General Practitioner*
- 319 – *General Surgeon*
- 320 – *Geriatric Practitioner*
- 321 – *Hand Surgeon*
- 323 – *Neonatologist*
- 324 – *Nephrologist*
- 325 – *Neurological Surgeon*
- 326 – *Neurologist*
- 327 – *Nuclear Medicine Practitioner*
- 328 – *Obstetrician/Gynecologist*

- 329 – *Oncologist*
- 330 – *Ophthalmologist*
- 331 – *Orthopedic Surgeon*
- 332 – *Otologist/Laryngologist/Rhinologist*
- 333 – *Pathologist*
- 334 – *Pediatric Surgeon*
- 336 – *Physical Medicine and Rehabilitation Practitioner*
- 337 – *Plastic Surgeon*
- 338 – *Proctologist*
- 339 – *Psychiatrist*
- 340 – *Pulmonary Disease Specialist*
- 341 – *Radiologist*
- 342 – *Thoracic Surgeon*
- 343 – *Urologist*
- 344 – *General Internist*
- 345 – *General Pediatrician*
- 346 – *Dispensing Physician*

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

The IHCP allows locum tenens physicians and substitute physicians to fill in for a member's regular physician, as described in the *Substitute Physicians and Locum Tenens Healthcare Providers* section.

Waiver Provider (Type 32)

Becoming a Home- and Community-Based Services (HCBS) 1915(c) waiver provider begins with the FSSA certification process and is finalized with the IHCP provider enrollment process.

FSSA Certification

Before submitting an IHCP enrollment application, the provider must first be certified by either the FSSA Division of Aging or the FSSA Division of Developmental and Rehabilitative Services (DDRS), depending on the HCBS waiver services being provided.

Prospective waiver providers must contact the appropriate FSSA HCBS Waiver Unit to request certification:

- For the intermediate care facility for individuals with intellectual disabilities (ICF/IID) level-of-care waivers (Community Integration and Habilitation [CIH] Waiver and Family Supports Waiver [FSW]), contact:

  MS18
  Director of Provider Services
  DDRS – Division of Disabilities and Rehabilitative Services
  402 W. Washington St., Room W453
  Indianapolis, IN 46204-2243

  Email: BDDSprovider@fssa.in.gov

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

  MS21
  IHCP Waiver/Provider Analyst
  FSSA Division of Aging – HCBS Waivers
  P.O. Box 7083
  402 W. Washington St., Room W454
  Indianapolis, IN 46027-7083

  Email: DAproviderapp@fssa.in.gov

IHCP Enrollment

Provider type 32 – *Waiver* may be enrolled as **billing** providers, **group** providers or **rendering** providers linked to a group.

Five specialties are associated with the waiver provider type:

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

Each specialty has multiple secondary specialties. For a list of the secondary specialties, see the *IHCP Provider Enrollment Type and Specialty Matrix*. The *Waiver Certification Form*, issued by the waiver agency, lists the specialties and secondary specialties for which the provider has been approved.

MRT Copy Center (Type 34)

Entities that provide only medical record copying and provision for the Medical Review Team (MRT) program are enrolled as **billing** providers under provider type 34 – *MRT Copy Center*. The only specialty associated with this provider type is specialty 366 – *MRT Copy Center*. See the *Provider Enrollment in the Medical Review Team Program* section for more enrollment information.

Genetic Counselor (Type 36)

Professionally licensed genetic counselors can enroll in the IHCP as provider type 36 – *Genetic Counselor* with specialty 800 – *Genetic Counselor*. To enroll with the IHCP as provider type 36, genetic counselors must hold a current professional license as a genetic counselor, as defined in *IC 25-17.3*. Although licensed physicians and nurses are not required to be licensed as a genetic counselor to provide genetic counseling within their scope of practice, *IC 25-17.3-4-4* stipulates that providers cannot use the title "genetic counselor" unless licensed as such.

Genetic counselors may enroll under provider type 36 as a **billing** provider, a **group** provider or a **rendering** provider under a group practice. Genetic counselor group practices can have only providers with specialty 800 – *Genetic Counselor* linked to the group as rendering providers. Genetic counselors enrolled as rendering providers can be linked with any of the following types of group practices:

- Type 08 – *Clinic* with the following specialty codes:
  - 082 – *Medical Clinic*
  - 083 – *Family Planning Clinic*

  - 084 – *Nurse Practitioner Clinic*
  - 087 – *Therapy Clinic*
- Type 09 – *Advanced Practice Registered Nurse* with the following specialty codes:
  - 090 – *Pediatric Nurse Practitioner*
  - 091 – *Obstetric Nurse Practitioner*
  - 092 – *Family Nurse Practitioner*
  - 093 – *Nurse Practitioner (other, such as clinical nurse specialist)*
  - 095 – *Certified Nurse Midwife*
- Type 11 – *Mental Health Provider* with the following specialty codes:
  - 110 – *Outpatient Mental Health Clinic*
  - 111 – *Community Mental Health Center (CMHC)*
  - 114 – *Health Service Provider in Psychology (HSPP)*
- Type 31 – *Physician*
  - All specialties
- Type 36 – *Genetic Counselor*
  - 800 – *Genetic Counselor*

Genetic counselor (type 36) providers – whether enrolled as a billing provider, group provider or rendering provider under any type of group practice – are limited to providing only genetic counseling services, as described in the *Genetic Testing* module.

Providers enrolled with the IHCP under a different provider type and that have genetic counseling within their scope of practice should bill for these services following standard billing guidance.

Medicare-Only Provider (Type 37)

Effective March 30, 2023, the IHCP allows providers to enroll for recognition as a Medicare-only provider to receive reimbursement for Medicaid cost-sharing obligations. These providers are classified as provider type 37 – *Medicare-Only Provider* with specialty 370 – *Medicare-Only Provider*. Medicare-only providers must enroll as a **billing** provider.

Medicare-only providers do not appear in the IHCP provider directory and will only be reimbursed any applicable cost-sharing obligations for dually eligible IHCP members. This provider type is intended for providers that see only dually eligible members (those who are enrolled with both Medicare and Medicaid).

Providers that intend to see dually eligible as well as other IHCP members should enroll according to the provider type and specialty appropriate to their qualifications and ***not*** enroll as a Medicare-only provider.

Community Health Workers

Community health workers (CHWs) do not enroll as providers with the IHCP. Rather, CHWs are required to be employed by an IHCP-enrolled billing provider and to deliver services under the supervision of one of the following IHCP-enrolled provider types:

- Physician
- Health Services Provider in Psychology (HSPP)
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant
- Podiatrist
- Chiropractor

The billing provider must maintain documentation of CHW certification for the individual providing the CHW services. The IHCP will recognize certification from the following entities to demonstrate that the core competencies of a CHW have been met:

- Mental Health America of Northeast Indiana (MANI)
- Affiliated Service Providers of Indiana (ASPIN)
- HealthVisions Midwest

For more information about CHW services, see the *Medical Practitioner Reimbursement* module.

Provider Enrollment Effective Dates

The normal effective date of IHCP provider enrollment is the date the Provider Enrollment Unit receives the enrollment application. In certain situations, retroactive provider enrollment may be allowed.

Retroactive Provider Enrollment

A retroactive provider enrollment date aligning with the claim timely filing limit may be considered for approval by the FSSA under appropriate circumstances. The FSSA will review requests to backdate enrollment prior to the application-received date for reasons including but not limited to the following:

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

Any provider enrollment application requesting a retroactive effective date must include a valid claim form or a remittance from a primary carrier as proof of service rendered.

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

> *Note: The provider's certification or license must be active for the entire retroactive period being requested. For providers that are surveyed by the IDOH and require certification for enrollment (Type 01 – Hospital, Type 02 – Ambulatory Surgical Center, Type 03 – Extended Care Facility, Type 05 – Home Health Agency and Type 06 – Hospice), the effective program start date cannot be earlier than the survey date or effective date provided by IDOH.*

Claim Filing

For a claim to be considered for reimbursement, the dates of service must be on or after the provider enrollment start date. For group and clinic provider entities, the dates of service being billed must be on or after the rendering practitioner linkage effective date.

Most claims are subject to a timely filing limit of 180 days from the date of service (or date of discharge, for inpatient claims). If the service was rendered more than 180 days prior to claim submission, the provider must submit a paper claim and the appropriate documentation to request a filing limit waiver. See the *Claim Submission and Processing* module for details on how to submit a claim with filing limit waiver documentation.

Prior Authorization

Prior authorization (PA) for medically necessary covered services, if applicable, can be requested for a period beginning from the effective date of the provider's enrollment.

If PA is required for a covered service that has already occurred, it can be requested retroactively. The provider must indicate on the PA request that the reason for the untimely request is "retroactive enrollment." Authorization is determined solely on the basis of medical necessity. See the *Prior Authorization* module for details about PA.

Section 3: Provider Enrollment Steps

Before applying to enroll with the Indiana Health Coverage Programs (IHCP), providers should visit the *IHCP Provider Enrollment Transactions* page at in.gov/medicaid/providers. Providers should review the *IHCP Provider Enrollment Type and Specialty Matrix* and the *IHCP Provider Enrollment Risk Category and Application Fee Matrix* to determine enrollment requirements for their business entity's provider type and specialty.

For instructions on enrolling as an ordering, prescribing or referring (OPR) provider, see *Section 5: Ordering, Prescribing or Referring Providers (Type 50)*.

General Enrollment Instructions

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

- If you are categorized as a high-risk provider, perform fingerprint activities as described in the *Fingerprint Background Check* section. (Fingerprint confirmation numbers will be required on the application.)
- Complete an enrollment application using the IHCP Provider Healthcare Portal (IHCP Portal) or the appropriate IHCP provider packet, as described in the following sections.
- Sign the provider agreement and signature authorization sections. (The IHCP Portal accepts electronic signatures.)
- Attach copies of the applicable certifications or licenses required for the enrolling provider's type and specialty. (The IHCP Portal allows electronic file transfer of attachments at the end of the application process, after the applicant confirms the summary page, creates a password, and receives an application tracking number [ATN].)

> *Note: The enrollment cannot be completed without the required documents.*

- Submit the application and required documents to the Provider Enrollment Unit, either via the IHCP Portal or by mail.
- Pay the required application fee, as described in the *Application Fee* section.

> *Note: Providers are strongly encouraged to use the IHCP Provider Healthcare Portal, accessible from the homepage at in.gov/medicaid/providers, for provider enrollment applications, revalidations and profile updates whenever possible, as electronic transactions can be processed more efficiently than paper submissions. Not only is the portal designed to reduce errors in initial submissions, but it also provides a tracking number that is helpful in tracking subsequent submissions if follow-up is needed for missing information or documents.*
>
> *However, providers unable to use the portal do have the option to submit paper enrollment applications.*

Enrolling Online Using the IHCP Provider Healthcare Portal

The IHCP Portal allows providers to enroll in the IHCP based on provider type and provider classification (group, billing, rendering or OPR).

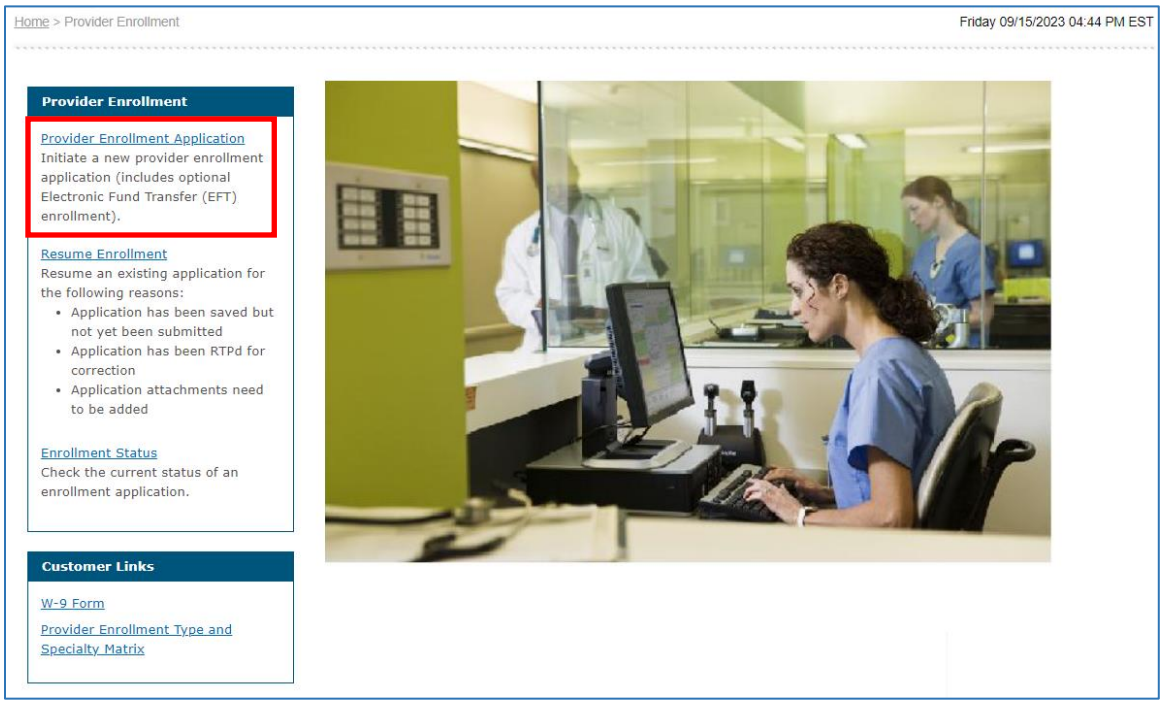
Prospective IHCP providers are able to submit an enrollment application, resume an enrollment application and check their enrollment status on the portal. To begin the enrollment process online, follow these steps:

1. Go to the IHCP Provider Healthcare Portal, accessible from the homepage at in.gov/medicaid/providers.
2. Click the **Provider Enrollment** link (see Figure 2).

Figure 2 – Provider Enrollment Option

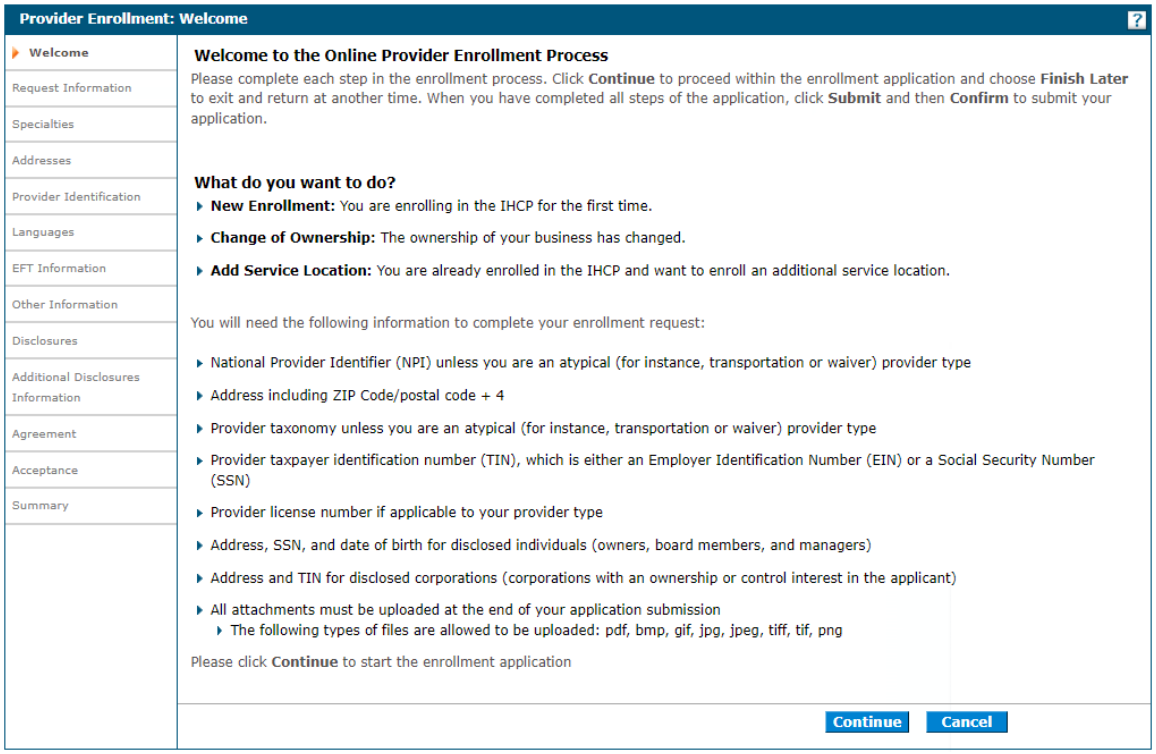
3. Click the **Provider Enrollment Application** link (see Figure 3).

Figure 3 – Provider Enrollment Application Link



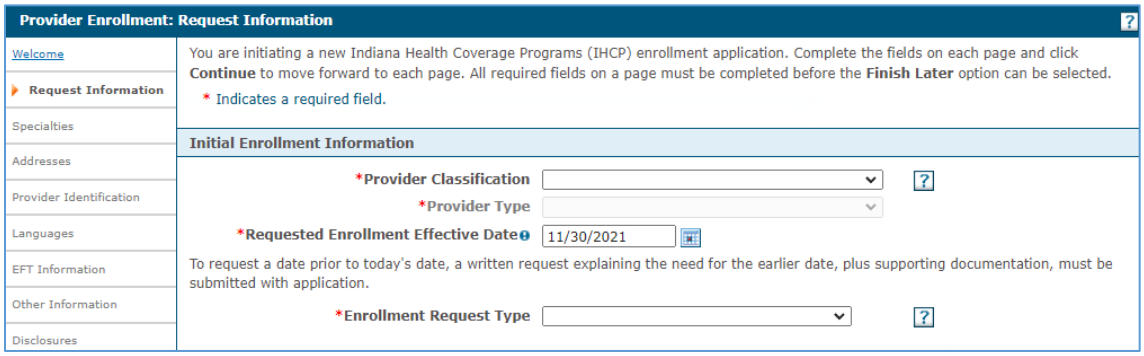
4. Read the introductory information on the *Welcome* page (see Figure 4) and then click **Continue**.

Figure 4 – Welcome Page



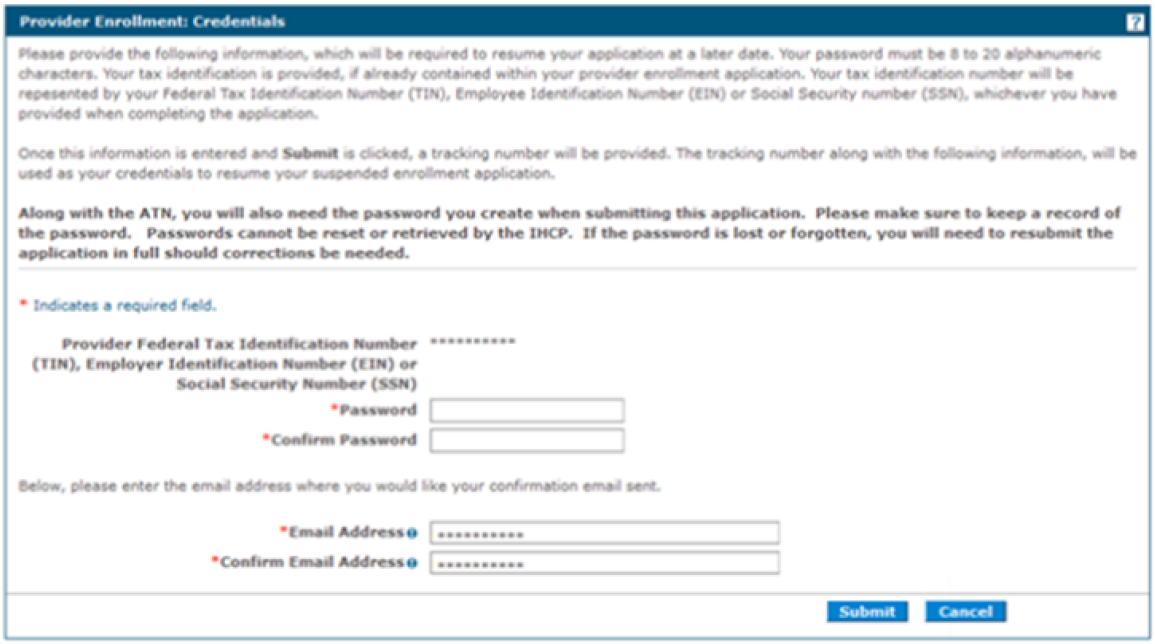
5. On the *Provider Enrollment: Request Information* page, in the *Initial Enrollment Information* section (see Figure 5), do the following:
   - Select the appropriate provider classification (group, billing, rendering or OPR) from the **Provider Classification** drop-down box. (See the *Provider Classifications* section for more information.)
   - Select the appropriate provider type from the Provider Type drop-down box. (See the *Provider Type and Specialty Requirements* section for more information.)
   - Select **New Enrollment** from the Enrollment Request Type drop-down box (unless the enrollment is a change of ownership or to add a service location for a currently enrolled provider).

Figure 5 – Request Information Page



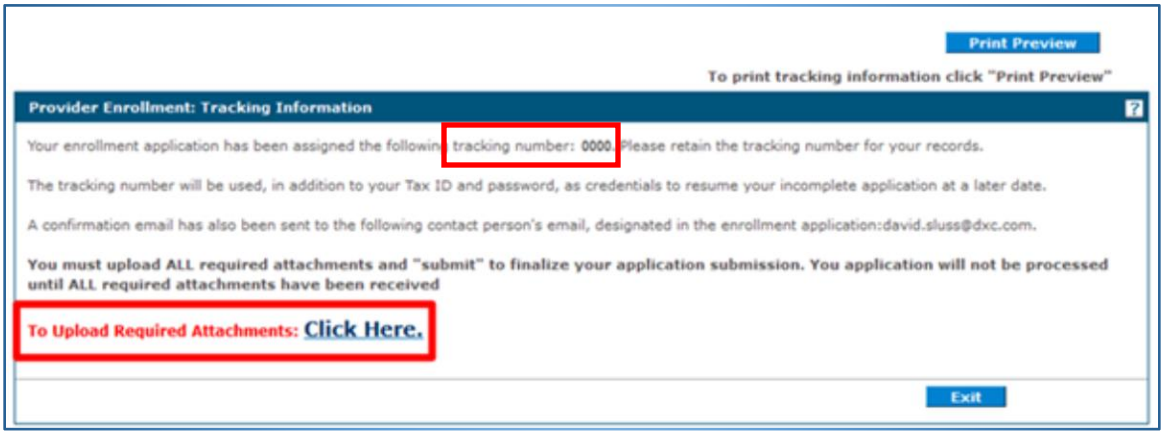
6. Follow instructions to complete the remaining sections of the application.
7. After completing all the sections, review the *Summary* page and, when you are satisfied with the information, click **Confirm**.
8. Create a password and provide an email address on the *Provider Enrollment Credentials* page, for application tracking purposes, and then click **Submit**.

Figure 6 – Provider Enrollment Credentials



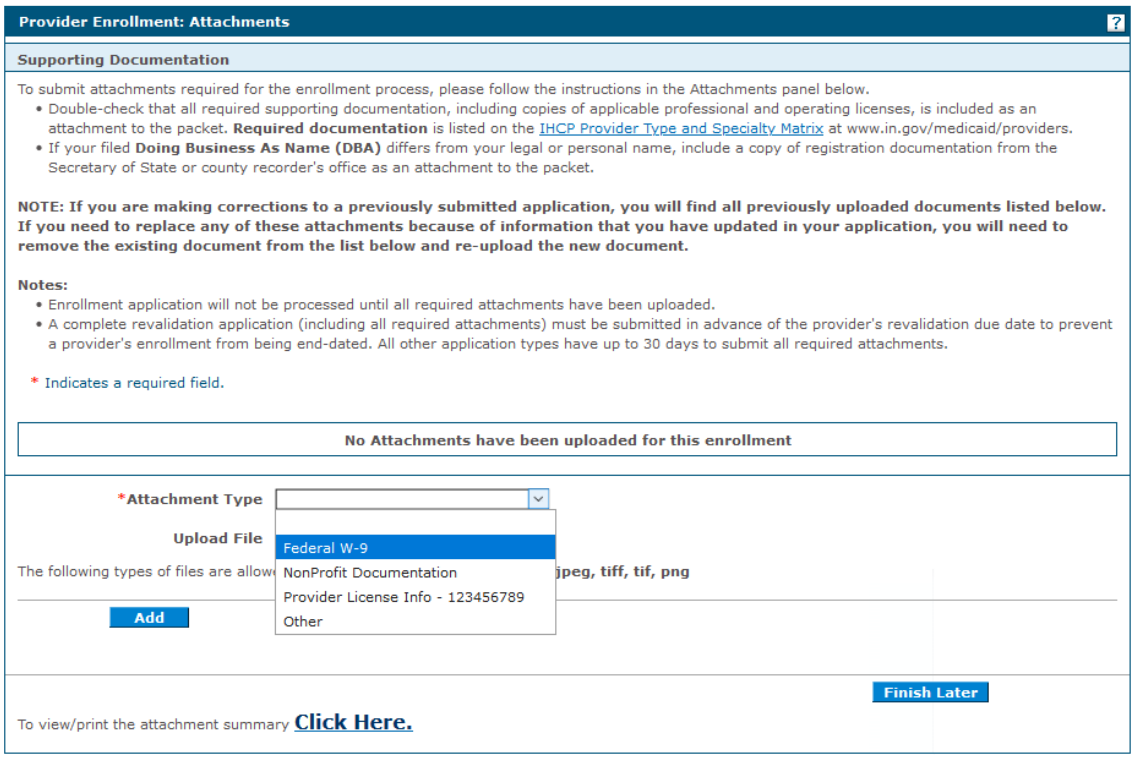
9. Make a note of the application tracking number that appears on the next screen (Figure 7). If applicable, this screen also contains a link for uploading supporting attachments.

Figure 7 – Tracking Number and Link to Upload Attachments



10. Click the link to upload required attachments (if applicable) and follow the steps to upload and submit all required attachments (see the *Required and Nonrequired Provider Documents* section for information on required attachments). After attachments are uploaded, providers can submit the application.

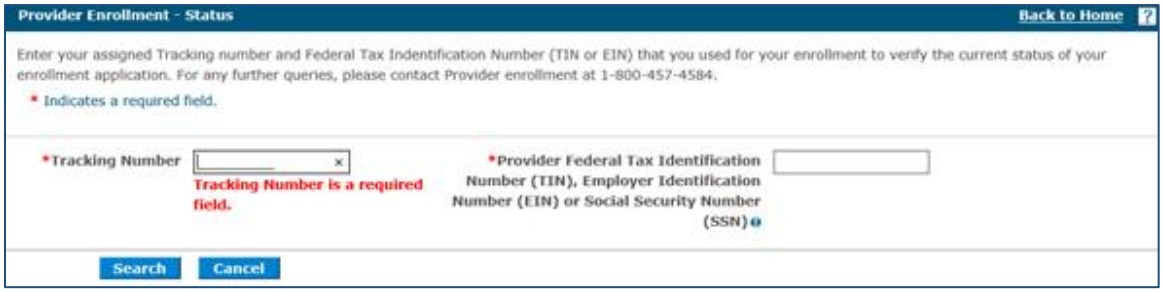
Figure 8 – Application Attachments



After submitting an enrollment application and attachments on the portal, providers can use the tracking number to check on the status of an enrollment, as follows:

1. Go to the IHCP Provider Healthcare Portal, accessible from the homepage at in.gov/medicaid/providers.
2. Click the **Provider Enrollment** link.
3. Click the **Provider Enrollment Status** link.
4. In the *Provider Enrollment – Status* panel (see Figure 9), enter the tracking number for the application and the federal employer identification number (EIN) or Social Security number (SSN) for the provider.

Figure 9 – Check Enrollment Status



After they are enrolled, providers can register to use the portal to update their enrollment information, complete revalidation tasks and disenroll from the IHCP, in addition to submitting claims, requesting prior authorization (PA), and performing other day-to-day transactions. For additional help using the IHCP Portal, online web-based training for the portal is available on the *IHCP Provider Healthcare Portal Training* page at in.gov/medicaid/providers.

Enrolling by Mail Using the IHCP Provider Packet

To enroll by mail using a printed IHCP provider packet, go to the *Complete an IHCP Provider Enrollment Application* page at in.gov/medicaid/providers and select the applicable provider type to access the appropriate enrollment packet.

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

Current and appropriate provider enrollment and profile maintenance forms are necessary to facilitate accurate enrollment and profile updates. Use the most current version of the forms, and read the instructions carefully before completing and submitting the form. (See *Section 4: Provider Profile Maintenance and Other Enrollment Updates* for information on updating existing information for an enrolled provider.)

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

All provider enrollment and profile maintenance forms are available as Adobe PDF files and have a "Save As" function. Providers may complete the forms electronically before printing them, or print them and complete them by hand. The following guidelines apply for paper enrollment submissions:

- The use of liquid correction fluid or correction tape is not acceptable in any area of the enrollment or profile maintenance form.
- Appropriate signatures are required.
- All signatures must be in blue or black ink.
- Signatures must be legible.

> *Note: An enrollment is not processed without a completed enrollment application, including a signed signature page and a signed provider agreement. For rendering provider forms, the signature page and the Rendering Provider Agreement must be signed by* ***both*** *an authorized official from the group and the rendering provider. Applications should be submitted within 90 days of the date the documents were signed. Applications with provider agreements that are received beyond the 90 days may not be accepted, and a new agreement will need to be submitted with updated signatures.*

Copies of the appropriate certifications or licenses are required to be attached to the enrollment application for certain providers, depending on their provider type and specialty. The *IHCP Provider Enrollment Type and Specialty Matrix* is available online at in.gov/medicaid/providers for reference when determining supporting document and enrollment requirements.

Completed forms should be mailed to the Provider Enrollment Unit at the address provided on the form.

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

Enrollment Application Details

This section includes detailed instructions for each component of the IHCP provider packet, which is used for enrollments submitted by mail. For **online** enrollment, follow instructions provided in the IHCP Portal.

> *Note: Providers are encouraged to enroll online, using the IHCP Provider Healthcare Portal, accessible from the homepage at in.gov/medicaid/providers. Most of the following forms are built into the electronic application process, eliminating the need to submit them separately. When separate addendums are required, the portal will prompt the provider to open, complete and submit the addendum during the application process.*
>
> *The portal enrollment process requires the same information as is required on the paper provider packet, although the order of the information requested and the names of the fields and sections may be somewhat different. For example, the portal does not divide enrollment information into Schedules A through C the way the paper packets do; however, it still requires the same information that is included under each of those schedules in the provider packet.*

Note that the sections of the enrollment packet and the specific information requested vary by provider type and classification. Follow the quality checklist and instructions in the beginning of the packet to help ensure that the enrollment application is completed and submitted correctly.

Depending on the provider type and classification, a provider enrollment packet may contain the following sections:

- **Schedule A** – This section indicates who the provider is and what the provider would like to do:
  - **Type of Request** – Choose to enroll for the first time, perform a change of ownership, add a new service location, revalidate enrollment or update existing profile information.

    > *Note: An enrollment conversion option has also been added to the Type of Request field on the paper enrollment packet, for providers converting from an OPR enrollment to a rendering enrollment, or from a rendering enrollment to an OPR enrollment. For information on performing a Rendering/OPR conversion via the IHCP Portal, see the Converting to OPR From Rendering or to Rendering From OPR section.*

  - **Provider Information** – Provide requested information, including NPI, nine-digit ZIP Code and all relevant taxonomy codes (identifying healthcare provider type and specialty) associated with the NPI.

    > *Note: If the NPI is used for multiple Provider IDs or service locations, identifiers such as ZIP+4 and taxonomy code will be used to identify the specific service location.*
    >
    > *Healthcare provider taxonomy codes are designed to categorize the type, classification and specialization of healthcare providers. More information about taxonomy, as well as a crosswalk between provider types and taxonomy codes, can be found on the Find Your Taxonomy Code page at cms.gov. Providers can also locate the taxonomy code assigned to the provider NPI through the NPPES Registry at cms.hhs.gov.*

    Applicants are also asked to indicate whether they are recognized by the Internal Revenue Service (IRS) as a disregarded entity for federal tax purposes, and to provide current and past IHCP enrollment information.
  - **Contact Information** – Provide the name, email address and telephone number for an individual who can answer questions about information provided in the packet. Also indicate the preferred method of communication.
  - **Service Location Name and Address** – Enter the name and location information of the entity (individual or business) providing services.

    > *Note: Providers operating under a doing business as (DBA) designation different from the name in line 1 of their W-9 form should enter the DBA name as their service location name. Providers that are disregarded as an entity separate from their owner may enter the name of the disregarded entity as the service location name. In either of these situations, the service location name must match the business name in line 2 of the W-9 form.*

    The service location address is generally the site where members obtain services and is typically where related records are kept. Providers that render services at a "place-of-service site," such as at a hospital, nursing facility or member's home, should enter their home/business office as their service location address. This address must be a physical location; a post office box or UPS store *cannot* be used.

    Providers located outside Indiana may complete the following sections, if applicable:

    - **Out-of-State Telemedicine** – Designated provider types that have a license issued by the Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification can select the Telemedicine subtype on the rendering or billing enrollment to indicate that they are eligible to perform telemedicine services without being subject to out-of-state prior authorization requirements. A copy of the license must be attached.

- **Out-of-State Questionnaire** – Out-of-state providers that are eligible to enroll in the IHCP and that are not located in an area that has been designated as "in-state" for prior authorization purposes can indicate any applicable circumstances that may qualify them for in-state enrollment status. Supporting documentation is required.

– **Provider Name and Legal Address** must exactly match the name and address information on the *W-9* submitted with the application. The associated taxpayer identification number (TIN) – either federal employer identification number (EIN) or Social Security number (SSN) – must also be entered. The legal address must be the same for all IHCP service locations using the same TIN. The IHCP mails annual 1099 forms and other legal or tax-related communication to this address.

> *Note: Any change to the legal (home office/owner) address must be reported to the IHCP with a copy of the W-9 form showing the same change was reported to the IRS. The provider must separately update the legal address and the W-9 form on file for **each** affected IHCP-enrolled service location. See the Address Changes section for details.*

– **Mailing Name and Address** is the address where notifications and general correspondence is sent. A post office box is acceptable.

– **Pay-to Name and Address** is the location where the IHCP sends checks (if the provider is not set up for electronic funds transfer [EFT]) and general claim payment information. A post office box is acceptable. If the provider is using a billing agent, proof of authorization for the billing agent must be included as an attachment to the packet.

– **Provider Specialty Information** – Identify the provider type and primary specialty (see the *Provider Type and Specialty Requirements* section), any applicable additional specialties, and associated taxonomy codes.

– **Licensure/Certification:** Provide any requested license or certification information; required licensure and certification varies by provider type. A copy of the license or certificate from the appropriate board or authority must be included as an attachment to the packet, when applicable. For example, providers may be required to provide:

- Indiana Department of Health (IDOH) certification information
- Clinical Laboratory Improvement Amendments (CLIA) certification information

- **Schedule B** – This section identifies how the business is structured and other information:
  – **Organizational Structure** – Provide information about how the provider entity is legally organized and structured, whether it is registered to transact business in Indiana with the Secretary of State, incorporation status, and so on.
  – **Other IHCP Program Participation** – Note any additional IHCP programs to include in the enrollment, such as 590 Program, Preadmission Screening and Resident Review (PASRR), and Medical Review Team (MRT). (See the *Provider Enrollment for Specific IHCP Programs* section for details.)
  – **Managed Care Program Provider** – This section is informational only, for providers interested in enrolling with the IHCP's managed care entities (MCEs).
  – **Mental Health and Substance Use Disorder Services** – Providers enrolling under type 11 – *Behavioral Health Provider* indicate (Yes or No) whether they provide substance use disorder (SUD) services and/or mental health services.
  – **Dental Providers Only** – Dental providers indicate whether they are accepting new patients and whether they are equipped to handle patients with special needs requirements.
  – **Medicare Participation** – Medicare providers must provide their Medicare identification numbers and associated service location address.
  – **Medicaid Participation for Out-of-State Providers** – Out-of-state providers indicate whether they are currently enrolled in their state's Medicaid program. If so, proof of participation must be attached to the packet.

  - **Patient Population Information** – Indicate the funding sources for the patient population; be sure the percentages equal 100%.

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

- **IHCP Provider Signature Authorization** – This page must be signed by a person who is listed in the application as an individual with an ownership or controlling interest or a managing individual (in section C.1 or C.3 of Schedule C of the packet), or by a delegated administrator that has been expressly indicated on an *IHCP Delegated Administrator Addendum/Maintenance Form*. As the provider, or having the authority to bind the provider to the terms of the provider agreement, the signer must agree to abide by and comply with all stipulations of the program. For group enrollments, an authorized official of the group or clinic provider must sign this page. For rendering providers, the provider must sign the *IHCP Provider Signature Authorization* section of the **rendering** provider packet (included within the group packet). Original signatures are required; a stamped signature is not acceptable. (The IHCP Portal accepts electronic signatures.)

- **IHCP Provider Agreement –** This document becomes the contract between the provider entity and the IHCP. Be sure to carefully read the agreement in its entirety. The agreement must be signed by the owner or authorized official ultimately responsible for operating the business. **If the person named as the delegated administrator is not reported as having ownership or controlling interest, that person is not permitted to sign a provider agreement.** (A *Rendering Provider Agreement* must also be completed for each rendering provider linked to a group.) Original signatures are required; a stamped signature is not acceptable. (The IHCP Portal accepts electronic signatures.)

  The application should be received within 90 days of the date of the signature on the provider agreement (and rendering provider agreements, if applicable). If the application is received more than 90 days after the agreement was signed, a new agreement may need to be submitted with updated signatures.

  The provider agreement is in effect for the entire period of an IHCP provider's enrollment.

- **IHCP Provider Federal W-9 Addendum** – Providers must submit the most current version of the *W-9* form from the IRS website at irs.gov. Providers should follow the instructions as provided on the W-9 form.

- **IHCP Provider Application Fee Addendum** – Certain enrolling providers are subject to an application fee and must complete and submit this addendum with the provider enrollment packet. The *IHCP Provider Enrollment Risk Category and Application Fee Matrix* provides a full list of provider types and indicates which types are subject to application fees.
- **IHCP Provider Screening Addendum** – Providers in the high-risk category must complete and submit this addendum with the enrollment application. See the *IHCP Provider Enrollment Risk Category and Application Fee Matrix*.
- **IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form** – Providers that wish to have their claim payments deposited directly into a bank account need to complete the *IHCP Electronic Funds Transfer Addendum*, which is included in the enrollment packet, or use the IHCP Portal to add or change banking information for EFTs.
- **IHCP Provider Change of Ownership Addendum** – If an enrolled entity has experienced a change of ownership, this addendum must be completed and included with the enrollment packet submitted by the new owner. This information helps identify the entity that is affected by the change.
- **IHCP Provider Delegated Administrator Addendum/Maintenance Form** – This form allows the owner or authorized official completing the enrollment packet to grant authority to an additional trusted individual within the organization to submit claims, accept payment or make selected changes to the provider information on file. Delegated administrators cannot sign a provider agreement on behalf of any owner or rendering provider.

> *Note: Designating a delegated administrator grants that person permission to sign and submit **paper** documents only. To grant permission for the individual to submit claims, update provider information and perform other tasks **online**, a Delegate account with the appropriate permissions must be created on the IHCP Portal for the individual.*

- **IHCP Hospital and Facility Additional Information Addendum** – Certain hospitals and extended-care facilities need to complete this one-page addendum when enrolling as an IHCP provider.
- **IHCP PRTF Attestation Letter/Maintenance Form** – Providers wishing to enroll as PRTFs must be licensed under *Indiana Administrative Code 465 IAC 2-11* as private, secure, child-caring institutions. To enroll as PRTFs, facilities must comply with the requirements in *42 CFR 482, Subpart G* governing the use of restraint and seclusion, and submit an attestation letter stipulating that they comply with federal and state requirements. See *405 IAC 5-20-3.1(3).* The *PRTF Attestation Letter* must be completed and included with the enrollment packet.
- **IHCP Outpatient Mental Health Addendum** – Providers wishing to enroll as an outpatient mental health clinic or as a community mental health center must complete and include the *IHCP Outpatient Mental Health Addendum*, which provides information about the supervising practitioner and a complete list of individual practitioners, who will provide outpatient mental health services, and their qualifications.
- **IHCP Rendering Provider Enrollment and Profile Maintenance Packet** – This enrollment packet allows a group provider to identify the practitioners associated with the group – those who actually provide the services offered by the entity. Only a group provider may enroll and link rendering providers employed by the group. A *rendering provider packet* must be completed for each practitioner providing care. The *IHCP Signature Authorization* section must be signed by both the rendering provider and the owner or authorized official of the entity. The *Rendering Provider Agreement* must also be signed by both the rendering provider and an authorized official of the entity. Both documents are required for enrollment.

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

Upon receiving an enrollment request, the Provider Enrollment Unit verifies that all the packets' schedules are complete, including date of birth and Social Security number for anyone listed on section C.1 or C.3 of Schedule C; all appropriate signatures are present; and all necessary documentation, including licenses and credentials, have been attached as described in the *Required and Nonrequired Provider Documents* section.

If the enrollment packet is incomplete or the required documentation is not included, the Provider Enrollment Unit contacts the provider in an attempt to complete the application. If the application cannot be completed after contacting the provider, a letter is sent to the enrolling provider outlining what is missing.

Enrollment Packet Tips – Avoiding Common Errors

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

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

- **Missing signature authorization addendum** – Enrollment packets must contain a signature authorization page signed by the owner or authorized official; for group enrollments, both the rendering provider and the owner or authorized official must sign the signature authorization section of each rendering provider packet.
- **Incomplete documents** – Examples include missing telephone numbers, specialty designations, license numbers and banking information for EFTs. Be sure to complete all required provider agreements with all appropriate signatures.
- **Incomplete Schedule C, Sections C.1 (A and B), C.2, C.3 and C.4 –** Sections C.1 and C.3 must be completed based on the business structure. Make sure that name, Social Security number and date of birth are included for any listed individual. Refusal to provide a Social Security number results in rejection of the application.
- **Provider agreement missing from packet** – A *current version* of the *IHCP Provider Agreement* or *Rendering Provider Agreement* must be submitted for every provider that bills or renders services that are reimbursed by the IHCP. If an older, retired version of the agreement is submitted, it is rejected.
- **Incorrect signature on provider agreement** – A delegated administrator is not permitted to sign a provider agreement. The *IHCP Provider Agreement* must be signed by an owner, board member or officer, with the signer being listed in section C.1 or C.3 of Schedule C. The *Rendering Provider Agreement* must be signed by the rendering provider and an authorized official of the entity.
- **Schedule A is inconsistent with *W-9*** – The provider name and address and taxpayer identification information entered in the enrollment application must match the information reported on the attached *W-9*. If a DBA name is used for the service location name on the application, this name must match the business name reported in line 2 of the attached *W-9* and registration documentation from the Secretary of State or the county recorder's office must be included showing that the DBA has been registered.
- **Current *W-9* form missing** – Submit the most current *W-9* available from the IRS; earlier versions are rejected and providers are asked to submit the most current version. Submission of a copy of the provider's IRS TIN registration confirmation letter is helpful to support the TIN reported to the IHCP.

- **Missing license or certificates** – Include a copy of the provider's professional license, if applicable. Include certificates that support the licensure specialty when a state does not license a specific specialty. See the *IHCP Provider Enrollment Type and Specialty Matrix* to determine documentation needs.
- **Additional service location not submitted on a separate application (with box checked)** – For each service location, submit a complete enrollment packet including Schedule A, Schedule B, Schedule C, *IHCP Provider Signature Authorization*, *IHCP Provider Agreement*, *W-9* and any other addenda related to the service location. At the top of the Schedule A, check the box for "Additional Service Location."
- **Missing Rendering Provider Agreement** – For group enrollments, the enrollment packet must include a *Rendering Provider Agreement*, and the agreement must be signed by an authorized official of the group or clinic ***and*** the rendering provider.
- **EFT information errors** – EFT submissions must contain the appropriate bank routing and bank account numbers. To ensure timely payment, complete the EFT form included in the enrollment application or download a form from the *Update Your Provider Profile* page at in.gov/medicaid/providers.
- **Old form copies used to request enrollments and updates** – Use current forms found on the *Complete an IHCP Provider Enrollment Application* and *Update Your Provider Profile* pages at in.gov/medicaid/providers. Older versions of the forms are not processed.
- **Instructions not followed** – The enrollment and maintenance forms contain information about the form's purpose and instructions about how to complete the forms. Read the instructions carefully and become familiar with required fields to avoid having the form rejected.

Disclosure Information

Federal program integrity regulations require states to obtain and validate certain disclosures from providers upon enrollment and periodically thereafter. When states obtain these disclosures and search exclusion and debarment lists and databases, they can take appropriate action on providers' participation in the Medicaid program.

Social Security numbers disclosed on an IHCP enrollment application, or through subsequent updates, are used to determine whether the persons and entities named are federally excluded parties. Refusal to provide a Social Security number will result in rejection of the application. Birth dates are also required to correctly identify the individual when performing sanction checks.

Providers must include disclosure information for ***all*** individuals and business entities that meet disclosure requirements – including individuals and/or corporations with an ownership (direct or indirect) or controlling interest in the applicant, subcontractors in which the applicant has a 5% or more ownership or controlling interest, and managing individuals (all agents, officers, directors and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity). Nonprofit providers and government-owned businesses must list board of directors or advisory board members as well as managing individuals.

> *Note: As defined in 42 CFR 455.101, a "person with an ownership or control interest" means a person or corporation that —*
>
> *(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;*
>
> *(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;*
>
> *(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;*
>
> *(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;*
>
> *(e) Is an officer or director of a disclosing entity that is organized as a corporation; or*
>
> *(f) Is a partner in a disclosing entity that is organized as a partnership.*

The following sections provide details about submitting disclosure information during the initial enrollment process – whether online or by mail (using the provider packet). After enrollment, providers can make changes to the disclosure information on file as described in the *Disclosure Changes* section of this module.

Disclosure Information Submitted on the IHCP Portal

Providers submit disclosure information during the online enrollment or revalidation process.

Providers enter disclosure information in the following sections of the IHCP Portal, according to the instructions provided:

- Individuals with an Ownership or Control Interest and Managing Individuals
- Corporations with an Ownership or Control Interest
- Subcontractors
- Additional Disclosures Information (relationship and background questions)

Disclosure Information Submitted in Schedule C of the Provider Packet

If providers are submitting a paper enrollment packet, disclosure information is included in Schedule C, which is divided into four sections: C.1 (A and B), C.2, C.3 and C.4. Providers must complete all four sections when applicable, and, at a minimum, C.1.(A) and C.3. Note that N/A is not acceptable on section C.3.

C.1 – Disclosure Information − Individuals and/or Corporations With an Ownership or Controlling Interest in the Applicant

Providers use this section to list any person or entity that has an ownership or controlling interest in the provider entity.

Section C.1.(A) − Individuals With Ownership or Controlling Interest

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

If the entity is publicly held and no person owns 5% or more of the corporation, or if it is a not-for-profit or government-owned entity, complete fields 1a (name of individual) and 4a (% of ownership) in this section. Then use section C.3 to list the board of directors or managing individuals as defined.

Section C.1.(B) − Corporations With an Ownership or Controlling Interest

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

C.2 – Disclosure Information – Subcontractors

Providers use this section to list ***all*** subcontractors in which the applicant has a 5% or more ownership or controlling interest.

C.3 – Disclosure Information – Managing Individuals

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

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

C.4 − Disclosure Information – Relationships and Background Information

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

1. If any parties listed in sections C.1 or C.3 are related to each other as spouse, parent, child or sibling, provide the name of each person and note their relationship.
2. If any parties listed in sections C.1 or C.3 are related to any individual with an ownership or controlling interest in any of the subcontractors listed in section C.2, provide the name of each person and note their relationship.
3. Indicate whether any persons or entities listed in section C.1 have an ownership or controlling interest in another organization that would qualify as a disclosing entity. If yes, list the name of each owner and the name of the other disclosing entities in which the owner has an ownership or control interest. If the entity is a nonprofit organization and does not have any owners, check NA.

> *Note: As defined in 42 CFR 455.101, "other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:*
>
> *a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);*
>
> *b) Any Medicare intermediary or carrier; and*
>
> *c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.*
>
> *Whereas "disclosing entity" is limited to Medicaid providers, "other disclosing entity" can include entities that are not enrolled in Medicaid.*

4. List any party with an ownership or controlling interest, or who is an agent or managing employee, who has ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid or Title XX service programs. Provide the name of the convicted party and the date of the conviction.
5. If any former agent, officer, director, partner or managing employee, has transferred ownership to a family member (spouse, parent, child or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion, provide the names of both parties and note their relationship.

Required and Nonrequired Provider Documents

The *IHCP Provider Enrollment Type and Specialty Matrix*, available at in.gov/medicaid/providers, lists the document requirements for each provider type and specialty, and should be reviewed prior to submitting enrollment applications to the IHCP. If any required documentation is missing, the Provider Enrollment Unit contacts the provider in an attempt to complete the application.

The following examples of nonrequired documents need not be submitted with an enrollment or update request:

- Diplomas
- Resumes and curricula vitae
- Lists of previous employment
- Lists of published works
- Letters of reference or commendation
- Medical doctors' insurance documents

Enrollment Confirmation

An enrollment confirmation letter is mailed to the provider upon successful enrollment in the IHCP. After receiving an enrollment confirmation letter, the provider can bill for covered services for dates of service that fall within the enrollment eligibility period.

The enrollment effective start date for providers within the state of Indiana is the date the Provider Enrollment Unit receives the completed IHCP provider packet or online enrollment application. As such,

providers may be at risk of not receiving reimbursement if they render services prior to completion of their enrollment.

> *Note: If a provider requests an enrollment effective date before the date the application was received, a copy of a valid claim form or a remittance from a primary carrier should be submitted with the application as proof of service rendered. See the Retroactive Provider Enrollment section for more information.*

Enrollment Denial or Rejection Appeal

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

Providers have the right to appeal an enrollment denial under *Indiana Code IC 4-21.5-3-7* and *405 IAC 1-1.4-12*. To preserve an appeal, providers must specify the reason for the appeal in writing and file the appeal with the ultimate authority for the agency within 15 calendar days of receipt of a notification letter.

The appeal should be sent to the following address:

MS07
Gwen Killmer, Office of Medicaid Policy and Planning
Secretary, Indiana Family and Social Services Administration
402 W. Washington St., Room W374
Indianapolis, IN 46204

If providers elect to appeal a determination, they must also file a statement of issues within 45 calendar days after receipt of notice of the determination. The statement of issues must conform to *405 IAC 1-1.4-12* and *IC 4-21.5-3* and be sent to the same address as the appeal request.

Provider Enrollment for Specific IHCP Programs

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

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

To enroll as a provider for the Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise managed care programs, a provider must first enroll as an IHCP provider. After enrollment with the IHCP is complete, providers may then enroll directly with the applicable managed care entities (MCEs), as described on the *Enrolling as a Managed Care Program Provider* page at in.gov/medicaid/providers.

Enrolling as a Primary Medical Provider

The following IHCP provider specialties (associated with the provider types listed) qualify to enroll as a primary medical provider (PMP) with a managed care entity (MCE):

- 31 – *Physician*
  - 316 – *Family Practitioner*
  - 318 – *General Practitioner*
  - 328 – *Obstetrician/Gynecologist*

  - 344 – *General Internist*
  - 345 – *General Pediatrician*
- 10 – *Physician Assistant*
  - 100 – *Physician Assistant*
- 09 – *Advanced Practice Registered Nurse*
  - 090 – *Pediatric Nurse Practitioner*
  - 091 – *Obstetric Nurse Practitioner*
  - 092 – *Family Nurse Practitioner*
  - 093 – *Nurse Practitioner (Other, such as clinical nurse specialist)*
  - 095 – *Certified Nurse Midwife*

> *Note: The same specialties eligible to become managed care PMPs are also eligible to become PMPs for the Right Choices Program, which includes both managed care and fee-for-service members. For more information, see the Right Choices Program module.*

Providers may enroll in one or more of the programs with separate panels. Each PMP must designate a panel size; that is, the number of managed care members the PMP is willing to accept.

HIP, Hoosier Care Connect and Hoosier Healthwise MCE enrollment specifics are as follows:

- Qualifying physicians, physician assistants and advanced practice registered nurses must be IHCP-enrolled prior to establishing their PMP enrollments.
- The prospective PMP must contact the MCEs to initiate the PMP enrollment process. The MCE verifies that the PMP is an IHCP-enrolled provider and sends a credentialing application and contract to the prospective PMP. After the PMP has been approved by the MCE's credentialing committee and has an executed provider contract on file, the MCE submits the PMP's enrollment information through the IHCP Portal for the PMP status to be entered into *Core*MMIS. PMPs may enroll with one or more MCEs.
- Rendering providers must be linked to an IHCP group prior to being linked to a group practice or clinic in the HIP, Hoosier Care Connect and Hoosier Healthwise managed care programs.
- All updates to IHCP enrollment information (address, EFT, linkage and other similar changes) must be submitted to the Provider Enrollment Unit (via the IHCP Portal or on the appropriate form, as described in *Section 4: Provider Profile Maintenance and Other Enrollment Updates*) for processing prior to submission of PMP enrollment changes. The IHCP Provider Enrollment Unit reports PMP-related updates to the appropriate MCE.

Provider Enrollment in the Medical Review Team Program

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

Newly Enrolling Providers Wanting to Provide MRT Services

New providers that want to participate in the MRT program follow the appropriate enrollment process for their provider type and category, either on the IHCP Portal or by submitting the appropriate provider packet downloaded from the *Complete an IHCP Provider Enrollment Application* page at in.gov/medicaid/providers.

The *Other IHCP Program Participation* section of the application allows the enrolling provider to indicate the desired option:

- Providers wishing to participate in the MRT program in addition to general IHCP enrollment (Medicaid or Hoosier Healthwise Package C participation), select **Medical Review Program/IHCP**.
- Providers enrolling for MRT assessment services, but no other IHCP programs, select **Medical Review Program Only**.
- Providers enrolling in the MRT program as a copy center to bill only for the copying and provision of medical records, when medical record copies are requested by the MRT, select the **Medical Review Program – Medical Records Only**. These providers follow the IHCP Portal or paper enrollment process for a billing provider, using provider type 34 – *MRT Copy Center*.

All newly enrolling providers must complete the enrollment application in full, as described in this module. The completed application – including signed *IHCP Provider Signature Authorization* addendum and signed *IHCP Provider Agreement* – must be submitted along with a current *W-9* form and any documentation required for their provider type and specialty (see the *IHCP Provider Enrollment Type and Specialty Matrix*). For MRT copy centers enrolling for medical records services **only**, no additional documentation, other than the *W-9*, is required with the application.

> *Note: To provide MRT services, providers must have one of the Medical Review Program options selected in the Other IHCP Program Participation section of the provider profile.*

Existing Providers Adding MRT Enrollment

Existing IHCP providers can indicate a desire to participate as an MRT provider by submitting an update via the IHCP Portal or by mail:

- On the portal, select **Other Information Changes** on the *Provider Maintenance* page and then, in the *Other IHCP Program Participation* section, select **Medical Review Program/IHCP** to add MRT participation to the existing IHCP enrollment.
- To send the update by mail, submit the appropriate provider packet (based on provider type and category) from the *Complete an IHCP Provider Enrollment Application* page at in.gov/medicaid/providers, completed as follows:
  - Select **Profile Update** in the *Type of Request* section (in Schedule A).
  - Complete the *Provider Information* section (in Schedule A).
  - Go to the *Other IHCP Program Participation* section (in Schedule B) and select **Medical Review Program/IHCP** to add MRT participation to the existing IHCP enrollment.
  - Complete the *IHCP Signature Authorization* addendum (located after Schedule C). The addendum must be signed by an owner, authorized official or delegated administrator.

Section 4: Provider Profile Maintenance and Other Enrollment Updates

The *provider profile* is the provider enrollment information on file with the Indiana Health Coverage Programs (IHCP). This information is an integral reference for provider participation and claim processing.

To maintain the accuracy of the provider profile, providers must notify IHCP Provider Enrollment within **30 business days** of any changes in the following information:

- Provider name or service location/doing business as (DBA) name
- Address, including changes to any of the following:
  - Mail-to address
  - Pay-to address
  - Service location (practice site) address
  - Legal (home office) address
- Medicare provider number
- Addition to or removal of a rendering provider from the group
- Specialty
- Taxpayer identification number (TIN)
- Ownership
- Electronic funds transfer (EFT) account information
- Enrollment status (disenrollment requests)

Providers must notify IHCP Provider Enrollment within **10 business days** of any changes in the following information:

- Licensure
- Certification, including Clinical Laboratory Improvement Amendments (CLIA) certification
- Permit

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

> *Note: Provider profile information can be viewed and updated online by providers that have a registered account on the IHCP Provider Healthcare Portal (IHCP Portal), and by registered delegates with appropriate permissions. Rendering providers are required to have their date of birth and their Social Security number (as their TIN) on file with the IHCP to establish an account on the IHCP Portal. For information about registering Provider and Delegate accounts on the IHCP Portal, see the Provider Healthcare Portal module.*

Provider Profile Update Methods

Changes to current provider profile data must be approved by written request from the provider or authorized delegate or by direction from the Family and Social Services Administration (FSSA). Provider profile information can be updated electronically on the IHCP Portal or changes can be submitted by mail, using the appropriate maintenance form located on the *Update Your Provider Profile* page at in.gov/medicaid/providers. Providers can also submit an IHCP provider packet with updates.

Providers must indicate the National Provider Identifier (NPI) and appropriate provider name on all correspondence. Delays in submitting this update information to Provider Enrollment may result in erroneous payments or denials.

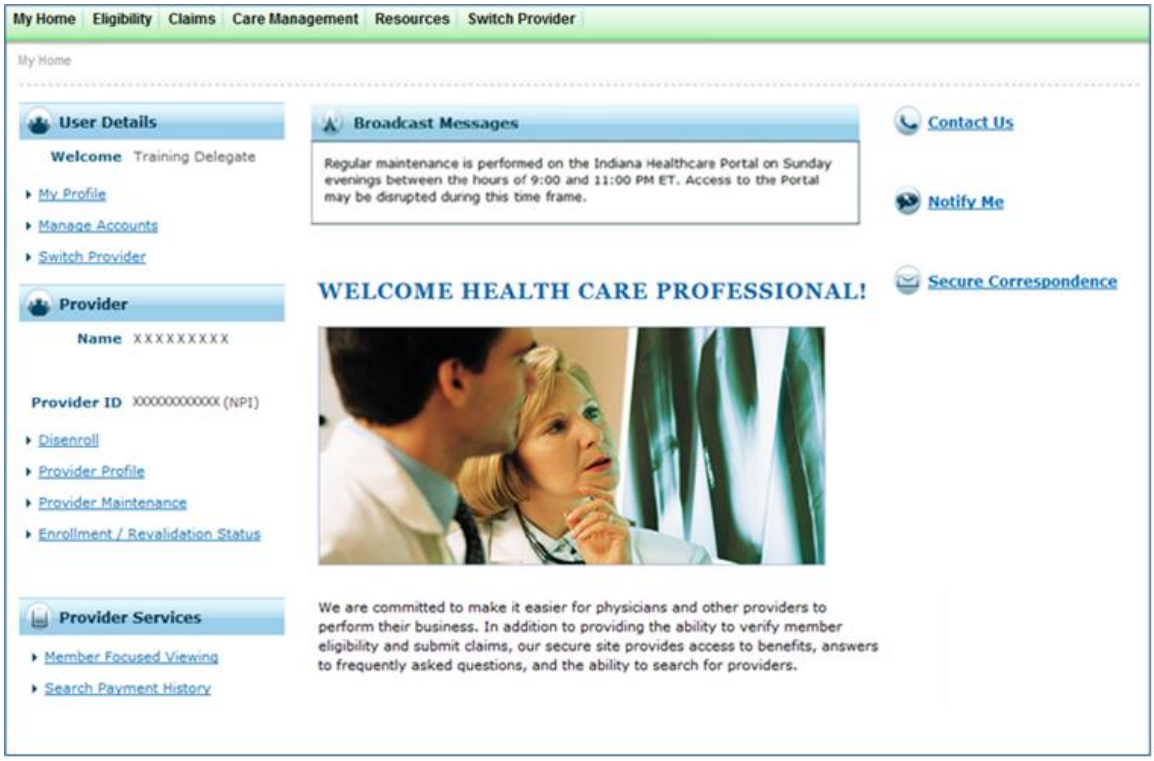
Viewing and Updating Provider Profile Information via the IHCP Portal

Registered IHCP Portal users with appropriate administrative permissions have the ability to view provider information online and to update the information electronically, rather than by sending a paper form. The portal is the preferred method of update submission, because the online process is faster and includes online help functions.

Information about registering a portal account and assigning administrative permissions can be found in the *Provider Healthcare Portal* module.

Most provider profile functions are available from the *My Home* page (see Figure 10), after the user has logged in to the portal. Some functions (such as revalidation, change in ownership and adding a service location) require the user to log out and create a new enrollment from the portal homepage.

Figure 10 – Provider Options on the My Home page of the IHCP Portal



View Provider Profile Information

Registered IHCP Portal users can view provider profile information online using the **Provider Profile** link on the *My Home* page. Group providers are also able to view information for all the rendering providers associated with their practice.

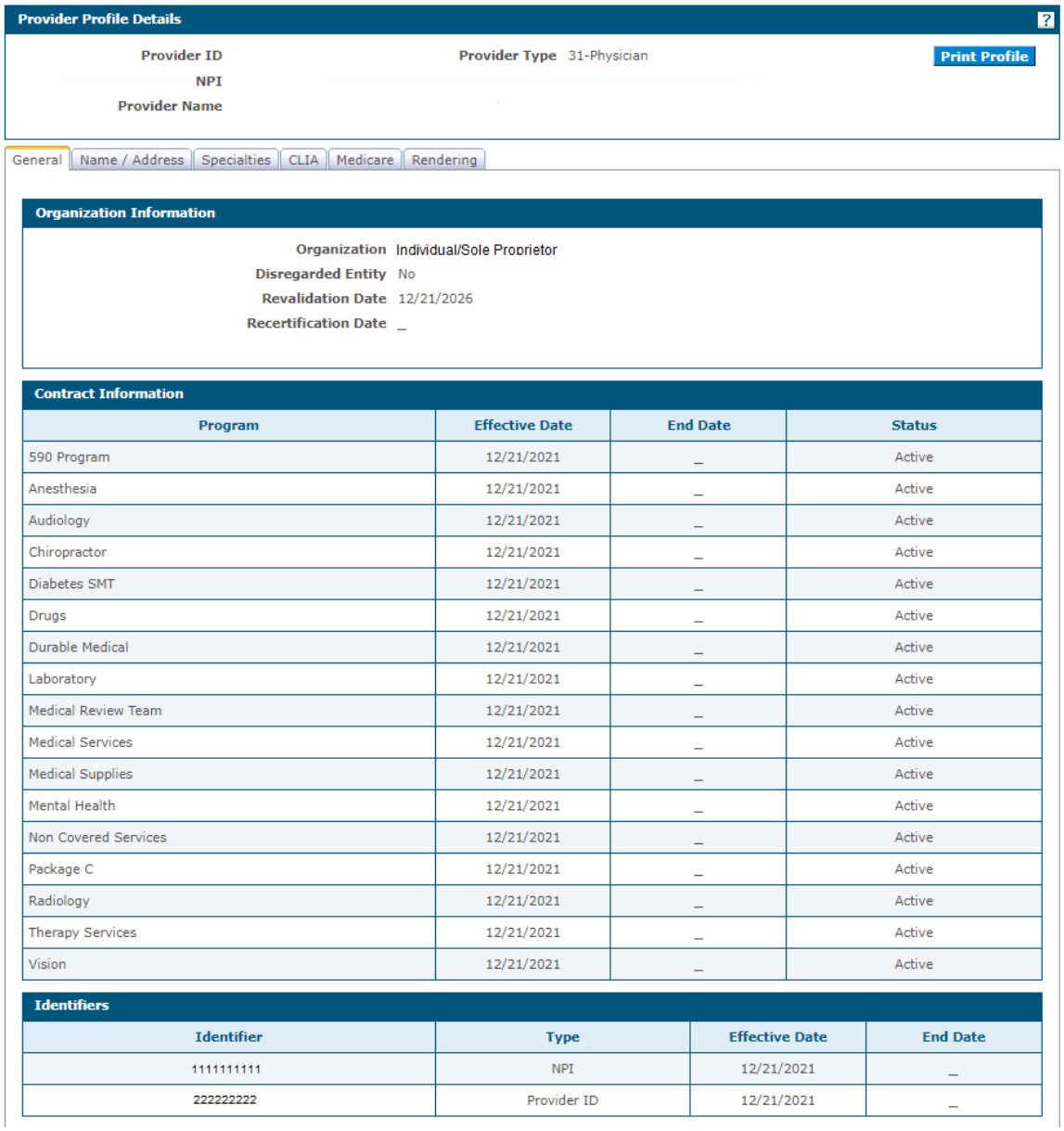
> *Note: To view provider profile information in the IHCP Portal, registered delegates must have the appropriate permission assigned to their account.*

The following provider information is viewable in the portal under *Provider Profile Details*:

- Current and historical NPI and IHCP Provider ID information
- Organizational structure
- Whether the provider is a disregarded entity
- Revalidation date, when applicable
- Recertification dates, when applicable
- Current and historical contract and program information with start and end dates
- When viewing a group's profile – Rendering provider information, such as primary medical provider (PMP) information and the start and end dates of current and historical rendering linkages
- When viewing a rendering provider's profile – Current and historical group linkages for the rendering provider
- All address information associated with the IHCP Provider ID
- Current taxonomy codes
- Current and historical license information
- Current and historical CLIA information
- Current Medicare participation information

Not all items in the preceding list are applicable for all providers, and additional information may also be displayed in the provider profile, depending on the provider type and classification.

Figure 11 – Provider Profile Details



Provider Profile Details

Provider ID
NPI
Provider Name
Provider Type 31-Physician
Print Profile

General | Name / Address | Specialties | CLIA | Medicare | Rendering

Organization Information

Organization Individual/Sole Proprietor
Disregarded Entity No
Revalidation Date 12/21/2026
Recertification Date _

Contract Information

Program	Effective Date	End Date	Status
590 Program	12/21/2021	_	Active
Anesthesia	12/21/2021	_	Active
Audiology	12/21/2021	_	Active
Chiropractor	12/21/2021	_	Active
Diabetes SMT	12/21/2021	_	Active
Drugs	12/21/2021	_	Active
Durable Medical	12/21/2021	_	Active
Laboratory	12/21/2021	_	Active
Medical Review Team	12/21/2021	_	Active
Medical Services	12/21/2021	_	Active
Medical Supplies	12/21/2021	_	Active
Mental Health	12/21/2021	_	Active
Non Covered Services	12/21/2021	_	Active
Package C	12/21/2021	_	Active
Radiology	12/21/2021	_	Active
Therapy Services	12/21/2021	_	Active
Vision	12/21/2021	_	Active

Identifiers

Identifier	Type	Effective Date	End Date
1111111111	NPI	12/21/2021	_
222222222	Provider ID	12/21/2021	_

Provider Maintenance Options

The **Provider Maintenance** link in the Provider section of the IHCP Portal's *My Home* page allows users to submit changes to the provider information reported to the IHCP.

The Provider Maintenance function is available to any user within the provider's organization who has been granted access to this function by the provider representative or an authorized delegate. To modify delegate access to these functions, see the instructions in the *Provider Healthcare Portal* module. It is the provider representative's responsibility ensure that Provider Maintenance access is granted to only the appropriate delegates. By limiting personnel who have access to this function, providers can prevent unauthorized changes to provider information. Providers should ensure that users do not share their user IDs and passwords.

At *My Home* page, click the **Provider Maintenance** link to view the *Provider Maintenance: Instructions* panel (Figure 12). If there are no pending requests, the *Current Maintenance Pending Requests* section displays the message: *There are no Pending Maintenance Requests to show*. If there are pending requests, a message will appear indicating pending requests and the section associated with the pending requests will appear grayed out and cannot be accessed until updates are finalized.

Table 1 provides information about the options available from this panel. See the *Provider Profile Maintenance Details* section for details about these options.

Figure 12 – Provider Maintenance: Instructions

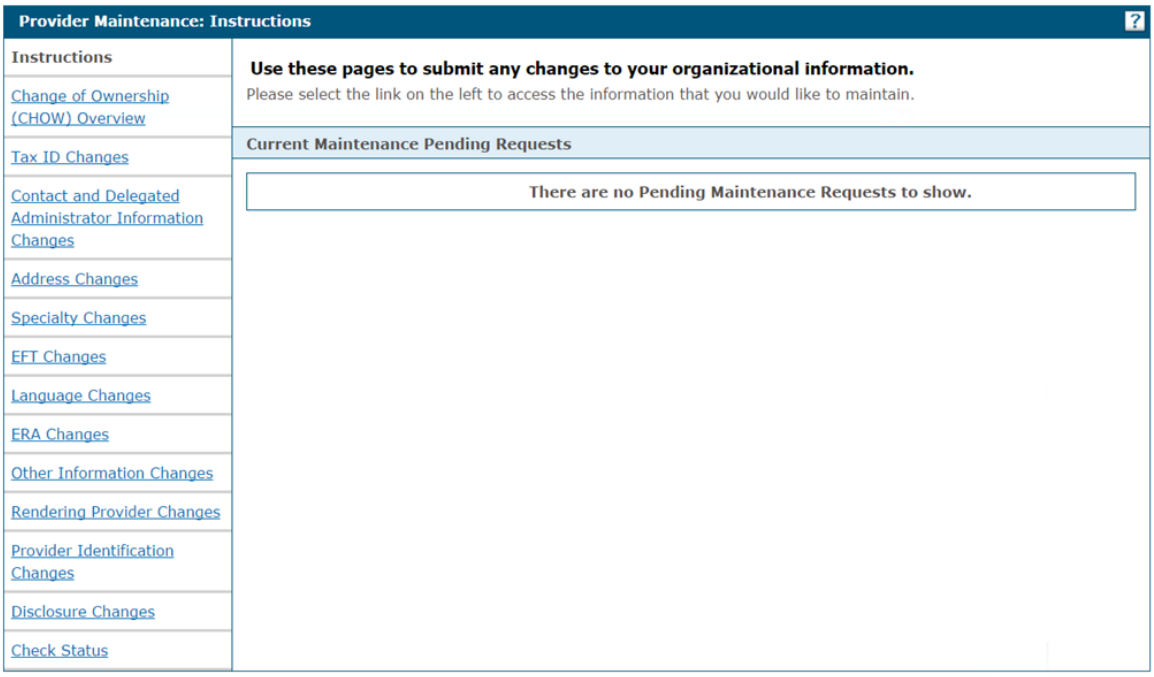


Table 1 – Provider Maintenance Options

Maintenance Options	Description
Change of Ownership (CHOW) Overview	Provides information about how to report a change of ownership (CHOW). *Note: CHOWs cannot be reported via the Provider Maintenance option. Instead, to report a CHOW, providers must follow the instructions in the Change of Ownership section – or, for applicable extended care facilities, the CHOWs for Extended Care Facilities subsection.*
Tax ID Changes	Allows users to update the federal taxpayer identification number (TIN) – either Social Security number or employer identification number (EIN) – associated with their enrollment, as long as the change is not a change of ownership. Submission of a *W-9* is required when making the change. Also allows providers to update their disregarded entity status.
Contact and Delegated Administrator Information Changes	Allows maintenance of contact information and delegated administrators: • Contact information corresponds to the individual to be contacted with questions about this location. • Delegated administrators are the individuals entered (during initial IHCP enrollment) for paper submissions only. *This option is **not** related to the task of registering delegates in the IHCP Portal.*

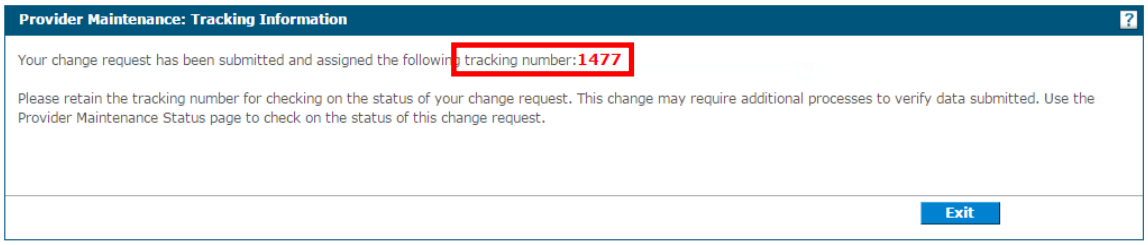
Maintenance Options	Description
Address Changes	Allows users to modify registered legal (home office), mail-to, pay-to and service location addresses. Changes to the legal address require submission of *W-9* and ***must exactly match*** the address reported to the IRS on the *W-9*. Dental providers can also use this option to indicate whether they are accepting new patients or patients with special needs.
Specialty Changes	Allows users to add or remove provider specialties and change primary specialty assignment. Restrictions apply for certain providers, such as transportation providers and specialties that are considered high- or moderate-risk.
Presumptive Eligibility Changes	Allows appropriate provider types to enroll as a qualified provider (QP) for the Presumptive Eligibility (PE) or Presumptive Eligibility for Pregnant Women (PEPW). Only certain specialties can enroll as qualified providers, and some are restricted to PEPW only. For more information, see the *Presumptive Eligibility* module.
EFT Changes	Allows users to enroll in electronic funds transfer (EFT) or change existing EFT information. It takes approximately 18 days for the bank to process and completely establish an EFT account. If claims are paid before an EFT is active, paper checks will be mailed to the *pay-to* address on file.
Language Changes	Allows users to add languages for which they are able to interpret. This field is not required.
ERA Changes	Allows users to sign up to receive claim payment information using electronic remittance advice (ERA) 835 transactions. If ERA 835 transactions are to be electronically exchanged, an account should be established using this page within the maintenance application.
Other Information Changes	Allows applicable providers to indicate special information such as: • Participation in the 590 Program or Medical Review Team (MRT) • Use of 340B stock • Whether they offer mental health and/or substance use disorder services • Whether they are accepting new dental patients and their ability to serve special-needs populations The access to change or view these options will only appear to providers whose type and specialty are appropriate.
Rendering Provider Changes	Allows group users to add or remove rendering providers linked to the group provider.

Maintenance Options	Description
Provider Identification Changes	Allows users to change provider identification data, which includes: • Provider name (as recognized by the IRS for tax purposes) • Doing business as (DBA)/service location name • Organizational structure • NPI • Taxonomy • Licensure and certificate information, including Clinical Laboratory Improvement Amendments (CLIA) certification • Medicare participation • Patient population • Drug Enforcement Agency (DEA) information • Insurance information, auto registration information and driver's license attestations (for applicable transportation specialties) These changes are not intended to report the sale or transfer of ownership of the enrolled entity.
Disclosure Changes	Allows users to report any new or departing owners, board members or managers and maintain address information for all disclosed individuals (owners and managers, individuals, and corporations). Also allows users to update disregarded entity, TIN, and percentage of ownership information for entities with an ownership or controlling interest, when applicable. Do not use the *Disclosure Changes* link to report CHOW information.
Check Status	Allows users to check the status of their change request using the tracking number assigned during the submission process and the provider's federal taxpayer identification number (TIN) – EIN or SSN.

Check Status

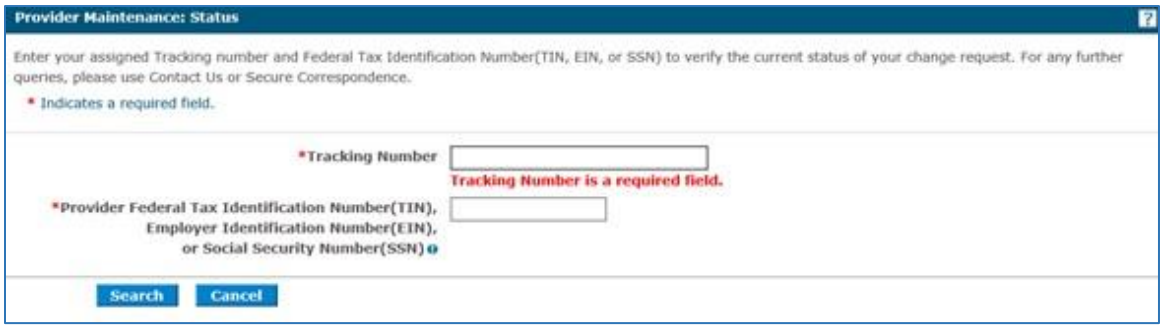
Each time a provider maintenance change request is submitted, a tracking number is assigned. Be sure to make a note of the tracking number for future reference, so that you can check the status of your request.

Figure 13 – Provider Maintenance: Tracking Information



To check the status of your request, click **Check Status** from the left menu of the *Provider Maintenance Instructions* page and enter the tracking number and the TIN (EIN or SSN).

Figure 14 – Provider Maintenance: Status



Submitting Provider Profile Updates by Mail

IHCP provider packets and profile maintenance forms are available for providers that choose to update their information by mail rather than via the IHCP Portal. Updates submitted by mail using anything other than the appropriate forms are not accepted and are returned to the provider. An authorized owner or officer of the company must sign the form.

Updates may be made using the applicable IHCP provider packet and following the instructions for updating an existing enrollment. Alternatively, the provider profile maintenance (update) forms enable providers to request very specific changes to their current information on file without having to submit an entire enrollment packet. The following maintenance forms are available on the *Update Your Provider Profile* page at in.gov/medicaid/providers:

- *IHCP Rendering Provider Agreement* is used when a group provider revalidates using paper forms. The group does not need to revalidate all rendering providers linked to the group. However, the group's revalidation packet must include an updated, signed *IHCP Rendering Provider Agreement* for each rendering provider actively linked to the group at the time of revalidation.
- *IHCP Rendering Provider Tax ID / Date of Birth Maintenance Form* is used for rendering providers that enrolled before the IHCP instituted a requirement that all practitioners who enroll with the IHCP as rendering providers must include their own Social Security number (SSN) and their date of birth in their IHCP provider profile. Rendering providers cannot establish accounts on the IHCP Portal for online transactions without their SSN and date of birth on file.
- *IHCP Provider CLIA Certificate Maintenance Form* is only used when there is a change to the level of CLIA certification a provider has been granted.
- *IHCP Provider Delegated Administrator Addendum/Maintenance Form* is used to grant, change or revoke authority for a specific individual to sign and submit certain documents on behalf of the provider. The form contains a list of the documents for which authority may be delegated.
- *IHCP Provider Disenrollment Form* is used to voluntarily disenroll from the IHCP.
- *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form* is used to request EFT instead of paper checks or to change direct-deposit information.
- *IHCP Provider Enrollment Recertification of Licenses and Certifications Form* is used for providers that are required to recertify their enrollment credentials to continue to be enrolled with the IHCP. The recertification form must be accompanied by supporting documentation as indicated on the *IHCP Provider Enrollment Type and Specialty Matrix*.
- *IHCP Provider Medicare Number Maintenance Form* is used to update Medicare numbers.
- *IHCP Provider Name and Address Maintenance Form* is used to update any of the four address types (service location, home office [legal], mail-to or pay-to) and for a change of provider name or doing business as (DBA) name that is not the result of a change of ownership.

- *IHCP Provider Ownership and Managing Individual Maintenance Form* is used to report ownership changes (business and individuals) and changes of managing individuals in instances such as a change in board members, officers or directors; a partner buyout; or the death of an owner. This form includes a section that mirrors *Schedule C – Disclosure Information* in the provider packet for billing and group providers. (*Note: This form is not appropriate if the ownership change is the result of the business entity undergoing a financial transaction such as a sale or merger.*)
- *IHCP Provider Specialty Maintenance Form* is used to request a change to the specialty.
- *IHCP Provider Taxpayer Identification Number Maintenance Form* is used to make a change to the TIN when it is not related to a change in ownership or transfer of assets.
- *IHCP MRO Clubhouse Provider Enrollment Addendum* is used to make changes to the disclosed individuals associated with a rendering MRO Clubhouse provider organization. This form applies to clubhouse providers rendering services through an IHCP-enrolled MRO provider.
- *IHCP PRTF Attestation Letter/Maintenance Form* is used for the "Psych Under 21 Rule" that requires PRTF facilities to provide attestations of compliance each year by July 21 (or by the next business day if July 21 falls on a weekend or holiday). This form applies only to provider type 03 – *Extended Care Facility*, specialty 034 – *Psychiatric Residential Treatment Facility*. Use this form when submitting the annual attestation.

To submit an update for which no stand-alone form exists, you must submit your updates using the appropriate *IHCP Provider Enrollment and Profile Maintenance Packet* and indicate **Profile Update** for the Type of Request (in *Section A*). The IHCP provider packet can also be used to make multiple updates in a single submission. For example, providers would use the packet specified by their provider type and classification to report an address change, a new EFT account and Medicare numbers at the same time.

For certain enrollment updates, an updated *W-9* form is also required. See the *W-9 Form Requirements* section for details.

Send all IHCP provider packets and profile maintenance forms, along with any required attachments, to the following address:

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

Provider Profile Maintenance Details

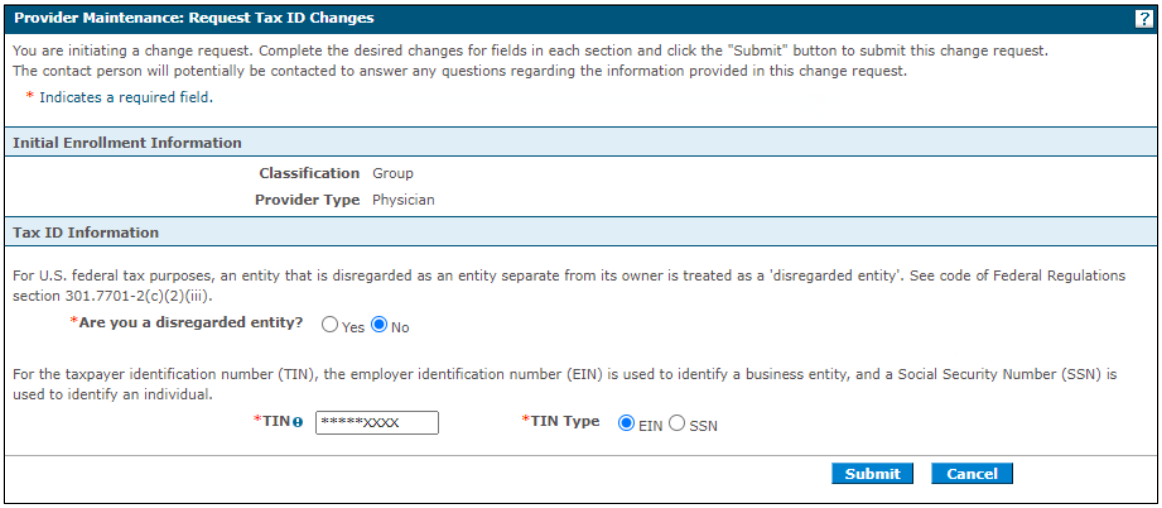
Providers must report any changes to their information on file to the IHCP. Most provider updates can be made through the IHCP Portal (for registered portal users with appropriate permissions). Some changes may require users to submit or upload additional supporting documentation before the change is finalized in the system.

Taxpayer Identification Changes

Providers must report a change to their TIN (Social Security number [SSN] or federal employer identification number [EIN]), either by mail, using the *IHCP Provider Taxpayer Identification Number Maintenance Form*, or via the *Provider Maintenance* page of the IHCP Portal are as follows:

1. Select the **Tax ID Changes** link to access the *Provider Maintenance: Request Tax ID Changes* panel (Figure 15).
2. Enter the new number.
3. Select either EIN or SSN.
4. Click **Submit**.

Figure 15 – Provider Maintenance: Request Tax ID Changes



The *Provider Maintenance: Request Tax ID Changes* panel also allows providers to update their response to the question of whether they are a disregarded entity recognized by the IRS. See the *Disregarded Entities* section in this module for special instructions related to disregarded entity enrollments.

For all TIN changes, whether submitted by IHCP Portal or by mail, providers are required to submit a *W-9* verifying the new EIN or SSN provided. A copy of the IRS TIN registration confirmation letter is required to support the new number.

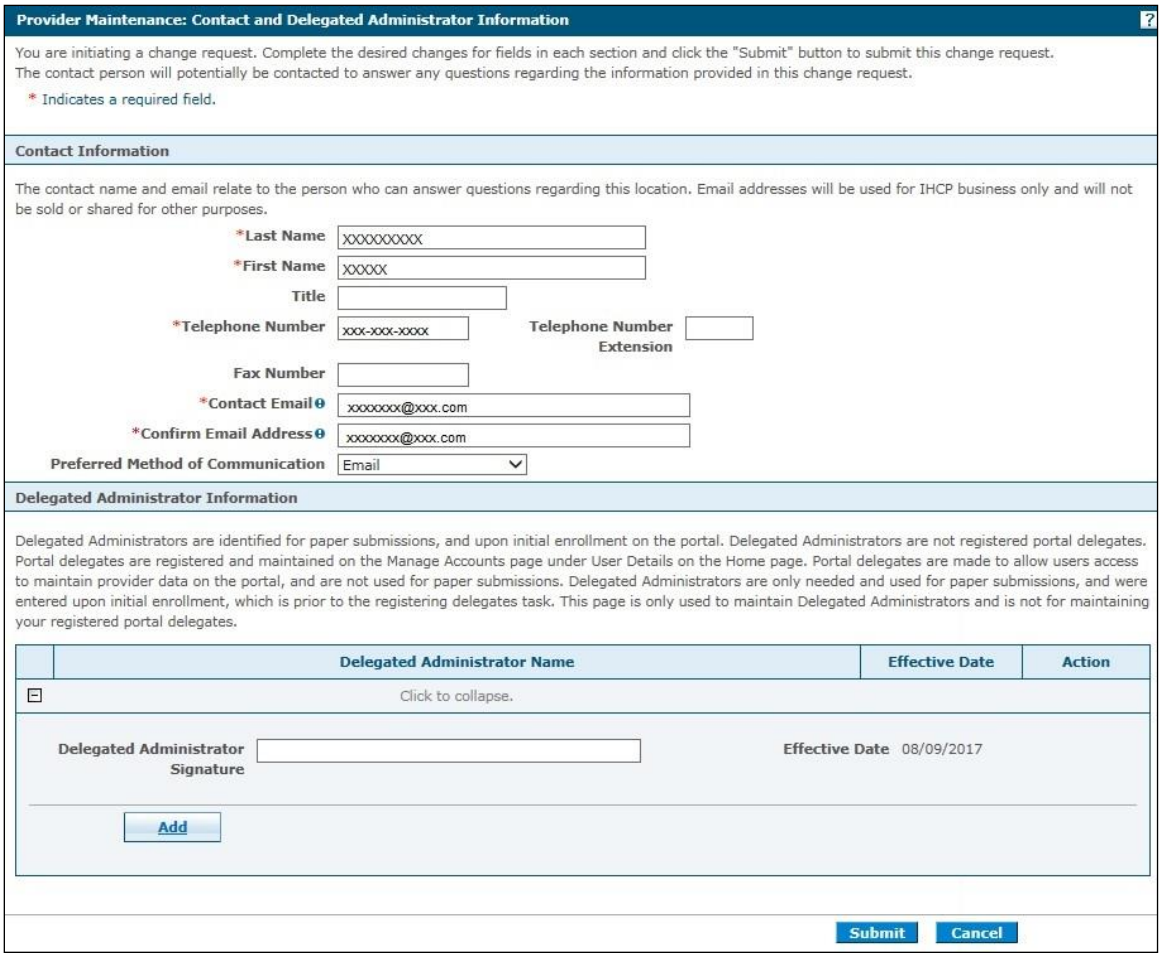
TIN changes resulting from a change of ownership (CHOW) require completion of a new IHCP enrollment application. See the *Change of Ownership* section.

Contact and Delegated Administrator Information Changes

IHCP providers can grant, change or revoke authority for a specific individual to sign and submit certain documents on behalf of the provider. Delegated administrator information may be submitted by mail, using the *IHCP Provider Delegated Administrator Addendum/Maintenance Form*, or via the IHCP Portal by selecting the **Contact and Delegated Administrator Information Changes** link on the *Provider Maintenance* page and making changes as instructed.

> *Note: A delegated administrator is an individual that the provider designates, during initial IHCP enrollment, as having the authority to submit provider profile updates **by mail** on the provider's behalf. This option is **not** related to the task of registering delegates in the portal to submit updates online.*

Figure 16 – Provider Maintenance: Contact and Delegated Administrator Information



Address Changes

It is extremely important that address information is current, because out-of-date address information can affect provider payment and receipt of program-related correspondence. The IHCP Provider Enrollment Unit maintains four addresses on file for each billing provider or group provider service location. The four addresses and their uses are listed in Table 2. All addresses must be current to avoid returned mail.

Providers that fail to maintain their address information are subject to termination if mail is returned to the IHCP Provider Enrollment Unit without a forwarding address. Provider Enrollment uses forwarding addresses to request an address update from providers, not to update information in *Core*MMIS.

Table 2 – Provider Enrollment File Addresses

Address Name	Description
Legal	Home office/owner address (such as corporate office or headquarters), as recognized by the IRS. Used for the following correspondence: • 1099s • IRS information
Mail To	Address used for the following correspondence: • Provider update and enrollment confirmation letters • Recertification Notice • Revalidation Notice • PMP disenrollment letters • Special correspondence
Pay To	Address to which IHCP payments are sent
Service Location	Physical location where services are rendered or claim documentation can be reviewed. *Note: The service location nine-digit ZIP Code is also used in the billing provider NPI crosswalk process for claim submission.*

If a provider's pay-to address is not up to date, resulting in a check being mailed to the wrong address, Gainwell will not send a replacement check to the provider until the pay-to address is updated in *Core*MMIS.

*Important: Any changes to the legal (home office) address reported to the IHCP require the submission of a W-9 showing the same change was reported to the IRS. Updated W-9 forms **must** be submitted using the version of the W-9 currently posted on the IRS website. Providers should go to the IRS website each time a new W-9 form is needed to make sure the correct version is being submitted.*

*If an existing provider's home office moves, the provider must separately update the legal (home office) address including submitting an updated W-9 form , for **each** affected IHCP-enrolled service location.*

The Address Changes section also allows dental providers to update information about whether they are accepting new patients and whether their facility can accommodate patients with various special needs.

Update an Address

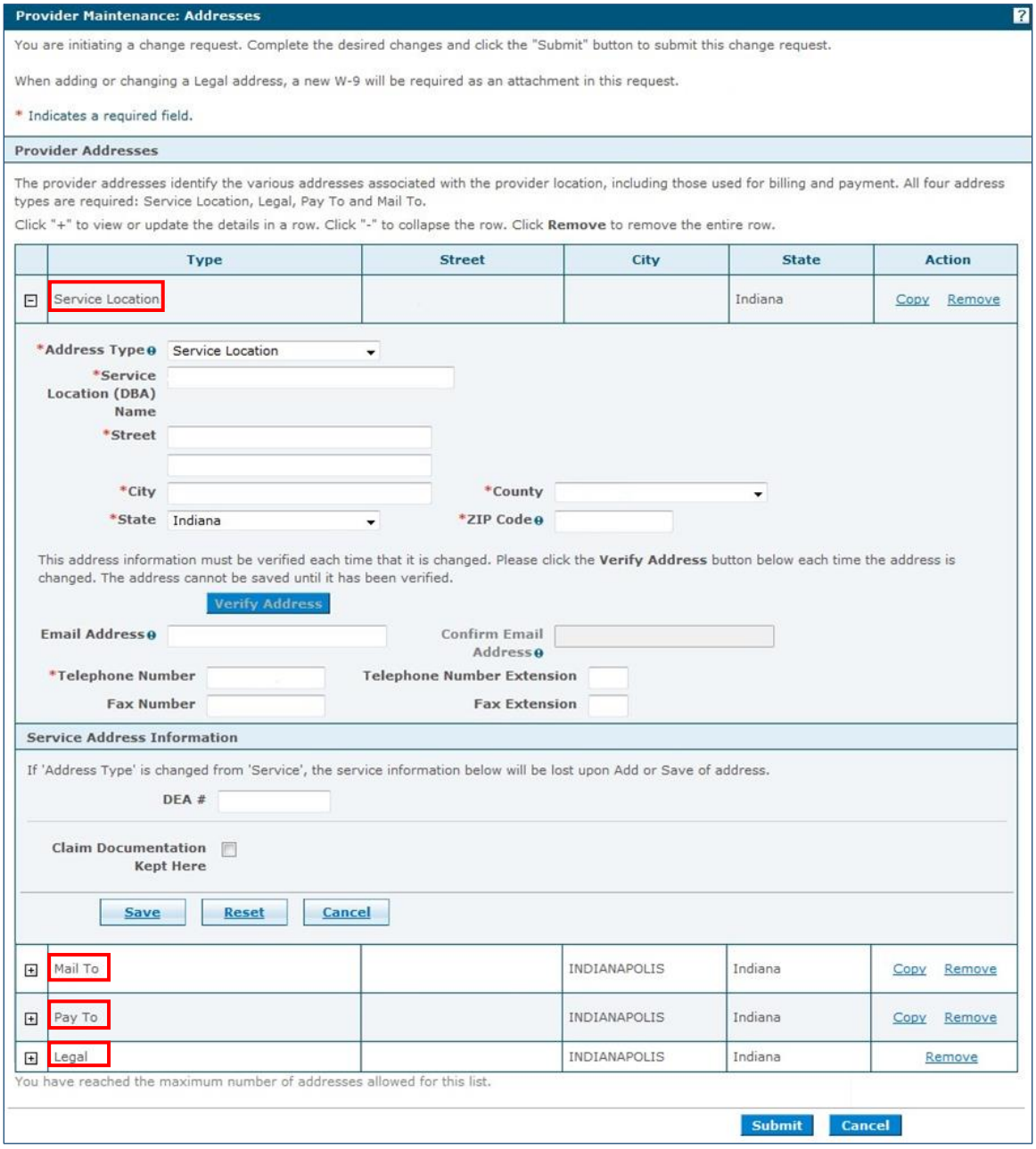
To ensure that their address information in *Core*MMIS is regularly maintained, providers can submit updates by mail, using the *IHCP Provider Name and Address Maintenance Form*, or online via the IHCP Portal's *Provider Maintenance* page as follows:

1. Select the **Address Changes** link to access the *Provider Maintenance: Addresses* panel (Figure 17).
2. Click the plus sign (+) to the left of each address type to view or change the details for the addresses on file:
   - Mail To
   - Pay To
   - Legal (home office)
   - Service Location

All four addresses are required.

> *Note: To add an additional service location for a billing provider, or to entirely remove a service location, providers must follow the instructions in the following sections.*

Figure 17 – Provider Maintenance: Addresses
(With Service Location Address Expanded)



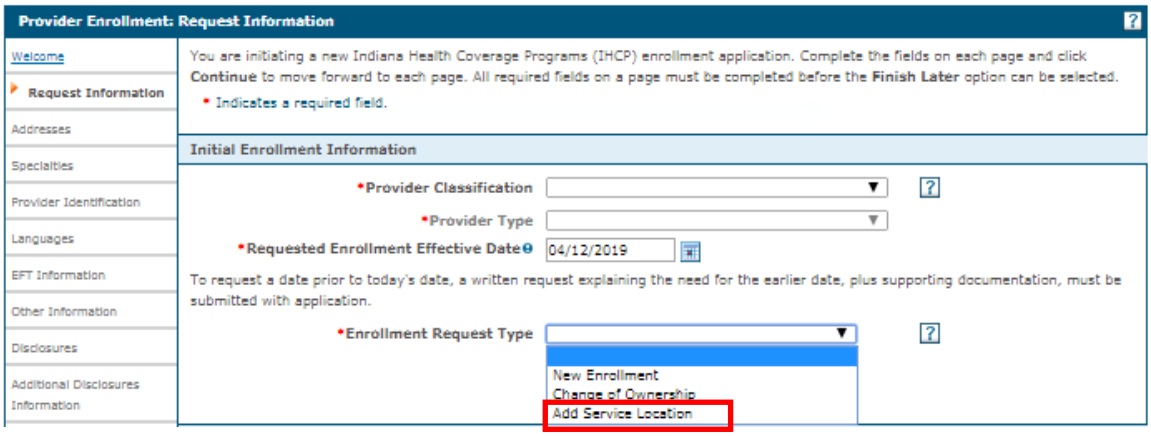
Add a Service Location (Practice Site)

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

To add a new service location, follow instructions for new enrollment, except as follows:

- On the IHCP Portal, select **Add a Service Location** for Enrollment Request Type (see Figure 18).
- In the provider packet, select **New Service Location** in the *Type of Request* section of Schedule A.

Figure 18 – Adding New Service Location



Close a Service Location

To disenroll a service location, providers may either use the Disenroll link on the IHCP Portal's *My Home* page (if they are registered portal users) or submit an *IHCP Provider Disenrollment Form*. If submitting the disenrollment by mail, providers should indicate on the form which service location they want to deactivate. An authorized official listed in section C.1 or C.3 of Schedule C must sign the form to ensure processing. Failure to indicate the request type or to include an authorized official's signature will result in the return of the document.

If the service location has active PMPs linked to it, the provider must contact the appropriate MCE to complete the PMP disenrollment before being able to deactivate a location.

Specialty Changes

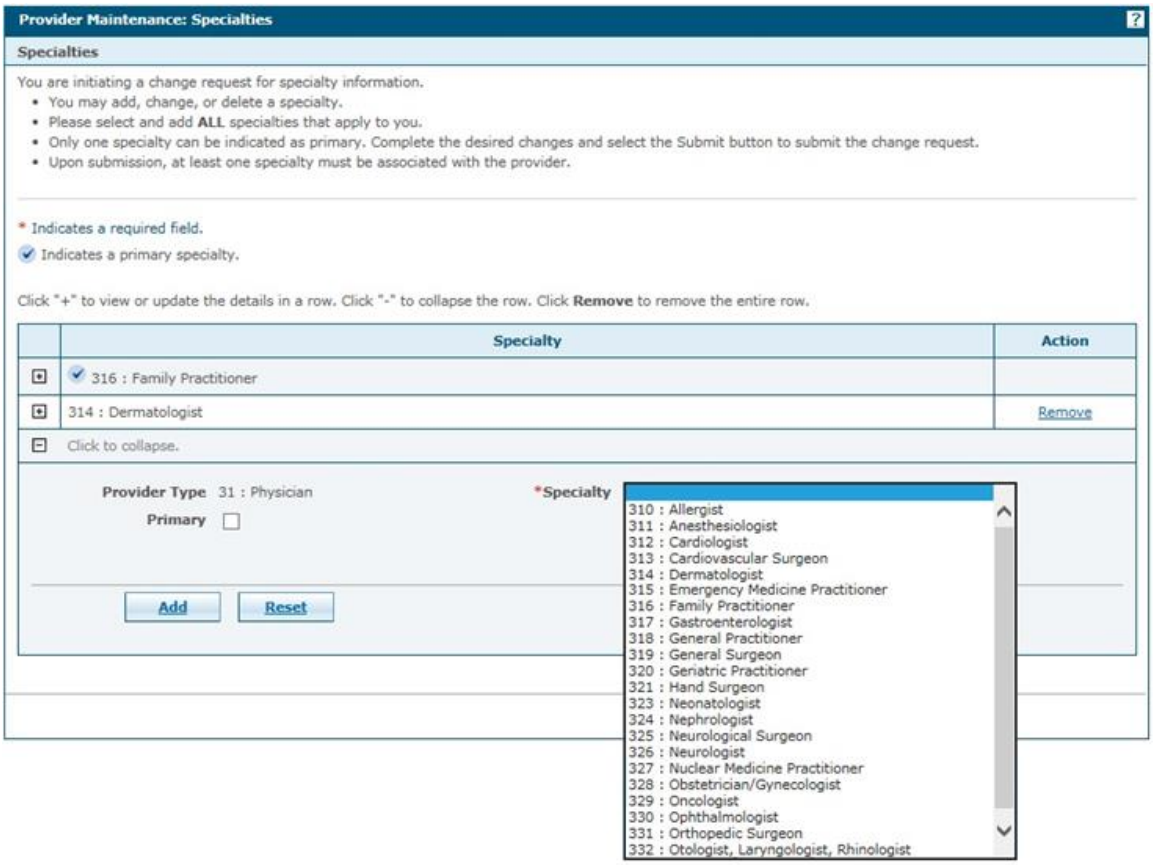
Providers can add or remove a specialty, as well as change their primary specialty assignment. See the *IHCP Provider Enrollment Type and Specialty Matrix* for enrollment requirements for each provider type and specialty.

> *Note: Specialty changes are not permitted for certain providers, such as transportation providers or specialties that are considered high- or moderate-risk.*

Changes to a specialty can be made online using the **Specialty Changes** option on the *Provider Maintenance* page of the IHCP Portal, or by mail using the *IHCP Provider Specialty Maintenance Form*.

Figure 19 shows a physician provider specialty being added on the portal.

Figure 19 – Provider Maintenance: Specialties



Presumptive Eligibility Changes

To enroll as a qualified provider (QP) for the Presumptive Eligibility (PE) process, providers must be registered IHCP Portal users. To initiate the QP enrollment process, go to the *Provider Maintenance* page, select **Presumptive Eligibility Changes** and complete the fields as instructed.

Not all provider types and specialties are eligible to enroll as a QP. Additionally, depending on provider type and specialty, a provider may have the option to enroll as a QP for all PE determinations or for Presumptive Eligibility for Pregnant Women (PEPW) only. See the *Presumptive Eligibility* module for more information and instructions.

Existing QPs can terminate their QP status by selecting the appropriate check box.

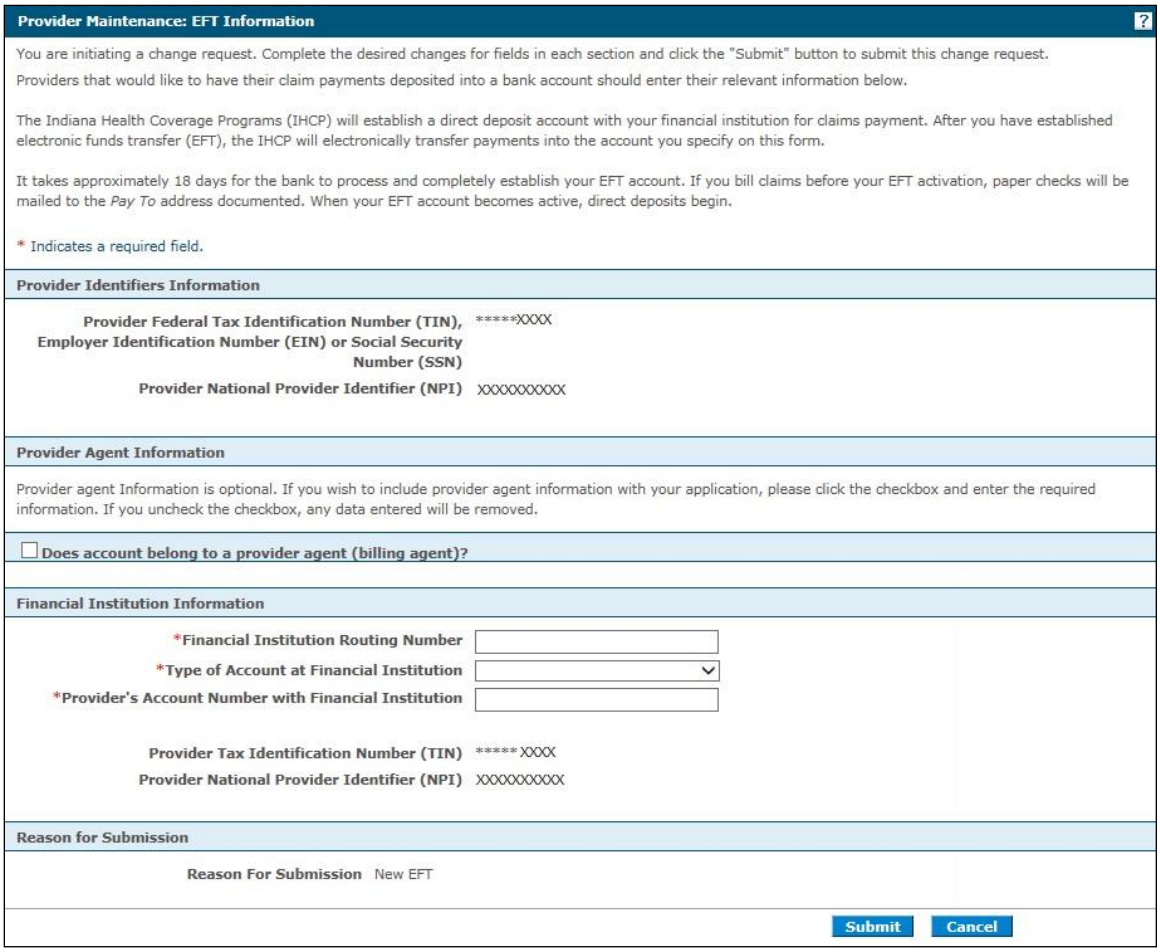
Electronic Funds Transfer Changes

Changes that affect a provider's account and routing number must be reported to avoid a failed electronic funds transfer of claim payments. To ensure the accuracy of EFT information in *Core*MMIS, billing providers initiating or changing EFT information must submit the information via the IHCP Portal (by selecting the **EFT Changes** option on the *Provider Maintenance* page) or by mail, using the *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form*.

Figure 20 shows the *Provider Maintenance: EFT Information* panel of the portal. To authorize the IHCP to establish a direct deposit account for electronic funds transfers, or to change account information for an existing direct deposit account, complete all information as instructed.

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

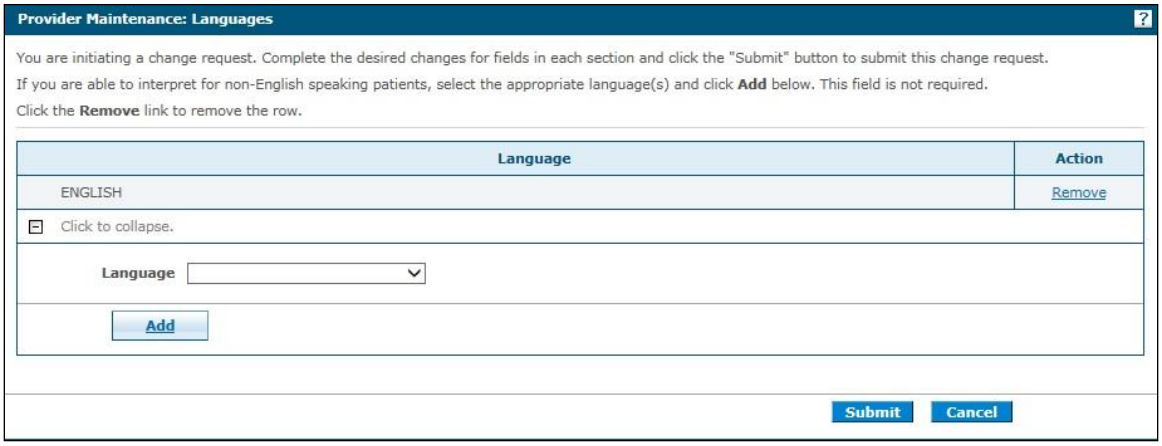
Figure 20 – Provider Maintenance: EFT Information



Language Changes

To add or remove languages that a service location is able to interpret for non-English-speaking patients, including American Sign Language (ASL) interpretation, select the **Language Changes** link on the *Provider Maintenance* page of the IHCP Portal and make changes as instructed.

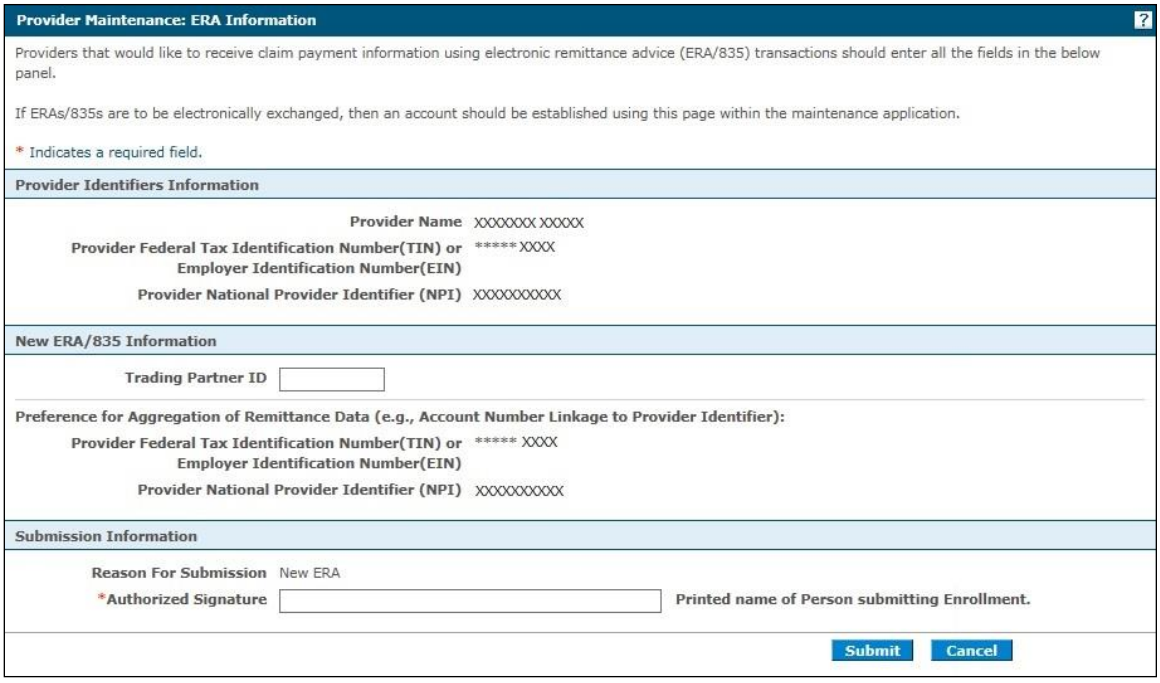
Figure 21 – Provider Maintenance: Languages



Electronic Remittance Advice Changes

To sign up to receive electronic remittance advice (ERA) as an 835 transaction, cancel receipt of 835 transactions or make related changes, providers must be registered IHCP Portal users. From the *Provider Maintenance* page, select the **ERA Changes** link and enter information as instructed.

Figure 22 – Provider Maintenance: ERA Information



Other Information Changes

IHCP providers can update their enrollment information regarding participation in the 590 Program, PASRR, or MRT and their use of 340B drug stock.

> *Note: Currently, all PASRR Level II services are being provided through a designated vendor. Therefore, the DDRS and DMHA are not contracting with any IHCP-enrolled providers to deliver this service at this time.*

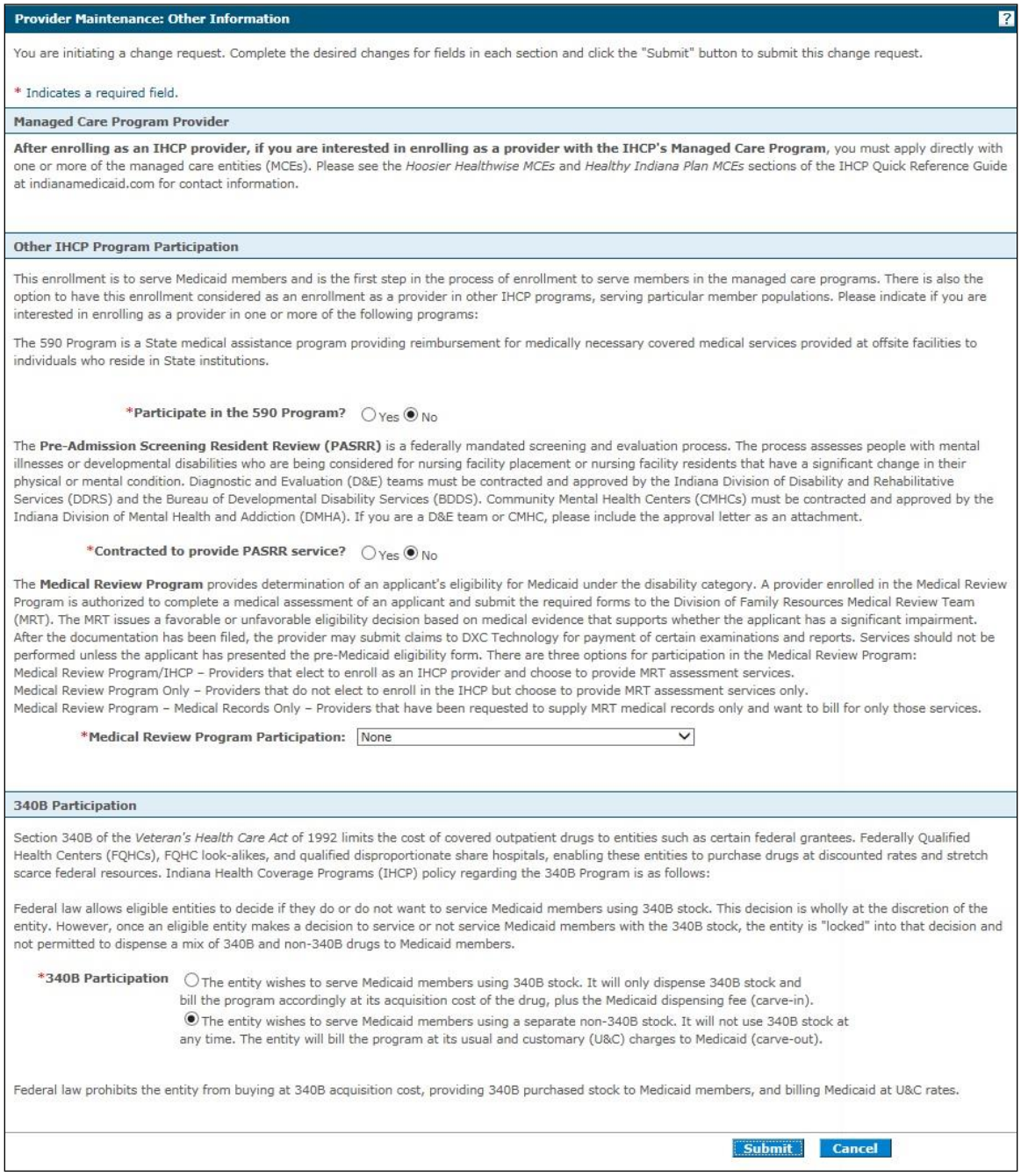
For behavioral health providers (provider type 11) to identify whether they provide substance use disorder (SUD)and/or mental health services. This information will be reflected in the IHCP Provider Locator, so that Medicaid members can search for and identify providers that offer SUD and mental health services. The IHCP Provider Locator is accessible from the homepage at in.gov/medicaid/providers.

Updates to any of this information can be made online or by mail, as follows:

- To make these updates on the IHCP Portal, select the **Other Information Changes** link from the *Provider Maintenance* page and make changes as instructed (see Figure 23).
- To make the changes by mail, submit the appropriate IHCP provider packet completed as follows:
  - Select **Profile Update** in the *Type of Request* section (in Schedule A).
  - Complete the *Provider Information* section (in Schedule A).
  - Go to the *Other IHCP Program Participation* or *Mental Health and Substance Use Disorder Services* section (in Schedule B) and select the appropriate options.

Not all options are available to all provider types, and additional documentation may be required. See the *Provider Enrollment in the Medical Review Team Program* section for more information.

Figure 23 – Provider Maintenance: Other Information



Provider Maintenance: Other Information

You are initiating a change request. Complete the desired changes for fields in each section and click the "Submit" button to submit this change request.

* Indicates a required field.

Managed Care Program Provider

After enrolling as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's Managed Care Program, you must apply directly with one or more of the managed care entities (MCEs). Please see the *Hoosier Healthwise MCEs* and *Healthy Indiana Plan MCEs* sections of the IHCP Quick Reference Guide at indianamedicaid.com for contact information.

Other IHCP Program Participation

This enrollment is to serve Medicaid members and is the first step in the process of enrollment to serve members in the managed care programs. There is also the option to have this enrollment considered as an enrollment as a provider in other IHCP programs, serving particular member populations. Please indicate if you are interested in enrolling as a provider in one or more of the following programs:

The 590 Program is a State medical assistance program providing reimbursement for medically necessary covered medical services provided at offsite facilities to individuals who reside in State institutions.

*Participate in the 590 Program? ○ Yes ◉ No

The **Pre-Admission Screening Resident Review (PASRR)** is a federally mandated screening and evaluation process. The process assesses people with mental illnesses or developmental disabilities who are being considered for nursing facility placement or nursing facility residents that have a significant change in their physical or mental condition. Diagnostic and Evaluation (D&E) teams must be contracted and approved by the Indiana Division of Disability and Rehabilitative Services (DDRS) and the Bureau of Developmental Disability Services (BDDS). Community Mental Health Centers (CMHCs) must be contracted and approved by the Indiana Division of Mental Health and Addiction (DMHA). If you are a D&E team or CMHC, please include the approval letter as an attachment.

*Contracted to provide PASRR service? ○ Yes ◉ No

The **Medical Review Program** provides determination of an applicant's eligibility for Medicaid under the disability category. A provider enrolled in the Medical Review Program is authorized to complete a medical assessment of an applicant and submit the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT issues a favorable or unfavorable eligibility decision based on medical evidence that supports whether the applicant has a significant impairment. After the documentation has been filed, the provider may submit claims to DXC Technology for payment of certain examinations and reports. Services should not be performed unless the applicant has presented the pre-Medicaid eligibility form. There are three options for participation in the Medical Review Program:
Medical Review Program/IHCP – Providers that elect to enroll as an IHCP provider and choose to provide MRT assessment services.
Medical Review Program Only – Providers that do not elect to enroll in the IHCP but choose to provide MRT assessment services only.
Medical Review Program – Medical Records Only – Providers that have been requested to supply MRT medical records only and want to bill for only those services.

*Medical Review Program Participation: None

340B Participation

Section 340B of the *Veteran's Health Care Act* of 1992 limits the cost of covered outpatient drugs to entities such as certain federal grantees. Federally Qualified Health Centers (FQHCs), FQHC look-alikes, and qualified disproportionate share hospitals, enabling these entities to purchase drugs at discounted rates and stretch scarce federal resources. Indiana Health Coverage Programs (IHCP) policy regarding the 340B Program is as follows:

Federal law allows eligible entities to decide if they do or do not want to service Medicaid members using 340B stock. This decision is wholly at the discretion of the entity. However, once an eligible entity makes a decision to service or not service Medicaid members with the 340B stock, the entity is "locked" into that decision and not permitted to dispense a mix of 340B and non-340B drugs to Medicaid members.

*340B Participation
○ The entity wishes to serve Medicaid members using 340B stock. It will only dispense 340B stock and bill the program accordingly at its acquisition cost of the drug, plus the Medicaid dispensing fee (carve-in).
◉ The entity wishes to serve Medicaid members using a separate non-340B stock. It will not use 340B stock at any time. The entity will bill the program at its usual and customary (U&C) charges to Medicaid (carve-out).

Federal law prohibits the entity from buying at 340B acquisition cost, providing 340B purchased stock to Medicaid members, and billing Medicaid at U&C rates.

Submit Cancel

> *Note: The IHCP does not cover drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies. This policy applies to the fee-for-service (FFS) pharmacy benefit. Questions regarding 340B policies of the managed care entities (MCEs) should be referred directly to the MCEs. See the Pharmacy Services module for more information.*

Rendering Provider Changes

Group practices must submit enrollment applications and updates for their rendering providers. Groups report changes to their rendering providers' status in addition to requests to enroll new rendering members. A current and active license is required for all rendering providers. The group must submit documentation that shows participation in either program for their rendering providers that apply for enrollment in the IHCP.

The IHCP policy requires rendering providers to be linked to each specific group service location where they render services. The IHCP Provider Enrollment Unit links new rendering providers to the appropriate service locations (practice sites) or terminates linkage when requested. If a rendering provider's services are billed for a service location to which the provider is not linked, the remittance advice (RA) for the claim will indicate EOB 1010 – *Rendering provider is not an eligible member of billing group or the group provider number is reported as rendering provider. Please verify provider and resubmit*. These claims will be systematically denied and providers will need to correct the linkage and resubmit the claim. Group providers should review their provider profiles to ensure that each group location has the correct rendering providers linked with accurate effective and end dates.

Rendering provider changes can be made on the IHCP Portal or by mail. Only registered group providers (or their authorized delegates) can access and make changes to the *Provider Maintenance: Rendering Providers* page.

Add Rendering Providers to a Group

Group providers must ensure that rendering providers are linked to each service location where they render services for the group practice:

- To add a linkage via the IHCP Portal, group providers use the **Rendering Provider Changes** option on the *Provider Maintenance* page. New rendering providers must first be enrolled in the IHCP before they can be linked to a group on the portal.
- To add a linkage via mail, group providers must submit the *IHCP Rendering Provider Enrollment and Profile Maintenance Packet*. Group providers may use this form to add a newly enrolling or currently enrolled rendering provider to their service locations. When adding new rendering providers to a group, the rendering provider's start date at the service location is indicated on Schedule B of the packet. Requests to enroll group members must be signed by an individual identified in section C.1 or C.3 of Schedule C in the group's packet.

Portal Instructions for Linking Rendering Providers to Group Service Locations

Only rendering providers that are already actively enrolled in the IHCP can be added (linked) to the group service location. If a group provider wants to add a rendering provider that is not yet enrolled in the IHCP, the group provider must enroll the rendering provider through the Provider Enrollment function on the IHCP Portal.

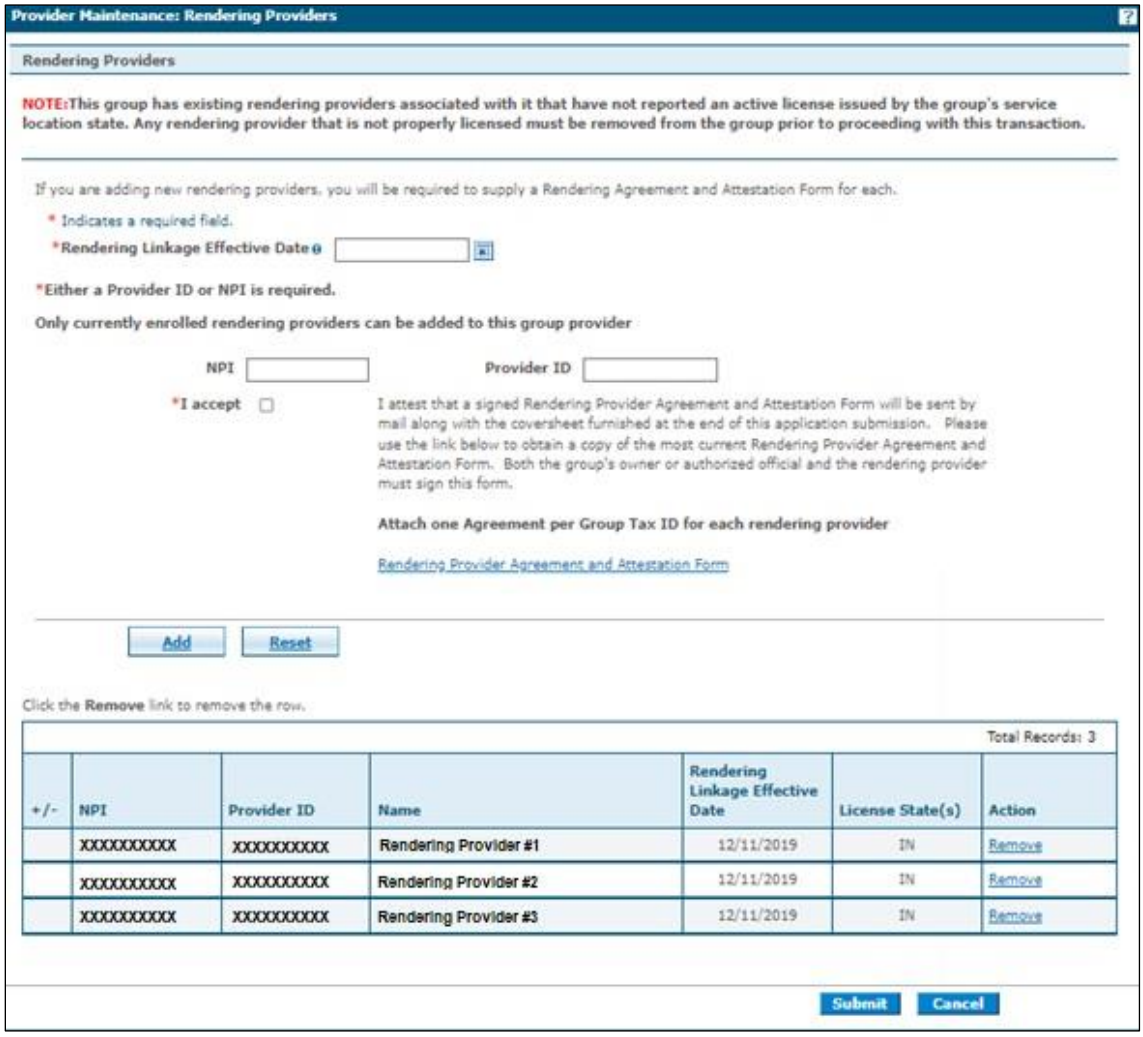
An IHCP-enrolled rendering provider can be linked to multiple service locations in a single portal transaction. The following parameters apply:

- The user submitting the transaction must be an authorized delegate for provider maintenance tasks on the portal accounts for each of the affected group service locations included in the transaction.
- Rendering linkages in a single transaction may be to group locations operating under different TINs. A separate *IHCP Rendering Provider Agreement and Attestation Form* is required to support the linkages of **each individual rendering practitioner** to the group service locations operating under **each unique group TIN** included in the transaction.
- The effective date of the linkages for an individual rendering practitioner must be the same for each service location when they are submitted in a single transaction. Linkages for that practitioner that have different effective dates will require separate transactions. If more than one practitioner is linked in a single transaction, each additional practitioner can have a unique effective date associated with their linkages.

To add (link) an enrolled rendering provider to a group service location, follow these steps:

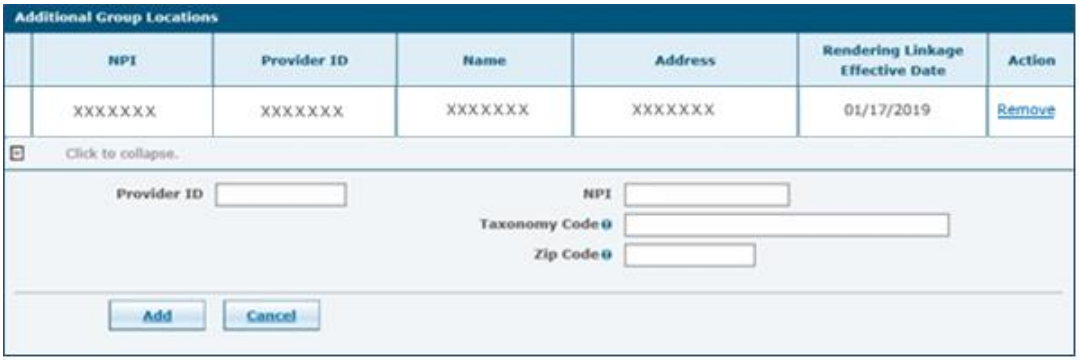
1. At the *Provider Maintenance: Rendering Providers* panel (Figure 24), enter an effective date in the Rendering Linkage Effective Date field.
2. Enter either an IHCP Provider ID or NPI for the rendering provider being added. (The Provider ID is preferred, but NPI is also an option. Waiver providers must enter a Provider ID and not an NPI.)
3. Select the **I Accept** check box to confirm that a signed *IHCP Rendering Provider Agreement and Attestation Form* will be uploaded or sent by mail (as described in steps 11–15).
4. Select the **Rendering Provider Agreement and Attestation Form** link and print the form.
5. Click **Add**.
6. To add that same rendering provider to *another* service location for the group, click the "+" button next to the newly added rendering provider's NPI.

Figure 24 – Provider Maintenance: Rendering Providers



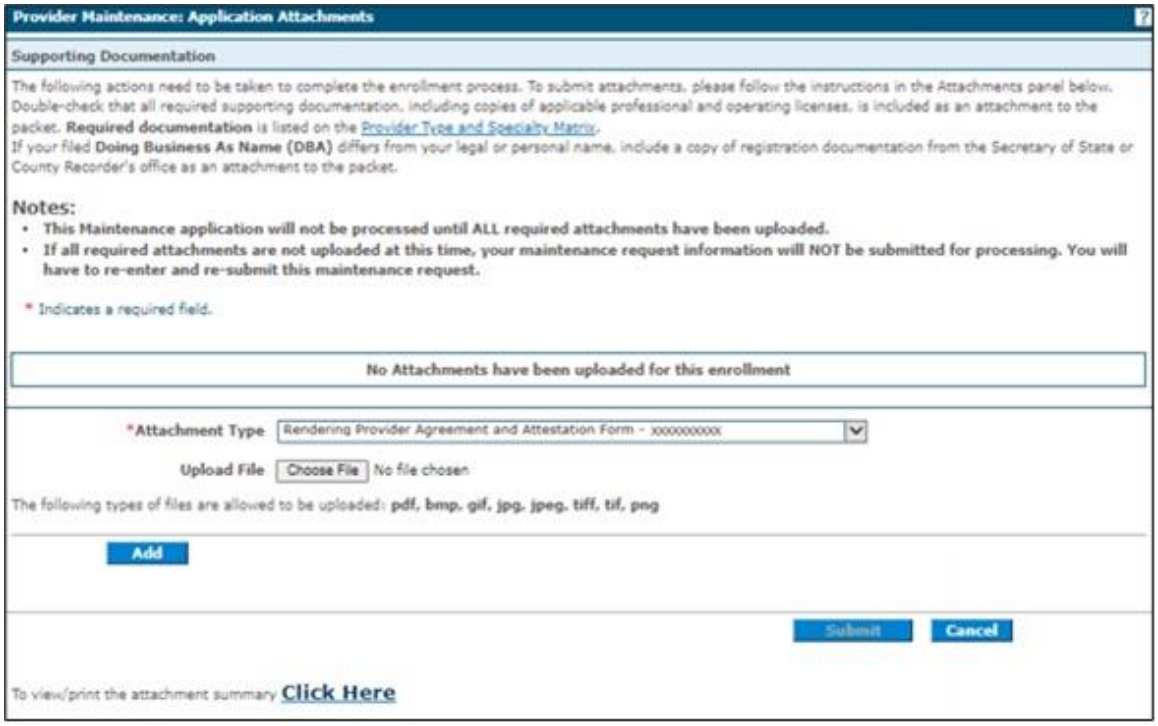
7. Complete the *Additional Group Locations* panel with the NPI or Provider ID, taxonomy, and nine-digit ZIP Code for the additional group location to which the rendering provider should be linked, and click **Add**. The panel will populate, showing the group service location's linkage entered.

Figure 25 – Additional Group Locations



8. Repeat steps 6 and 7 for each additional group service location to which that same rendering provider should be linked.
9. If you have more rendering providers to add to this group service location, complete steps 1 through 8 for each rendering provider. **Do not click Submit** until you have added all rendering providers that you intend to add during this session.
10. After you finish adding all rendering providers, click **Submit**.
11. At the *Provider Maintenance: Application Attachments* page (Figure 26), in the Attachment Type drop-down menu, select the **Rendering Provider Agreement and Attestation Form** option for one of the rendering providers added. Each form is identified with an NPI or Provider ID that was entered in step 2.

Figure 26 – Provider Maintenance: Application Attachments



12. Complete the required *IHCP Rendering Provider Agreement and Attestation Form* (printed in step 4) for the rendering provider. Both the group provider (or authorized official) and the rendering provider must sign the form.

> *Note: A signed Rendering Provider Agreement and Attestation Form must be submitted for every rendering provider that was added to a group service location. A single agreement/attestation form can be used to support the linkages of a single practitioner to multiple group service locations operating under a single group TIN; however, separate agreement/attestation forms are required to support linkages of that same practitioner to group locations operating under different group TINs. The agreement/attestation forms must be uploaded to the Provider Maintenance: Application Attachments page.*

13. Digitize the signed form and then attach it using the Upload File field.
14. Click **Add** to finalize the process for the selected attachment.
15. Repeat steps 11–14 for all rendering providers added during this session.
16. Click **Submit** to complete the transaction.

> *Note: The transaction creates only one automated tracking number (ATN), regardless of how many rendering provider linkages were requested.*

Remove Rendering Provider from Group Service Location

When rendering providers leave a group, the group provider must remove the rendering provider from the group, either by using the **Rendering Provider Changes** option on the *Provider Maintenance* page of the IHCP Portal or by submitting an *IHCP Rendering Provider Enrollment and Profile Maintenance Packet* or an *IHCP Provider Disenrollment Form* to request that the linkage be deactivated. The deactivation request should give the date of termination from the service location (must be current or past date) for the rendering provider. The form must be signed.

Portal Instructions for Removing Rendering Providers from Group Service Locations

To remove a rendering provider from the group service location via the IHCP Portal, follow these steps:

1. At the bottom of the *Provider Maintenance: Rendering Providers* panel (Figure 27), click the **Remove** link for each provider you wish to remove (unlink from the group).

> *Note: If the rendering provider is currently enrolled as a PMP, the provider must first contact the appropriate MCE to change the provider's PMP status before the Remove option will appear on this screen.*

2. Click **Submit**.

Figure 27 – Provider Maintenance: Rendering Providers – Bottom Half

Click the **Remove** link to remove the row.

Total Records: 11

NPI	Provider ID	Name	Rendering Linkage Effective Date	Action
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	04/01/2011	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	04/06/2015	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	01/26/2011	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	01/26/2011	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	01/26/2011	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	01/12/2011	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	04/06/2015	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	05/02/2011	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	01/26/2011	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	04/06/2015	Remove
xxxxxxxxx	xxxxxxxx	xxxxxxx xxxxx	01/26/2011	Remove

Submit Cancel

Provider Identification Changes

Providers are required to keep their name, certifications and other identifying information current in their IHCP provider profiles. The **Provider Identification Changes** link on the *Provider Maintenance* page of the IHCP Portal enables providers to make changes to any of the following:

- Provider name and/or doing business as (DBA) name (not related to a CHOW)
- Organizational structure
- NPI
- Taxonomy
- License and certification information (including CLIA, Indiana Department of Health and other professional licenses and certifications, as well as driver's license information [for applicable transportation providers])
- Driver's license attestations (for applicable transportation providers only)
- Insurance information (for applicable transportation providers only)
- Auto registration information (for family member/associate transportation providers only)
- Medicare number
- Patient population information
- Drug Enforcement Administration (DEA) number

These changes can also be made by mail, using the appropriate IHCP provider packet or one of the following update forms:

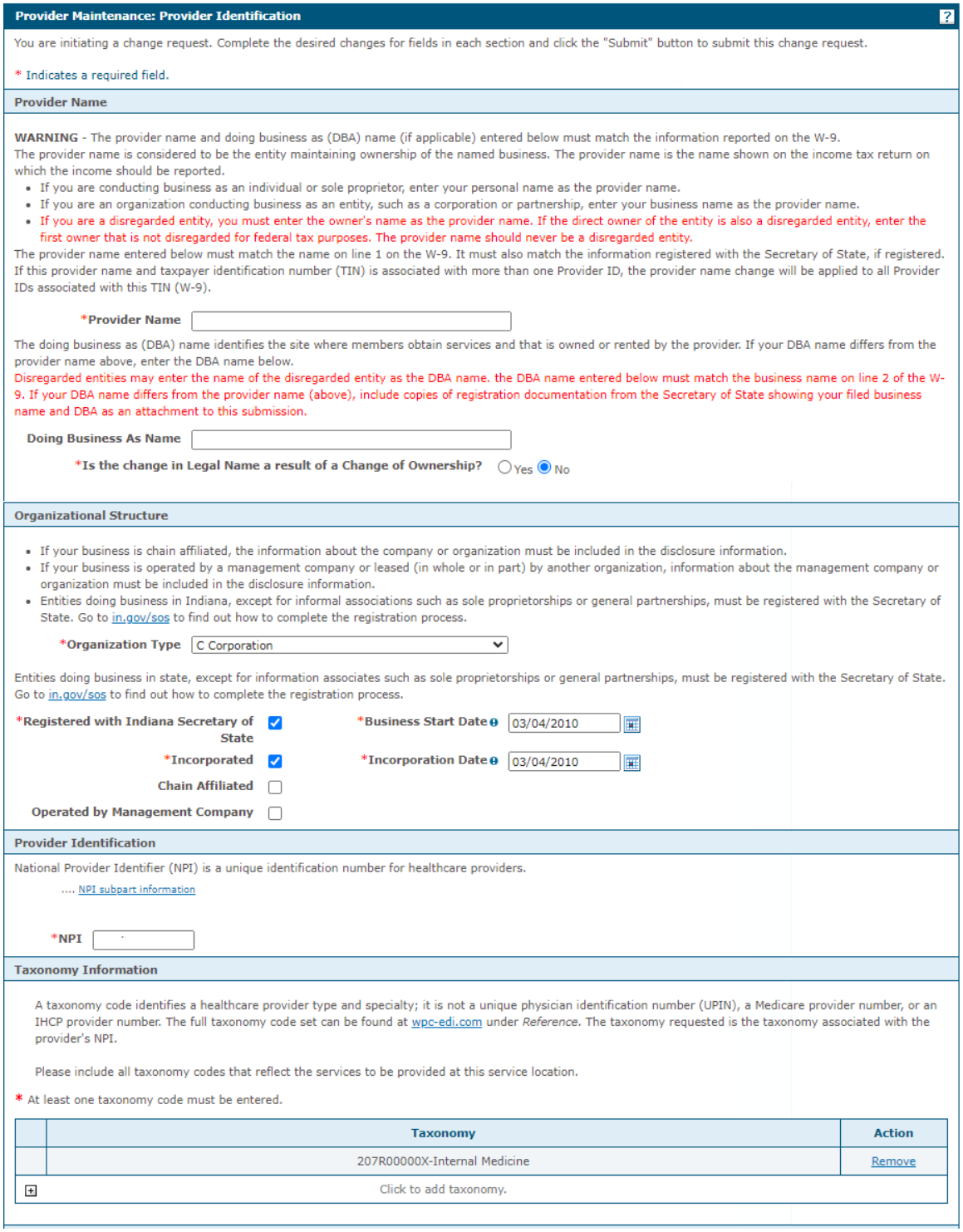
- *IHCP Provider Name and Address Maintenance Form*
- *IHCP Provider Enrollment Recertification of Licenses and Certifications Form*
- *IHCP Provider Medicare Number Maintenance Form*
- *IHCP Provider CLIA Certification Maintenance Form*

> *Note: The name in the Provider Name field should be the name on the income tax return on which the income should be reported (line 1 of the W-9 form). The name in the Doing Business As field is the service location name (line 2 of the W-9 form).*
>
> *If a provider is recognized by the IRS as a disregarded entity, the Provider Name should be the name of the owner (or the first owner that is not a disregarded entity); the name of the disregarded entity may be entered in the Doing Business As field.*

When reporting a change of provider name or DBA/service location name, providers must submit a *W-9* that shows the new information. If the DBA name differs from the provider name, copies of registration documentation from the Secretary of State must be included with the submission. For name changes related to a CHOW, see the *Change of Ownership* section.

For recertification updates, the appropriate certificate, approval letter or notice, proof of insurance, or license to extend their eligibility must be submitted along with the update. For more information about license and certification requirements, see the *Maintaining Licensure and Certification* section.

Figure 28 – Provider Maintenance: Provider Identification (Top Half)



Provider Maintenance: Provider Identification

You are initiating a change request. Complete the desired changes for fields in each section and click the "Submit" button to submit this change request.

* Indicates a required field.

Provider Name

WARNING - The provider name and doing business as (DBA) name (if applicable) entered below must match the information reported on the W-9.
The provider name is considered to be the entity maintaining ownership of the named business. The provider name is the name shown on the income tax return on which the income should be reported.

- If you are conducting business as an individual or sole proprietor, enter your personal name as the provider name.
- If you are an organization conducting business as an entity, such as a corporation or partnership, enter your business name as the provider name.
- If you are a disregarded entity, you must enter the owner's name as the provider name. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. The provider name should never be a disregarded entity.

The provider name entered below must match the name on line 1 on the W-9. It must also match the information registered with the Secretary of State, if registered. If this provider name and taxpayer identification number (TIN) is associated with more than one Provider ID, the provider name change will be applied to all Provider IDs associated with this TIN (W-9).

*Provider Name

The doing business as (DBA) name identifies the site where members obtain services and that is owned or rented by the provider. If your DBA name differs from the provider name above, enter the DBA name below.
Disregarded entities may enter the name of the disregarded entity as the DBA name. the DBA name entered below must match the business name on line 2 of the W-9. If your DBA name differs from the provider name (above), include copies of registration documentation from the Secretary of State showing your filed business name and DBA as an attachment to this submission.

Doing Business As Name

*Is the change in Legal Name a result of a Change of Ownership? Yes No

Organizational Structure

- If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.
- If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.
- Entities doing business in Indiana, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to in.gov/sos to find out how to complete the registration process.

*Organization Type C Corporation

Entities doing business in state, except for information associates such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to in.gov/sos to find out how to complete the registration process.

*Registered with Indiana Secretary of State
*Business Start Date 03/04/2010
*Incorporated
*Incorporation Date 03/04/2010
Chain Affiliated
Operated by Management Company

Provider Identification

National Provider Identifier (NPI) is a unique identification number for healthcare providers.

.... NPI subpart information

*NPI

Taxonomy Information

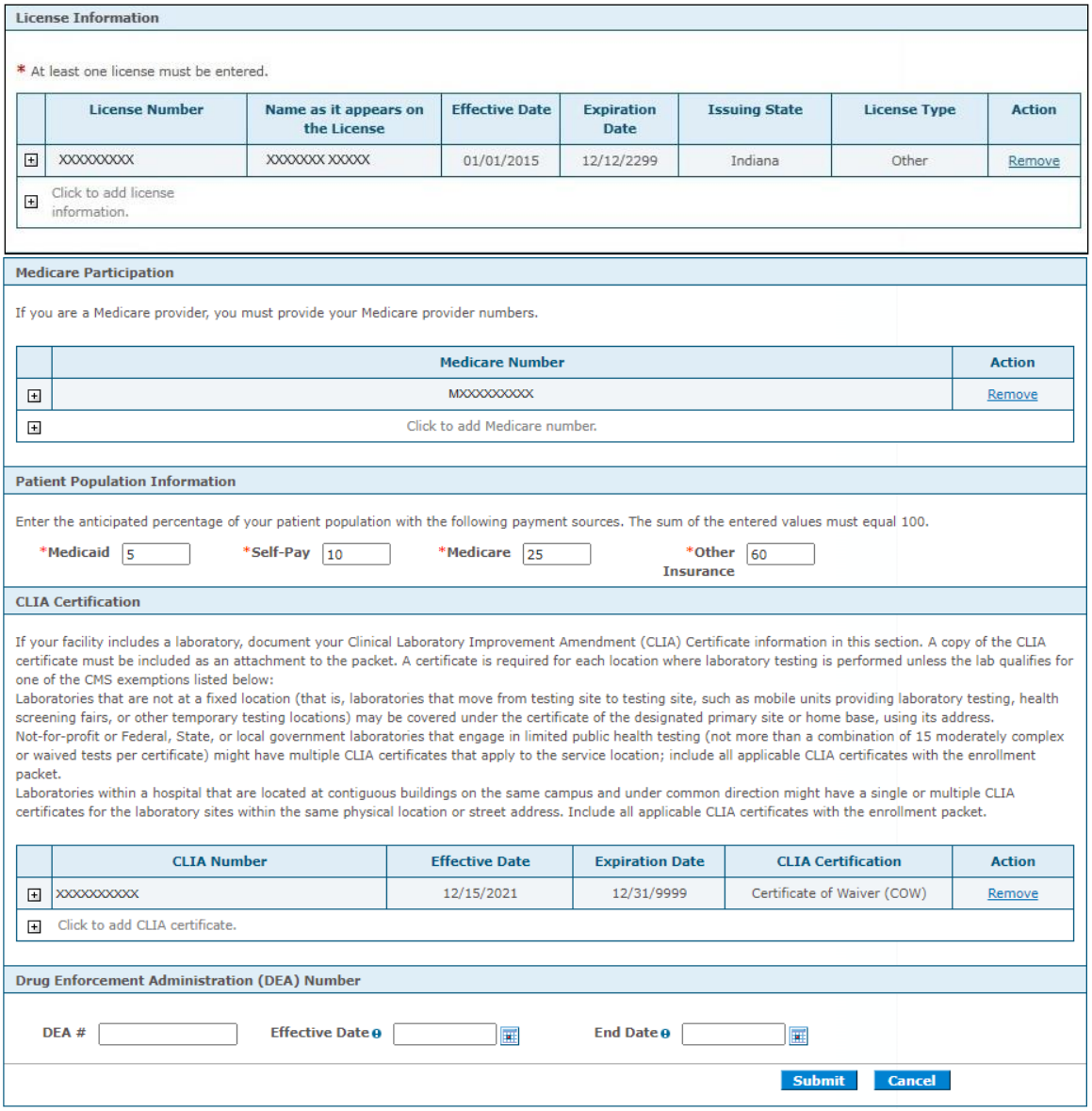
A taxonomy code identifies a healthcare provider type and specialty; it is not a unique physician identification number (UPIN), a Medicare provider number, or an IHCP provider number. The full taxonomy code set can be found at wpc-edi.com under *Reference*. The taxonomy requested is the taxonomy associated with the provider's NPI.

Please include all taxonomy codes that reflect the services to be provided at this service location.

* At least one taxonomy code must be entered.

	Taxonomy	Action
	207R00000X-Internal Medicine	Remove
⊞	Click to add taxonomy.	

Figure 29 – Provider Maintenance: Provider Identification (Bottom Half)



License Information

* At least one license must be entered.

	License Number	Name as it appears on the License	Effective Date	Expiration Date	Issuing State	License Type	Action
⊞	XXXXXXXXX	XXXXXXX XXXXX	01/01/2015	12/12/2299	Indiana	Other	Remove
⊞	Click to add license information.						

Medicare Participation

If you are a Medicare provider, you must provide your Medicare provider numbers.

	Medicare Number	Action
⊞	MXXXXXXXXX	Remove
⊞	Click to add Medicare number.	

Patient Population Information

Enter the anticipated percentage of your patient population with the following payment sources. The sum of the entered values must equal 100.

*Medicaid 5 *Self-Pay 10 *Medicare 25 *Other Insurance 60

CLIA Certification

If your facility includes a laboratory, document your Clinical Laboratory Improvement Amendment (CLIA) Certificate information in this section. A copy of the CLIA certificate must be included as an attachment to the packet. A certificate is required for each location where laboratory testing is performed unless the lab qualifies for one of the CMS exemptions listed below:
Laboratories that are not at a fixed location (that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations) may be covered under the certificate of the designated primary site or home base, using its address.
Not-for-profit or Federal, State, or local government laboratories that engage in limited public health testing (not more than a combination of 15 moderately complex or waived tests per certificate) might have multiple CLIA certificates that apply to the service location; include all applicable CLIA certificates with the enrollment packet.
Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction might have a single or multiple CLIA certificates for the laboratory sites within the same physical location or street address. Include all applicable CLIA certificates with the enrollment packet.

	CLIA Number	Effective Date	Expiration Date	CLIA Certification	Action
⊞	XXXXXXXXXX	12/15/2021	12/31/9999	Certificate of Waiver (COW)	Remove
⊞	Click to add CLIA certificate.				

Drug Enforcement Administration (DEA) Number

DEA # Effective Date End Date

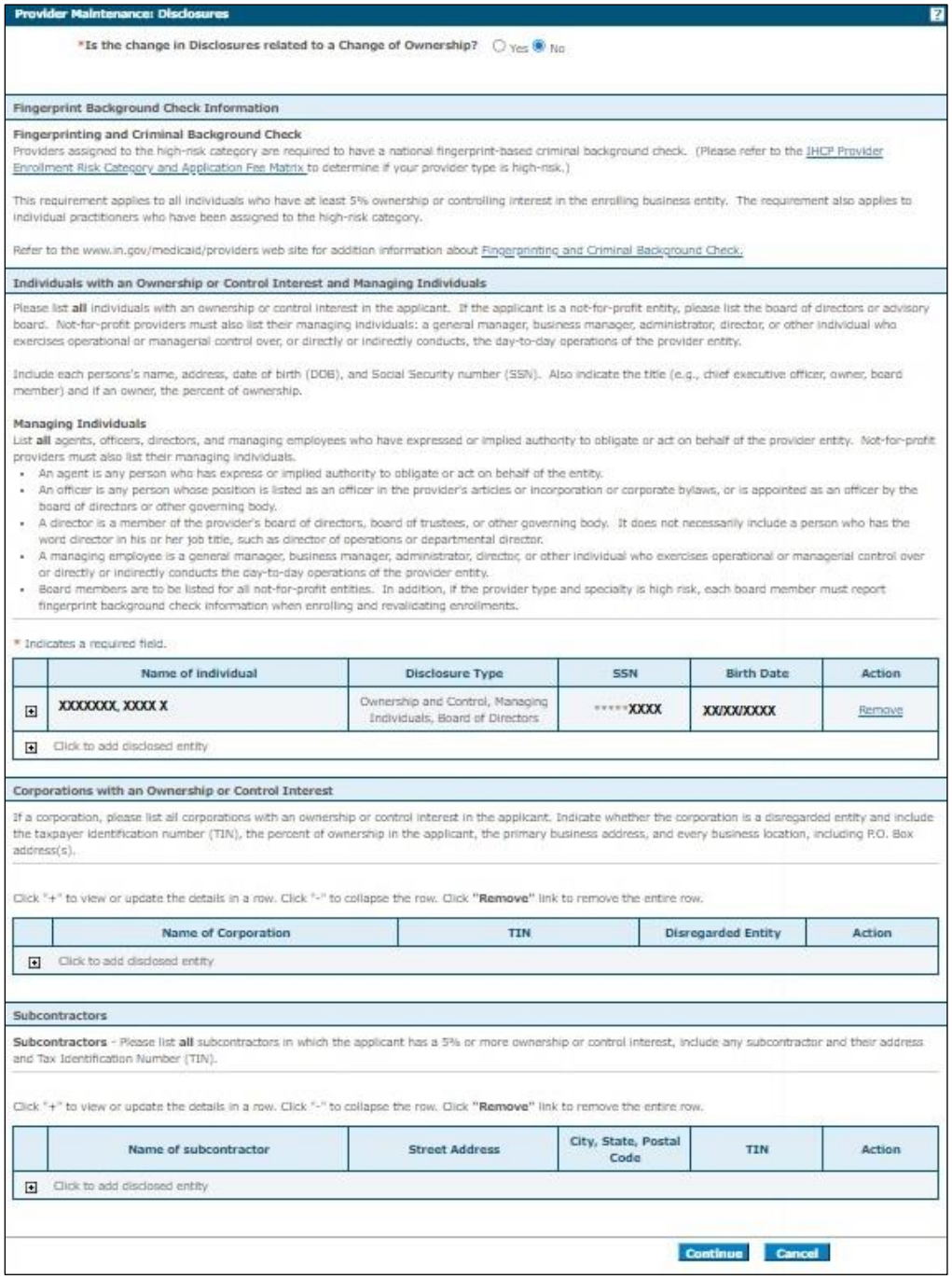
Submit Cancel

Disclosure Changes

All providers are required to maintain accurate disclosure information, as described in the *Disclosure Information* section of this module.

To report new or departing owners, board members or managers or to update information for disclosed corporations and subcontractors, select the **Disclosure Changes** link on the *Provider Maintenance* page and make changes as instructed. Do not use the Disclosure Changes link to report CHOW information.

Figure 30 – Provider Maintenance: Disclosures



Provider Maintenance: Disclosures

*Is the change in Disclosures related to a Change of Ownership? ○ Yes ◉ No

Fingerprint Background Check Information

Fingerprinting and Criminal Background Check
Providers assigned to the high-risk category are required to have a national fingerprint-based criminal background check. (Please refer to the IHCP Provider Enrollment Risk Category and Application Fee Matrix to determine if your provider type is high-risk.)

This requirement applies to all individuals who have at least 5% ownership or controlling interest in the enrolling business entity. The requirement also applies to individual practitioners who have been assigned to the high-risk category.

Refer to the www.in.gov/medicaid/providers web site for addition information about Fingerprinting and Criminal Background Check.

Individuals with an Ownership or Control Interest and Managing Individuals

Please list **all** individuals with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers must also list their managing individuals: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of the provider entity.

Include each persons's name, address, date of birth (DOB), and Social Security number (SSN). Also indicate the title (e.g., chief executive officer, owner, board member) and if an owner, the percent of ownership.

Managing Individuals
List **all** agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers must also list their managing individuals.

- An agent is any person who has express or implied authority to obligate or act on behalf of the entity.
- An officer is any person whose position is listed as an officer in the provider's articles or incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing body.
- A director is a member of the provider's board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word director in his or her job title, such as director of operations or departmental director.
- A managing employee is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of the provider entity.
- Board members are to be listed for all not-for-profit entities. In addition, if the provider type and specialty is high risk, each board member must report fingerprint background check information when enrolling and revalidating enrollments.

* Indicates a required field.

	Name of individual	Disclosure Type	SSN	Birth Date	Action
⊞	XXXXXXX, XXXX X	Ownership and Control, Managing Individuals, Board of Directors	*****XXXX	XX/XX/XXXX	Remove
⊞	Click to add disclosed entity				

Corporations with an Ownership or Control Interest

If a corporation, please list all corporations with an ownership or control interest in the applicant. Indicate whether the corporation is a disregarded entity and include the taxpayer identification number (TIN), the percent of ownership in the applicant, the primary business address, and every business location, including P.O. Box address(s).

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

	Name of Corporation	TIN	Disregarded Entity	Action
⊞	Click to add disclosed entity			

Subcontractors

Subcontractors - Please list **all** subcontractors in which the applicant has a 5% or more ownership or control interest, include any subcontractor and their address and Tax Identification Number (TIN).

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

	Name of subcontractor	Street Address	City, State, Postal Code	TIN	Action
⊞	Click to add disclosed entity				

Continue Cancel

To submit disclosure changes by mail, providers can use the appropriate IHCP provider packet or the *IHCP Provider Ownership and Managing Individual Maintenance Form*.

> *Note: When submitting an update to the Schedule C sections, providers must include the names of **all** individuals that meet the disclosure requirements, even if the individuals had been previously disclosed. When an update is processed, any previously disclosed individuals that are not listed on the maintenance form will be removed. In other words, the previous list of disclosed individuals will be replaced with the updated list of disclosed individuals.*

Change of Ownership

All providers must report any change in ownership (CHOW), including but not limited to **any change** in direct or indirect ownership or controlling interest, merger, corporate reorganization, change in provider (owner) or DBA name, or change in federal TIN.

To report a CHOW, providers must submit a new enrollment application for each service location. Providers are encouraged to use the IHCP Portal to perform CHOW enrollments. The portal provides step-by-step instructions for enrolling as a CHOW.

The new ownership entity must submit the following:

- A portal enrollment application with **Change of Ownership** selected as the enrollment request type

  Or

  An IHCP provider packet with **Change of Ownership** selected as the type of request (in Schedule A) and all required sections completed, including a signed *IHCP Provider Agreement* **and** an *IHCP Provider Change of Ownership Addendum*
- A *W-9* form
- A copy of the purchase agreement or bill of sale
- Appropriate licensure, where applicable
- Any other appropriate forms or attachments necessary for enrollment

> *Note: Clicking the **Change of Ownership (CHOW) Overview** link on the Provider Maintenance page of the portal displays information about when to report a change of ownership and how to do it. CHOWs cannot be reported via the Provider Maintenance option. Instead, to report a CHOW, log out of the IHCP Portal and select the Provider Enrollment link from the portal homepage.*
>
> *Extended care facilities must follow a different process to perform a CHOW on the portal, as described in the following section.*

CHOWs for Extended Care Facilities

According *to Indiana Administrative Code (IAC) 405 IAC 1-20*, the provider assuming ownership of an extended care facility is required to take over the seller's Medicaid enrollment and Provider ID when undergoing a CHOW. This requirement applies to IHCP provider type 03 – *Extended Care Facility* providers with any of the following specialties:

- 030 – *Nursing Facility*
- 031 – *Intermediate Care Facility for Individuals with Intellectual Disabilities*

- 032 – *Pediatric Nursing Facility*
- 033 – *Residential Care Facility*

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

- A copy of the agreement of sale or transfer
- The expected date of the sale or transfer
- If applicable, the name of any individual who meets at least one of these qualifications:
  - Has an ownership or controlling interest
  - Is a managing employee
  - Is an agent of the transferor (selling provider) who will also hold an ownership or controlling interest, be a managing employee, or be an agent of the transferee (purchasing provider)

Mailing Instructions for an Extended Care Facility CHOW

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

LTC providers must mail the documentation to the following address:

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

Portal Instructions for an Extended Care Facility CHOW

Extended care facility providers are encouraged to submit CHOW applications and the required supporting documentation through the IHCP Portal as described in this section. To use this option, the selling provider must have a registered account on the portal.

To submit an extended care facility CHOW via the portal, follow these steps:

1. The purchaser must log in to the portal using the registered seller's security credentials and click the **Extended Care Facility CHOW** link on the *My Home* page.

> *Note: After the CHOW is processed, the new owner can establish new security credentials and change access delegations for the provider's portal account as appropriate.*

Figure 31 – Extended Care Facility CHOW Link on My Home Page

2. The *Provider Enrollment* page appears, allowing the purchaser to start a new CHOW application, resume an unfinished CHOW application or check the status of a previously submitted CHOW application.

Figure 32 – Extended Care Facility CHOW Application Links on the IHCP Portal Provider Enrollment Page

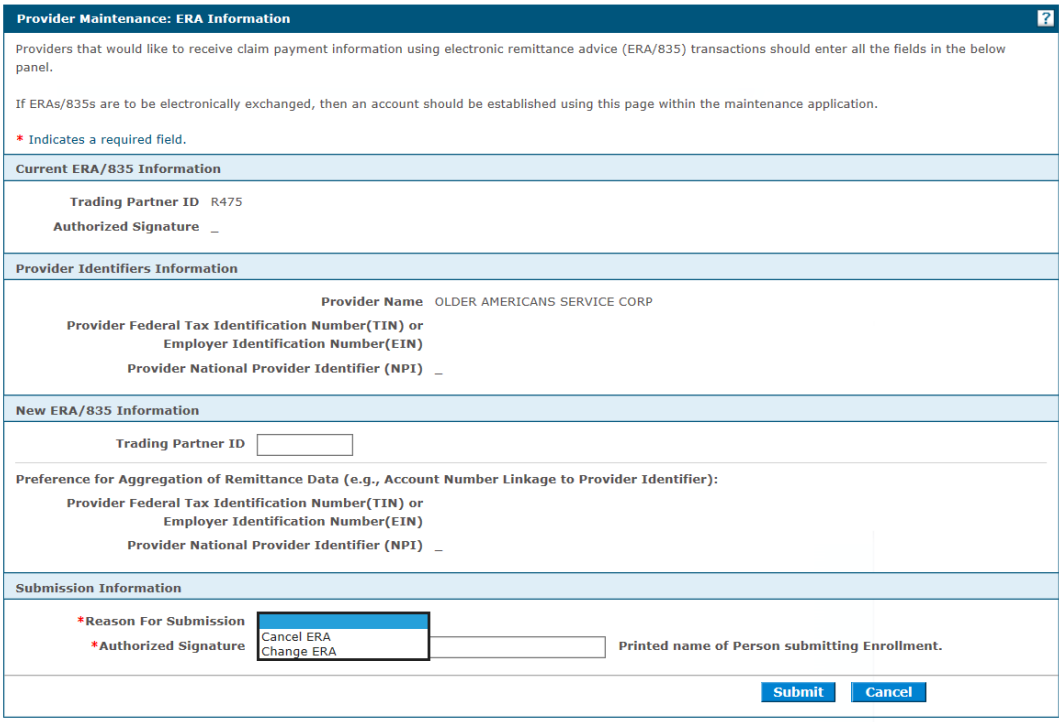
3. To complete a new Extended Care Facility CHOW application, the purchaser must enter the new owner's TIN, new ownership disclosure information and any other pertinent information related to the change of ownership. The supporting documentation required as attachments to the CHOW application include:
   - *W-9* form
   - Copy of the bill of sale

If the previous owner was set up to receive the electronic remittance advice (ERA) 835 transactions, and the trading partner ID that will be receiving the ERA 835 is not changing, then no new trading partner information from the new owner is needed. However, if the trading partner receiving the ERA 835 is changing, then the new owner must access the *Provider Maintenance/ERA Information* page on the IHCP Portal and change the trading partner ID on that page.

To change the trading partner ID, follow these steps:

1. From the *My Home* page in the portal, click the **Provider Maintenance** link.
2. On the *Provider Maintenance: Instructions* page, click the **ERA Changes** link.
3. Enter the new trading partner ID in the New ERA 835 Information section of the *Provider Maintenance: ERA Information* page.
4. Choose **Change ERA** from the Reason For Submission drop-down menu.
5. Type in an authorized electronic signature.
6. Click **Submit** at the bottom of the page to submit the change.

Figure 33 – Fields for Changing the Trading Partner ID on the Provider Maintenance/ERA Information Page



Revalidation

Federal regulations require all providers participating in the IHCP to revalidate their enrollment at least every five years. Durable medical equipment (DME) providers and pharmacy providers with DME or home medical equipment (HME) specialties revalidate every three years. Federal regulations do not permit the IHCP to reimburse for services rendered after a provider's enrollment is end dated due to failure to revalidate by the specified date.

Providers receive written notification of their revalidation deadline. In addition to the written notification, providers that are registered with the IHCP Portal also receive notice on their portal account when a revalidation is due. A list of providers with upcoming revalidation dates is also available on the *Provider Enrollment Revalidation* page at in.gov/medicaid/providers.

Providers that submit their revalidation request before the required date will be processed upon successful revalidation. Providers that fail to complete revalidation by the required date will be deactivated and will be required to complete a brand-new provider enrollment application.

> *Note: Providers are encouraged to use the IHCP Provider Healthcare Portal, accessible from the homepage at in.gov/medicaid/providers for revalidation processes. The IHCP Portal allows for electronic signatures.*

Revalidation of an enrollment requires use of the Revalidation option in the portal or submission by mail of a new IHCP provider packet. For designated provider types, an application fee is also required for revalidation, as described in the *Application Fee* section. All revalidations require screening activities associated with the provider's assigned risk level, such as site surveys or background checks, as described in the *Risk Category Requirements* section.

> *Note: Providers that do not intend to revalidate their enrollment should complete the disenrollment process on the portal or submit the IHCP Provider Disenrollment Form available at in.gov/medicaid/providers, which allows the IHCP to complete a voluntary disenrollment and keep its provider database up-to-date.*

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

- Providers are required to revalidate their enrollment with Medicare and the IHCP separately. Revalidating with Medicare will not revalidate a provider's IHCP enrollment.
- Revalidation is a reenrollment process, not an update process. When revalidating enrollment online, providers choose the Revalidation icon on the IHCP Portal and follow the prompts to complete the pages required. Providers will be required to reenter some of the information that previously had been prepopulated on revalidation submissions. Providers should be prepared to provide the following information for enrollment revalidations:
  - All providers will be required to reenter all disclosure information at the time of revalidation.
  - All group providers will be required to verify every rendering provider's status with the group and remove any rendering providers no longer active at the service location that is revalidating.
  - All group providers will be required to include a newly signed and dated *Rendering Provider Agreement* for each rendering provider that remains active at the service location that is revalidating.

> *Note: The revalidation must be received within 90 days from the date the provider agreements are signed. Applications that are received more than 90 days after the provider agreements are signed may not be accepted and a new agreement with updated signatures may need to be submitted.*

- When revalidating enrollment by mail, providers must indicate revalidation by checking the Revalidate Enrollment box on the IHCP provider packet, and then complete *all applicable fields*, not just those fields with new information. If a packet is submitted with only "Revalidate Enrollment" marked in item 1, and the rest of the packet blank, or with only some fields completed, the packet will be considered incomplete. Incomplete packets will be returned to providers with a request that they be resubmitted with the missing information added.
- A properly completed *W-9* must be submitted with the portal revalidation or IHCP provider packet. Discrepancies on the *W-9* will result in the application being returned to the provider, delaying revalidation.
- Disclosures on the application must contain complete and thorough information about all disclosed individuals, including name, Social Security number and date of birth. The application must contain a **complete** list of disclosures, not just those individuals added or deleted from a prior disclosure.
- When revalidating by mail, using the IHCP group provider enrollment packet, group providers should disregard the *IHCP Rendering Provider Enrollment and Maintenance Packet* portion of the packet. Instead, as an attachment to the group's enrollment packet, a group should include a list of rendering providers linked to the service location at the time of revalidation and a signed rendering provider agreement for each of the rendering providers linked to the group. The list of rendering providers must include the information outlined in the instructions on page 1 of the IHCP group provider enrollment packet. Any new rendering provider must first enroll and then be linked to the group.
- A revalidation notice is mailed to providers 90 days before their revalidation due date, using the mail-to address on file. (Providers registered on the IHCP Portal will also have a Revalidation icon displayed on their portal account 90 days before their revalidation is due.) A second notification letter is mailed 60 days before the revalidation due date. Providers with multiple service locations (practice sites) must revalidate each location individually and will receive a separate letter for each location.
  - Providers should not revalidate until they see the revalidation icon on the portal or receive their notification by mail.
  - Providers that fail to submit properly completed revalidation paperwork by their revalidation due date will be disenrolled. After being disenrolled, the provider will need to complete the provider enrollment process on the portal or submit a new *IHCP Enrollment and Profile Maintenance Packet* to reenroll with the IHCP. Disenrollment with subsequent reenrollment may result in a gap in the provider's eligibility.

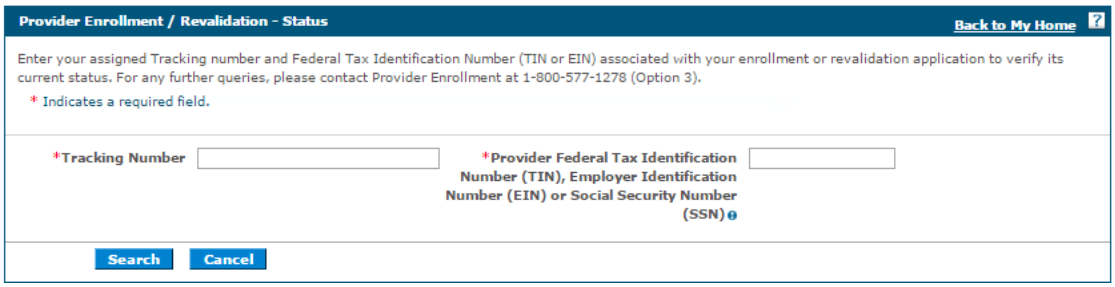
Note: Providers should not take any steps to revalidate until they see the revalidation icon on their portal account or receive their notification letters. It is important that providers keep their address information up to date to ensure that they receive this notice. Failure to submit the required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

Checking Provider Revalidation Status

The IHCP Portal allows users to check the status of their revalidation online.

Portal users can select the **Enrollment/Revalidation Status** link on the *My Home* page and enter the tracking number and the EIN or SSN associated with the revalidation application to monitor the status of the revalidation.

Figure 34 – Provider Enrollment/Revalidation Status



Provider Disenrollment

> *Note: The term "disenrollment" refers to an action taken by the provider, while the term "deactivation" refers to an action taken by the IHCP.*

Providers may voluntarily end their IHCP enrollment at any time. Requests for voluntary disenrollment must be submitted via the IHCP Portal, using the **Disenroll** link on the portal's *My Home* page and completing the fields in the *Disenroll Provider* panel (Figure 35), or by mail, using the *IHCP Provider Disenrollment Form*. Requests for disenrollment from the IHCP ensure that the provider's profile history is accurately maintained.

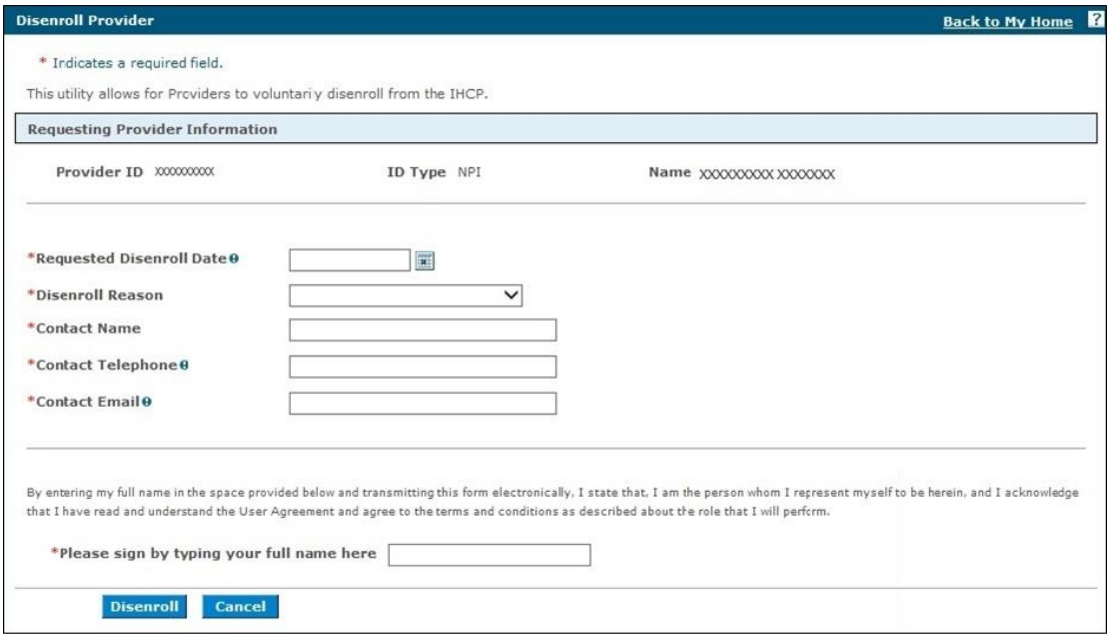
> *Note: Providers enrolled as a PMP with an MCE must contact the MCE first to begin the disenrollment process. See the Managed Care Disenrollment section.*
>
> *If enrolled as a waiver provider, the provider must contact the state waiver agency first to begin the disenrollment process.*

The disenrollment date is the date the disenrollment form is signed or the date the request is submitted via the portal, unless otherwise requested. Providers may request a disenrollment date *prior to* the date the form is completed, but a future date is not allowed.

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

After the Provider Enrollment Unit processes the disenrollment, a notification will be sent to the provider to verify disenrollment from the IHCP.

Figure 35 – Disenroll Provider



Managed Care Disenrollment

Termination from the IHCP – whether voluntary disenrollment or involuntary deactivation – results in the provider's immediate disenrollment from HIP, Hoosier Care Connect and Hoosier Healthwise.

Providers that want to disenroll from only the HIP, Hoosier Care Connect or Hoosier Healthwise components of the IHCP must contact the contracting MCEs. If the provider serves as a primary medical practitioner (PMP) for one or more members, and the IHCP Provider Enrollment Unit receives the request before the PMP disenrollment, IHCP Provider Enrollment coordinates with the MCEs. Providers can contact their MCE for additional details about disenrollment from a health plan program.

Involuntary Termination or Deactivation

The FSSA or its fiscal agent may deactivate or terminate a provider's IHCP enrollment for the following reasons:

- License or certification expiration, suspension or revocation
- Conviction of Medicaid or Medicare fraud
- Violation of federal or state statutes or regulations
- Name matched against the following:
  - U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) exclusion list
  - System for Award Management (SAM) exclusion list
  - Adverse Action Report
- Breach of any provisions in the *IHCP Provider Agreement*
- Returned mail
- No claim activity for more than 18 months

Payment for Services After Deactivation or Termination

Providers have up to 180 days from the date of service (or date of discharge, for inpatient billing) to file claims for service dates that fall within their eligibility period.

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

Appeal Process

Under *IC 4-21.5-3-7* and *405 IAC 1-1.4-12*, providers have the right to appeal deactivation or termination action. To preserve an appeal, providers must specify the reason for the appeal in writing and file the appeal with the ultimate authority for the agency within 15 calendar days of receipt of a notification letter.

Send the appeal to the following address:

MS07
Gwen Killmer, Office of Medicaid Policy and Planning
Secretary, Indiana Family and Social Services Administration
402 W. Washington St., Room W374
Indianapolis, IN 46204

Providers that elect to appeal a determination must also file a statement of issues within 45 calendar days after receipt of notice of the determination. The statement of issues must conform to *405 IAC 1-1.4-12* and *IC 4-21.5-3* and be sent to the same address as the appeal request.

Section 5: Ordering, Prescribing or Referring Providers (Type 50)

For Medicaid to reimburse for services or medical supplies that are provided as a result of a provider's order, prescription or referral, federal regulations *(Code of Federal Regulations 42 CFR Parts 405, 447, 455, 457* and *498)* require that the ordering, prescribing or referring (OPR) provider be enrolled in Medicaid. Indiana Health Coverage Programs (IHCP) providers that render services to Medicaid members must verify IHCP enrollment of the OPR provider before the service or supplies are rendered. For this verification, providers can use the OPR Search Tool, accessible from the *Ordering, Prescribing or Referring Providers* page at in.gov/medicaid/providers.

To address this requirement and to encourage nonenrolled practitioners to enroll in the IHCP, a category of enrollment has been created for OPR providers. The OPR provider category is appropriate for practitioners who do not plan to bill the IHCP for payment of services rendered, but who may occasionally see an individual who is an IHCP member and who needs an order, prescription or referral for additional services or supplies that will be covered by the Medicaid program.

For organizations enrolling as an OPR provider, all practitioners within the organization who might order, prescribe or refer services or supplies for IHCP members will need to enroll separately as individual OPR providers.

Participating in the IHCP as an OPR provider allows other providers to be reimbursed for the Medicaid covered services and supplies that the OPR provider orders, prescribes or refers for IHCP members. A simplified application process requires minimal information and time and makes participation easy.

> *Note: OPR providers cannot submit claims to the IHCP for payment of services rendered. If a provider wants to be able to submit claims, enrollment as another IHCP provider type is required. Providers that are already enrolled as another type of provider in the IHCP do not need to enroll as an OPR provider.*

OPR Requirements

Enrollment as an OPR provider is appropriate only for providers that meet the following criteria:

- Are not enrolled in the IHCP under any other provider type
- Do not want to be enrolled in the IHCP as a billing, group or rendering provider
- Do not plan to submit claims to the IHCP for payment of services rendered
- Have obtained a National Provider Identifier (NPI)

Providers located outside Indiana are eligible for enrollment under the OPR provider type.

Enrolling as an OPR Provider

Enrollment in the IHCP as an OPR provider can be completed online or by mail.

To enroll **online**, follow these steps:

1. Go to the IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers.
2. Click the **Provider Enrollment** link.

3. Click the **Provider Enrollment Application** link.
4. Read the introductory information and then click **Continue**.
5. Select **Ordering, Prescribing, Referring (OPR)** from the Provider Category drop-down box in the Initial Enrollment Information section. This action automatically enters the OPR provider type (50) into the Provider Type field.
6. Follow instructions to complete the remainder of application.

To enroll **by mail**, follow these steps:

1. Go to the Participating as an OPR Provider section of the *Ordering, Prescribing or Referring Providers* page at in.gov/medicaid/providers.
2. Click the *IHCP Ordering, Prescribing or Referring Provider Enrollment and Profile Maintenance Packet* link.
3. Follow instructions in the packet to enroll in the IHCP as an OPR provider.
4. The IHCP provider packet is an interactive PDF file, allowing providers to type information into the fields, save the completed file to their computer and print the file for mailing.
5. Submit the packet using the mailing instructions in the packet.

OPR providers are not required to pay an application fee.

Updating OPR Provider Information

When an enrolled provider's information changes (for example, when license information, contact information, name or address changes), the provider is *required* to submit updated information to the IHCP within 30 business days.

Providers are encouraged to use the **IHCP Portal** to submit updates. See the *Viewing and Updating Provider Profile Information via the IHCP Portal* section for instructions.

If submitting updates **by mail**, follow these instructions:

1. Complete only the following fields of the *IHCP Ordering, Prescribing or Referring Provider Enrollment and Profile Maintenance Packet*:
   - Field 1 – Type of request
   - Field 5 – Name of enrolling individual or entity
   - Field 36 – Enter your NPI
   - Any other fields with information that needs to be updated
   - Fields 45–47 – Provider Signature/Attestation
2. Submit the packet using the mailing instructions in the *Submitting and Processing OPR Provider Transactions* section.

OPR Conversions

Providers that are enrolled with the IHCP as an OPR provider may decide to change their enrollment status so they can bill for services rendered to their patients who are Medicaid members. Conversely, providers enrolled under another classification may decide to change their enrollment to be limited to providing orders, prescriptions and referrals only.

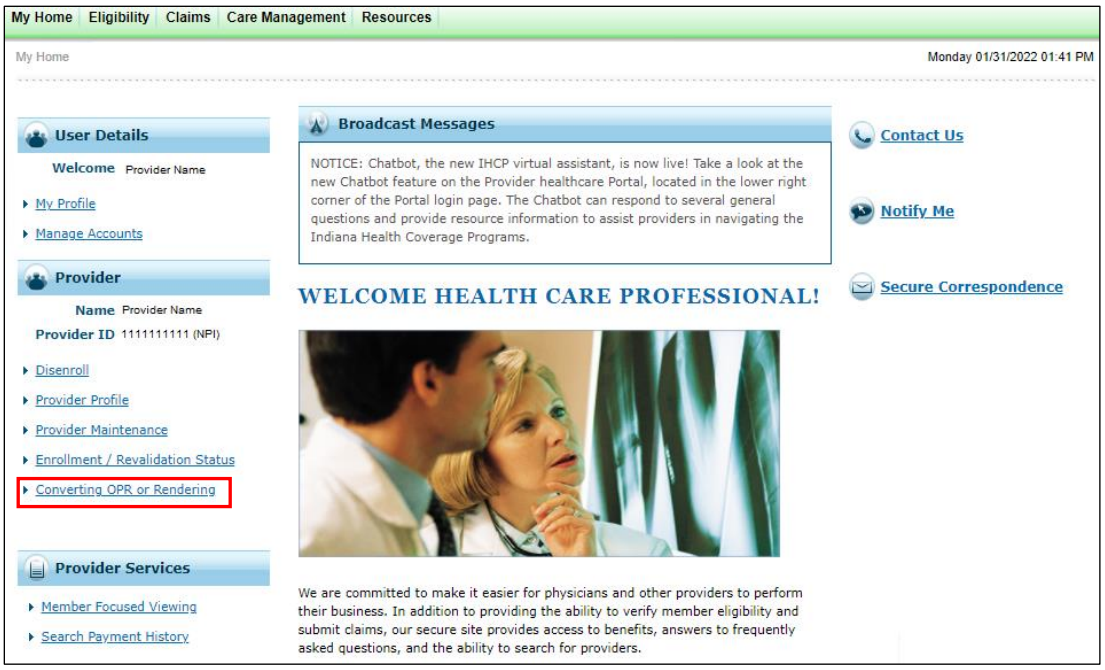
Converting to OPR From Rendering or to Rendering From OPR

An actively enrolled OPR provider can convert to a rendering provider, or an actively enrolled rendering provider can convert to an OPR provider, in a single IHCP Portal transaction. This process applies to conversions between these two classifications only. The provider must be a registered portal user to perform the conversion on the portal.

Providers can access this feature by following these steps:

1. Log in to the portal as a registered OPR provider or as a registered rendering provider.
2. On the *My Home* page, under the Provider section, select the **Converting OPR or Rendering** link.

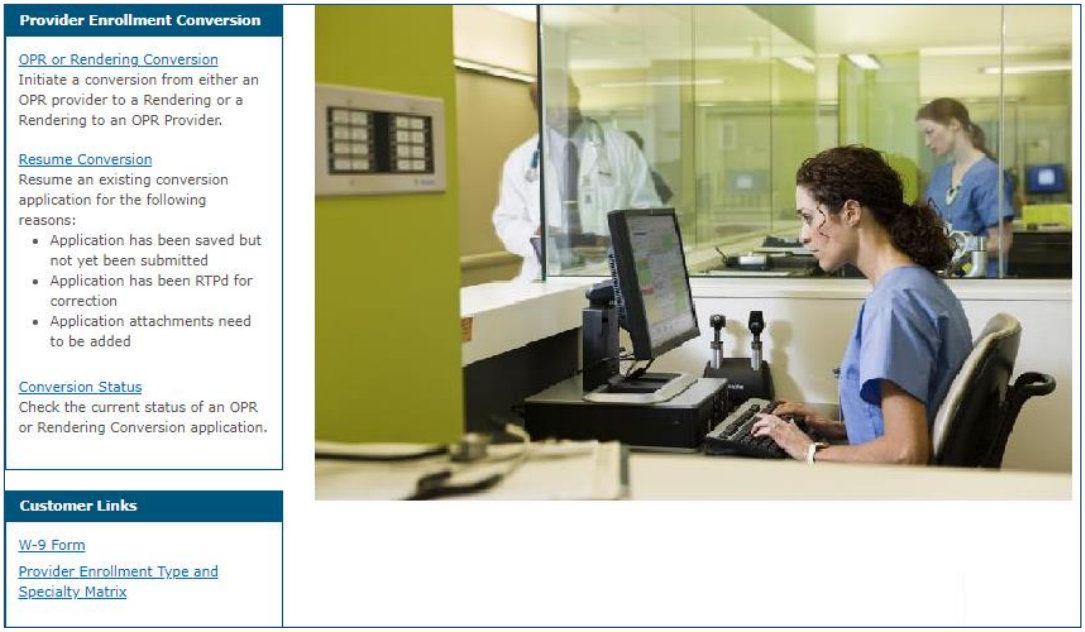
Figure 36 – Portal Link for Converting OPR or Rendering Provider Classifications



3. On the *Provider Enrollment Conversion* panel, select **OPR or Rendering Conversion** to begin a new request.

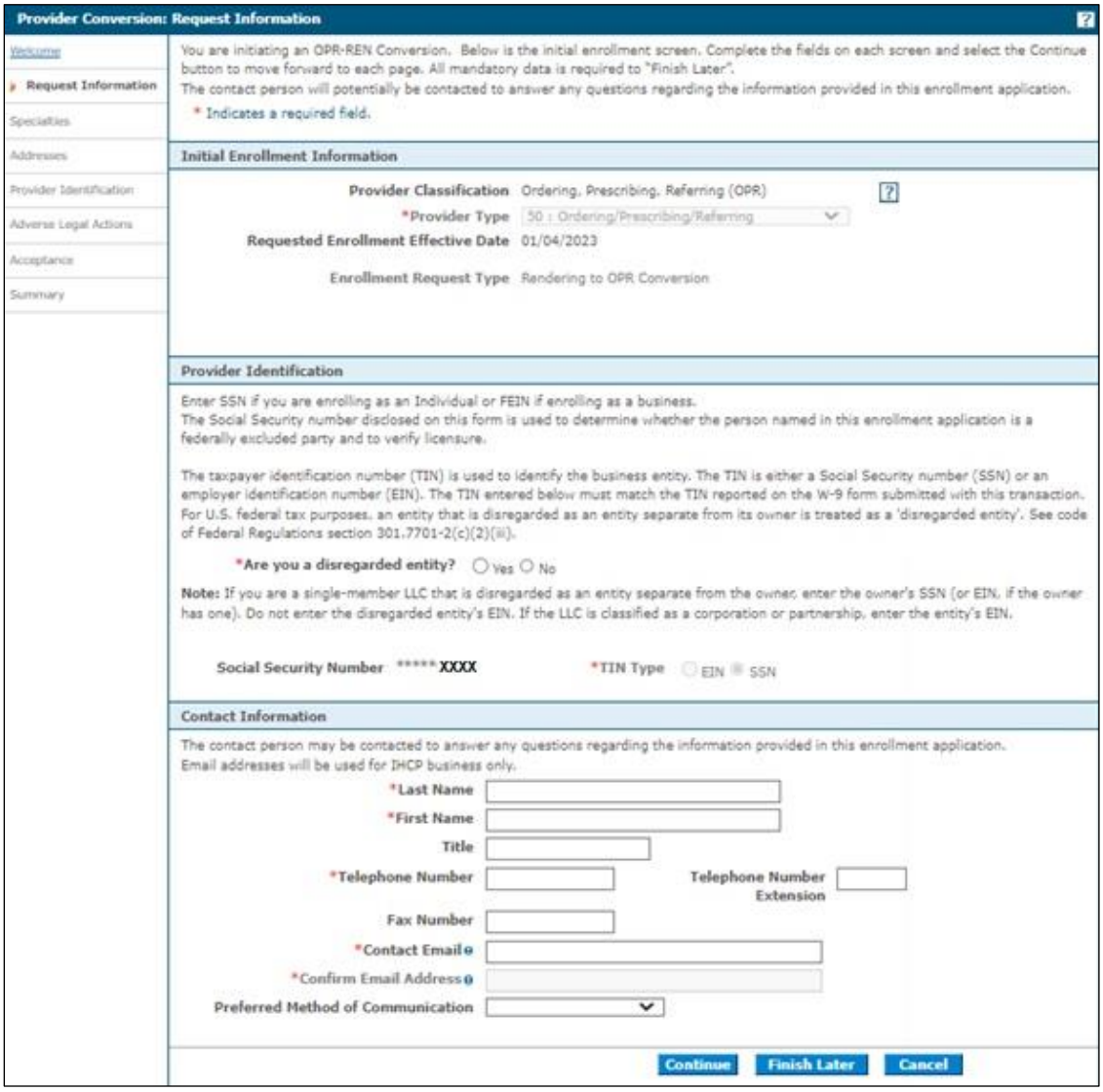
   To resume a conversion request previously started but not yet completed and submitted, select **Resume Conversion**. To view the status of a conversion request already submitted, select **Conversion Status**.

Figure 37 – Choose a Conversion Option



4. When selecting the option to begin a new request or to resume a request, the *Provider Conversion*: *Request Information* page is displayed. Enter an effective date for the change. The effective date can be a retroactive date but not a future date.

Figure 38 – Provider Conversion: Request Information Page
to Begin a Conversion Request



5. Follow all prompts to enter the required enrollment data for the new classification (either OPR or rendering) and to upload any required attachments, if applicable, and select **Confirm** on the *Summary* page to submit your request.

> *Note: There is no need to complete a deactivation to convert between these two provider classifications; the system will end date the old classification (either OPR or rendering) associated with the enrolled provider profile and activate the new classification. The provider's existing IHCP Provider ID will automatically be assigned to the new provider profile.*

The IHCP Portal is the preferred method for converting between the OPR and rendering provider classifications. However, the IHCP does continue to accept these conversion requests by mail, as follows:

- **OPR to Rendering** – Providers currently enrolled under the OPR classification may submit an *IHCP Rendering Provider Enrollment and Profile Maintenance Packet* to request enrollment as a rendering provider. **Conversion from OPR to rendering** must be selected as the Type of Request, and all applicable sections of the packet must be completed.

- **Rendering to OPR** – Providers currently enrolled under the rendering classification may submit an *IHCP Ordering, Prescribing, or Referring Provider Enrollment and Profile Maintenance Packet* to request enrollment as an OPR provider. **Conversion from rendering to OPR** must be selected as the Type of Request, and all applicable sections of the packet must be completed.

A disenrollment form for the classification the provider is converting from is not required when the appropriate packet is submitted with the conversion option selected as described.

Converting to OPR From Billing or Group, or to Billing or Group From OPR

To convert from a billing or group enrollment to an OPR enrollment, the provider must disenroll as their current provider type, as described in the *Provider Disenrollment* section, and enroll under the OPR classification and type, as described in the *Enrolling as an OPR Provider* section.

Similarly, to convert from OPR to a group or billing provider, the provider is required to disenroll as an OPR provider and then enroll with the IHCP as a billing or group provider under the appropriate provider type and specialty. See the *Disenrolling as an OPR Provider* section for instructions on disenrolling. For more information about enrolling as another provider type, see the *Complete an IHCP Provider Enrollment Application* page at in.gov/medicaid/providers.

> *Note: Currently, using the IHCP Portal to switch from an OPR provider to a group or billing provider type requires the provider to submit a disenroll transaction and then submit a new application as the new provider type. This process could result in an approximate 30-day gap between the two enrollments. However, if **paper forms** are used to disenroll as an OPR and to enroll as the new provider type, and the two transactions are submitted **at the same time, in the same envelope**, the new enrollment will start the day after the OPR enrollment is deactivated.*

Recertifying OPR Provider Enrollment

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

Revalidating OPR Provider Enrollment

The IHCP requires enrolled OPR providers to revalidate every five years based on their initial enrollment date. OPR providers will receive notification with instructions for revalidating in advance of the revalidation deadline. Notices will be sent to the mailing address on the OPR provider's enrollment file. It is important to keep address information up-to-date to ensure delivery of these notices. Providers that fail to revalidate in a timely manner will be disenrolled from the IHCP and must reenroll to participate.

OPR providers are encouraged to revalidate through the IHCP Portal using the Revalidation option. The portal guides users through the process, and supporting documentation can be attached and submitted online. Providers must be registered on the portal to take advantage of electronic revalidation.

OPR providers can also revalidate by mail by submitting a new *IHCP Ordering, Prescribing or Referring Provider Enrollment and Profile Maintenance Packet.*

OPR providers are not required to pay an enrollment fee at revalidation. OPR providers are considered limited-risk providers, which simplifies the revalidation screening process.

Disenrolling as an OPR Provider

OPR providers may voluntarily disenroll from the IHCP at any time. Registered IHCP Portal users with appropriate permissions can disenroll an OPR provider from the IHCP by using the **Disenroll** link on the portal's *My Home* page and completing the fields in the *Disenroll Provider* panel (Figure 35).

> *Note: When a provider is disenrolled from the IHCP, none of their prescriptions for Medicaid members can be filled, and medical orders may not be accepted.*

Alternatively, providers may disenroll by mail as follows:

1. Complete the *IHCP Ordering, Prescribing or Referring Provider Enrollment and Profile Maintenance Packet*. Detailed instructions are included in the packet. Complete **only** the following:
   - Field 1 – Select Disenroll as the type of request
   - Field 3 – Enter the requested effective date for the disenrollment (current or past dates only)
   - Field 5 – Enter the name of the disenrolling individual or entity
   - Field 36 – Enter your NPI
   - Fields 45–47 – Complete the *Provider Signature/Attestation* section as instructed
2. Submit the packet using the mailing instructions in the *Submitting and Processing OPR Provider Transactions* section.

Providers that are enrolled with the IHCP as an OPR provider may decide to change their enrollment status so they can bill for services rendered to their patients who are Medicaid members. To convert from OPR to a rendering provider, see the *Converting to OPR From Rendering or to Rendering From OPR* section. To convert from OPR to a group or billing provider, the provider is required to disenroll as an OPR provider and then enroll with the IHCP as a billing or group provider; see the *Converting to OPR From Billing or Group, or to Billing or Group From OPR* section for special instructions.

Submitting and Processing OPR Provider Transactions

Providers are encouraged to submit enrollment applications and updates via the IHCP Portal. If submitting these transactions by mail, the following information applies.

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

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

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

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

Opioid Treatment Programs Enrolled as OPRs

Opioid treatment programs certified by the Family and Social Services Administration (FSSA) DMHA must be enrolled as IHCP providers. Opioid treatment programs (OTPs) can be enrolled as billing providers (under either the billing or group classifications), as described in the *Opioid Treatment Programs* section, or they can be enrolled as ordering, prescribing or referring (OPR) providers. OTPs enrolled as OPR providers do not bill the IHCP for services, but may order, prescribe or refer services and supplies for patients that are IHCP members, and the rendering provider would be reimbursed. Note that practitioners who work with opioid treatment programs and write orders, referrals or prescriptions for IHCP members must also individually enroll with the IHCP for those services to be covered and reimbursed.

All OTPs enrolling with the IHCP (whether as OPR providers or as billing providers) are required to have a DEA license as well as certification from the DMHA.

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

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

Section 6: Provider Responsibilities and Restrictions

All providers must sign and abide by the *Indiana Health Coverage Programs (IHCP) Provider Agreement*. The provider agreement is in force and legally binding for the entire program eligibility period.

> *Note: All providers have an obligation under federal civil rights laws to ensure access to services for members with limited English proficiency. See the Introduction to the IHCP module for instructions on posting information to demonstrate nondiscrimination compliance.*

Updating Provider Information

It is the provider's responsibility to ensure that the enrollment information on file for that provider is complete and current, and to notify the IHCP of any changes within 30 business days of the change (10 business days for licensure, certification or permit changes). Returned mail may cause termination of the provider's program eligibility, resulting in denials for reimbursement of services; therefore, it is very important to keep profile information updated, including address changes. Providers are required to submit all updates to their enrollment information either electronically, via the IHCP Provider Healthcare Portal (IHCP Portal), or by mail, using the appropriate enrollment packet or profile maintenance form. See *Section 4: Provider Profile Maintenance and Other Enrollment Updates* for more information.

Screening for Excluded Individuals

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

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

As a condition of enrollment, providers must agree to comply with the following obligations:

- Screen all employees and contractors to determine whether any of them have been excluded. Providers can access the Exclusions Database at oig.hhs.gov and search by the name of any individual or entity.
- Search the Exclusions Database periodically to capture exclusions and reinstatements that have occurred since the last search.
- Report any exclusion information discovered to the IHCP by contacting the Provider and Member Concerns Line toll-free at 800-457-4515.

Maintaining Records

As outlined in *Indiana Administrative Code 405 IAC 1-1.4-2*, all providers participating in the IHCP must maintain such medical or other records, including X-rays, as are necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the IHCP. Providers must meet the following requirements:

- Records must be maintained for a period of seven years from the date services are provided.

> *Note: A copy of a claim form submitted by the provider for reimbursement is not sufficient documentation to comply with this requirement. Providers must maintain records documented at the time the services are provided or rendered and prior to associated claim submission.*

- Such medical or other records must be legible and must include, at the minimum, the following information and documentation:
  - Identity of the individual to whom service was rendered
  - Identity, including dated signature or initials, of the provider rendering the service
  - Identity, including dated signature or initials, and position of provider employee rendering the service, if applicable
  - Date that the service was rendered to the member
  - Diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only
  - A detailed statement describing services rendered, including duration of services rendered
  - The location at which the services were rendered
  - Amount claimed through the IHCP for each specific service rendered
  - Written evidence of physician involvement, including signature or initials, and personal patient evaluation to document the acute medical needs
  - When required under Medicaid rules, physician progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and redefine goals
  - X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records
- Financial records must be maintained for a period of at least three years following submission of financial data to the IHCP. A provider must disclose this financial data when the information is to be used during the rate determination process, as well as during audit proceedings.

Records maintained by providers are subject to prepayment and postpayment review and must be openly and fully disclosed and produced to the Family and Social Services Administration (FSSA), Indiana Department of Health (IDOH), or authorized representative with reasonable notice and request. This notice and request can be made in person, in writing, or orally, although some situations may require a request to review records without notice.

Maintaining Licensure and Certification

All providers are required to be duly licensed, registered or certified (*405 IAC 5-1.4-3*) to participate in the IHCP. IHCP Provider Enrollment uses a license verification process that includes all states' licensing board data to enhance provider information on file. Additionally, the Indiana Professional Licensing Agency (IPLA) submits monthly electronic provider license status reports to the IHCP Provider Enrollment Unit. The status reports permit the Provider Enrollment Unit to deactivate providers that no longer have active or unrestricted licensure. Out-of-state licensing board websites are used to validate licensure and to ensure licensing information is current and in good standing for providers that render services in other states. Any provider that is not appropriately licensed in the state where services are rendered is not eligible for enrollment in the IHCP for payment of services.

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

If a provider is required to recertify, a notification is mailed to the provider 60 business days prior to the end date for program participation:

- Providers that fail to renew their program eligibility within two weeks after the recertification end date must submit a new IHCP enrollment application along with the new license information and all required supportive documentation. Providers can submit the application online through the IHCP Portal or complete and submit an enrollment packet, available on the *Complete an IHCP Provider Enrollment Application* page at in.gov/medicaid/providers.
- If a provider recertifies prior to the program eligibility end date, an update via the *Provider Maintenance* page of the IHCP Portal (or update via a recertification form) and any required documentation are all that is required to extend the program eligibility.

All transportation providers are required to recertify based on either their insurance end date or the motor carrier's certificate end date. If the provider is required to have a surety bond, proof of surety bond is also required. For more information about recertification, see the *Recertify Provider Enrollment Licenses and Other Certifications* webpage.

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

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

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

Additional Information Needed for IPLA

Providers renewing their licenses with IPLA are required to include information about education background and practice characteristics. This information, gathered by questions during the renewal process, provides Indiana with an accurate representation of the state's workforce.

The education background and details about the practice are required from all providers licensed under the following licensing boards:

- Indiana Medical Licensing Board
- Indiana State Board of Nursing
- Indiana State Board of Dentistry
- Behavioral Health and Human Services Licensing Board
- Indiana State Psychology Board
- Indiana Board of Pharmacy

Most professional licenses issued by the IPLA can be renewed online at the IPLA website at in.gov/pla. The IPLA sends reminders to all licensees for each upcoming renewal cycle, and also accepts renewal applications by mail (online is preferred). For more information about renewing a license, refer to the IPLA website.

Substitute Physicians and Locum Tenens Healthcare Providers

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

Substitute Physicians

A substitute physician is a physician who is asked by the regular physician to see a member in a reciprocal agreement when the regular physician is unavailable to see the member. A substitute physician may be asked to see a member if the regular physician is not available or on call. The substitute arrangement does not apply to physicians in the same medical group with claims submitted in the name of the medical group.

In a substitute physician arrangement, both the regular physician and the substitute physician **must be enrolled** as IHCP providers.

The regular physician reimburses the substitute physician by paying the substitute the amount received for the service rendered, or reciprocates by providing the same service in return. To indicate that a substitute physician rendered the services, providers should include the modifier **Q5** with procedure codes on the professional claim (*CMS-1500* claim form, IHCP Portal professional claim or 837P electronic transaction).

A substitute physician arrangement should **not exceed 14 days**.

Locum Tenens Healthcare Providers

Providers can create a locum tenens arrangement when regular healthcare providers must leave their practice due to illness, vacation or medical education opportunity and do not want to leave their patients without care during this period.

The locum tenens policy applies to the following healthcare providers, according to the *Social Security Act United States Code 42 USC §1395x(r)*:

- Doctor of medicine or osteopathy
- Dentist
- Optometrist
- Podiatrist
- Chiropractor

Providers use the locum tenens arrangement in a single or a group practice, but the locum tenens healthcare provider cannot be a member of the group in which the regular healthcare provider is a member. The locum tenens healthcare provider usually has no practice of their own and moves from area to area as needed. The healthcare provider is usually paid a fixed per diem amount with the status of an independent contractor, not an employee.

The locum tenens healthcare provider must meet all the requirements for practice in Indiana, as well as all the hospital or other institutional credentialing requirements before providing services to IHCP members. The healthcare provider providing locum tenens care is **not required to be an IHCP provider**.

The regular healthcare provider's office personnel submit claims for the locum tenens care using the regular healthcare provider's NPI and modifier **Q6** for applicable procedure codes. The regular healthcare provider's office must maintain documentation of the locum tenens arrangement, including what care was rendered and when it was provided.

Locum tenens arrangements should **not exceed 90 consecutive days**. If the healthcare provider is away from the practice for more than 90 days, a new locum tenens would be necessary. If locum tenens providers remain in the same practice for more than 90 days, they must enroll as an IHCP provider.

Charging Members for Noncovered Services

Federal and state regulations prohibit providers from charging any IHCP member, or the family of a member, for any amount *not* paid for covered services following a reimbursement determination by the IHCP. This applies to providers in both the fee-for-service (FFS) and managed care delivery systems. See *Code of Federal Regulations, Title 42, Part 447, Subpart A, Section 447.15*; *Indiana Administrative Code, Title 405, Article 1, Rule 1, Sections 3(i)*.

Providers are also bound by a provision in the *IHCP Rendering Provider Agreement* that no member or family of a member may be billed in excess of the amount paid by the IHCP for covered services, and agree to the following:

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

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

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

Charging for Missed Appointments

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

Charging for Copies or Transfers of Medical Records

IHCP providers are *not* permitted to charge IHCP members for copies or transfers of medical records, including mailing costs. Federal regulation *42 CFR 447.15* states that providers participating in Medicaid must accept the state's reimbursement as payment in full (except that providers may charge for applicable deductibles, coinsurances or copayments). IHCP reimbursement for services is intended to cover certain overhead costs. Providers do not receive additional reimbursement from the IHCP, or authorized agents for the IHCP, for any cost associated with medical record duplications or medical record transfers, except for members in the Medical Review Team (MRT) benefit plan.

The IHCP considers physicians who charge Medicaid patients for copying or transferring medical records to be in violation of federal regulation and their *IHCP Provider Agreement*. Providers identified as showing a pattern of noncompliance with federal regulations and IHCP policy are subject to being audited.

Member Billing Exceptions

The following exceptions pertain to all IHCP members, regardless of their eligibility category or program.

An IHCP provider may bill an IHCP member for **noncovered** services ***only*** when the following conditions are met:

- The IHCP member must understand, **before receiving the service**, that the service is **not covered** under the IHCP and that the member is responsible for the service charges.
- The provider must maintain documentation in the member's file that clearly demonstrates that the member voluntarily chose to receive the service, knowing it was not covered by the IHCP. A provider may use a "waiver" form to document such notification; however, a "waiver" form is not required. Forms are subject to the following:
  - If a waiver form is used to document that a member has been informed that a service is noncovered, the waiver must not include conditional language such as "if the service is not covered by the IHCP, or not authorized by the member's PMP, the member is responsible for payment." This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or prior authorization (PA) as needed.
  - A generic consent form is not acceptable unless it identifies the specific procedure to be performed and the member signs the consent before receiving the service. If written statements are used, the statements must not contain conditional language such as, "If an IHCP service is not covered...."
  - Obtaining a signed waiver will not prevent the IHCP from investigating the facts alleged in the waiver.

Additional conditions for billing members apply based on circumstances, and adhere to federal regulations and Indiana code as noted:

- If the member has a PMP and wishes to receive services from a non-IHCP provider, the PMP must inform the member before services are rendered that the services will not be covered and may include an additional out-of-pocket expense.
- The service to be rendered must be determined to be noncovered by the IHCP. For example, the member has exceeded the program limitations for a particular service or PA for the service was denied.

- The covered or noncovered status of embellishments or enhancements to basic services can be considered separately from the basic service only if a separate procedure, revenue or National Drug Code (NDC) exists:
  - If a separate code exists, a noncovered embellishment or enhancement may be billed to the member and the basic charge billed to the IHCP.
  - If a separate code does not exist, the service, in its entirety, is considered covered or noncovered.

    Example: Because no separate procedure exists for embellishments to a standard pair of eyeglass frames, it is not allowable for the IHCP to be billed for the basic frames and for the member to be billed for additional charges. The entire charge for embellished frames is noncovered by the IHCP in accordance with the IAC guidance for covered services.
- Providers can bill a member in situations where, after the provider takes appropriate action to ascertain and identify a responsible payer for a service, there is no indication that the individual has coverage under any IHCP program. This means:
  - The provider may bill the member if the member failed to advise the provider of Medicaid eligibility.
  - If the provider is notified of the member's Medicaid eligibility within the 180-day timely filing limit, the IHCP must be billed for the covered service. Any monies that were collected by the IHCP provider from the IHCP member must be reimbursed in full to the member immediately.

    Note: For information about claim filing limits, see the Claim Submission and Processing module.
  - Documentation must be maintained in the file to establish that the member was billed or information was requested within the timely filing limit.
- The provider may bill the member the amount credited to the member's waiver liability as identified on the remittance advice (RA) following the final adjudication of the claim.
- Providers may bill a member if the service is not covered by the member's benefit plan, such as services not related to family planning for Family Planning Eligibility Program members, and nonemergency services for to Package E (Emergency Services Only) members.
- Providers may bill a member when a service required prior authorization but the authorization was denied by the IHCP.
- Providers may bill a member for services that exceed a benefit limit when prior authorization is not available to receive additional services.
- A hospital can bill a member for services if the hospital's utilization review (UR) committee established under *42 CFR 482.30* makes a determination that a continued stay is not medically necessary. The determination must comply with the requirements of *42 CFR 482.30(d)(1)*, which states:

  The determination that a continued stay is not medically necessary:

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

  II. Must be made by at least two members of the UR committee in all other cases. Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.
- If the UR committee decides that admission to or continued stay in the hospital is not medically necessary, the committee must give written notification, no later than two business days after the

determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in *Section 482.12(c).*

- Before billing the patient, the provider must notify the patient or the patient's healthcare representative in writing that the patient will be responsible for the cost of services provided after the date of the notice.
- Providers should consult with their attorneys or other advisors about any questions concerning their responsibilities in the UR process.

Refusing or Restricting Services to Members

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

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

A sample nondiscrimination posting is included in the *Introduction to the IHCP* module. It addresses civil rights and prohibits discrimination when providing IHCP-covered services.

Solicitation, Fraud and Other Prohibited Acts

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

- Door-to-door solicitation
- Screenings of large or entire inpatient populations, except where such screenings are specifically mandated by law
- Any other type of inducement or solicitation to cause a member to receive a service that the member does not want or does not need

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

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