Summary of Indiana Medicaid Provider Credentialing Policy

This summary explains the process used for providers who apply to join the Optum network serving the Medicaid members covered through UnitedHealthcare Community Plan of Indiana. Optum processes every Indiana network application according to Indiana state law and Optum credentialing standards.

- Optum uses the Family and Social Services Administration (FSSA) standard provider credentialing form during the credentialing process. The Provider Enrollment Form and the Credentialing Form can be found on the Indiana Health Coverage Programs (IHCP) Provider Enrollment Transactions webpage.
- Optum will notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider within 5 business days after the completed unclean credentialing application is received. The notice must:
  - Provide a description of the deficiency; and
  - State the reason why the application was determined to be an unclean credentialing application.
  - The provider shall respond to the notification within 5 business days after receipt of the notice.
- Federal database checks for Practitioners and Facilities are conducted through the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) prior to credentialing/recredentialing decision.
- Additional requirements include:
  - Verification of sanctions of Practitioners and Facilities through FSSA Termination of Provider Participation in Medicaid and CHIP at initial and recredentialing
  - Work history that includes a minimum of 5 years on the curriculum vitae at initial credentialing
  - Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing
- Recredentialing process must include data from at least 3 of the following 6 sources:
  - Member complaints
  - Quality reviews (practice-specific)
  - Utilization management (profile of utilization)
  - Member satisfaction (practice-specific)
  - Medical record review
  - Practice site reviews
- A provider will be credentialed within 30 calendar days of receipt of a complete application. All credentialed providers are loaded into the claims system within 7 business days of credentialing. The Contractor shall set the provider's enrollment date to the initial date the provider's credentialing application was received by the Contractor or State's credentialing vendor.

  NOTE: If a decision on a clean application is not made within 15 calendar days of receipt of the application, and the provider is applying to the health plan for first time participation with the health plan, Optum must consider the provider to be provisionally credentialed when the provider meets the NCQA requirements to be considered provisionally credentialed.

- Providers will be effective with Optum on the first of the month following the receipt of a complete network participation request and following the additional guidance below:
    - A brand-new provider that is not part of an existing contract with Optum will be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the Optum receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
    - A provider that is being added to an existing contract will also be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date Optum receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
    - In order to be able to render services, the contract or contract amendment must still be executed by both parties.
    - Optum will use the standard out-of-network process for services rendered by providers prior to the effective date if needed for member access to care.
    - The Optum network effective date must also be after the IHCP effective date. Providers must be enrolled and effective with IHCP prior to being effective with Optum.
    - The effective date will be the first of the month following the receipt of a complete network participation request, regardless of the contract execution date or credentialing completion date. In most cases, the effective date will be retroactive back to the first of the month following receipt of the complete network participation request since providers will not be fully effective until they are credentialed by and have a signed contract or contract amendment with the Managed Care Entity (MCE).

      NOTE: If a provider is unable to be credentialed with Optum, the provider will not be effective with Optum.

      NOTE: If a provider and Optum cannot come to terms with a contract, the provider will not be effective with Optum.
- Providers should hold all claims until the final welcome letter from Optum is received confirming that they are effective with the Optum network. Optum and providers are expected to complete all pieces of the network participation process timely. However, in instances where the network participation process extends for a time period longer than the standard timeframe, Optum will not hold providers to the timely filing limit for claims rendered before the provider was confirmed effective.
- Network providers will be required to participate in the state Medicaid program. Optum will conduct validation of providers' enrollment with IHCP as a contracted provider.
- The same provider credentialing standards apply across all Indiana Medicaid programs.
- Optum's provider credentialing and selection policies do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.