DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Go Green with DMAP

Updated Electronic Claims Submission Requirements

Effective July 1, 2023, the Delaware Medical Assistance Program (DMAP) will require all claims to be submitted electronically as part of the Go Green initiative.

The process for transitioning from paper claims to electronic claims consists of 3 phases:

- **Phase 1**: Dental billing claims – Effective January 1, 2017
- **Phase 2**: UB-04 billing claims – Effective January 1, 2023
- **Phase 3**: CMS-1500 billing claims – **Effective July 1, 2023**

Any paper claims submitted after June 30, 2023, will not be processed, or returned.

We are currently in Phase 2: UB-04 Electronic Claims.

Effective January 1, 2023, all UB-04 billing claims must be submitted electronically. The UB-04 claim form is used by inpatient and outpatient hospitals, long-term care and assisted living facilities, hospice, and home health providers in billing DMAP for services provided to eligible Medicaid members. All member services must be billed on separate claim submissions.

All UB-04 claims submitted using a paper form will be returned to the provider and must be re-submitted electronically through one of the approved methods.

…continued on page 4.

In This Edition:

gainwell

What's New: From the Provider Portal homepage, visit the How-To Corner to open the pathway to Provider Guides. Review documents related to your interests.

Continuity of Care for Delaware First Health (DFH) Members

On January 1, 2023, DFH began serving Delaware Medicaid members. **DFH's current membership includes members who may have been previously enrolled with Highmark Health Options (HHO) and/or AmeriHealth Caritas (AHC), as well as new Delaware Medicaid members who selected DFH during the open enrollment period in fall 2022.** Please be advised that Delaware Medicaid members may have changed their MCO to DFH. However, **the DFH provider network needs additional providers to meet the growing demands of the Delaware Medicaid Program.**

During the DFH 120-day continuity of care period (dates of services January 1, 2023 - May 1, 2023), DFH will cover services for participating and non-participating providers under the following circumstances:

- If you have an authorization from another MCO for an outpatient service; or
- If you are treating a member in an ongoing course of treatment; and/or
- If you have an authorization from another MCO for in-patient services. Even though a request for an in-patient prior authorization is waived, providers must still notify DFH of admission for concurrent review and discharge planning.

For information about provider enrollment with Delaware First Health, please reach out to DFH Provider Enrollment:

- Complete the online Contract Request Form.
- Call DFH toll free 1-855-688-6589.
- Email DFH at contracting@delawarefirsthealth.com.

Electronic Visit Verification (EVV) is Here! EVV is Live!

Effective Friday, December 30, 2022, providers of In-Home Personal Care Services (PCS) and Home Health Care Services (HHCS) must validate in-home services provided to Medicaid members using an electronic system such as a phone, tablet, or other device. These services **must** be verified each time with either the state provided EVV solution, Sandata, or an alternate EVV solution of the provider's choice that meets state and federal requirements. For more information regarding EVV, please click the following link: https://dhss.delaware.gov/dhss/dmma/info_stats.html.

All providers of in-home PCS and HHCS are also required to register with the Sandata provider self-registration portal. Visit the Sandata EVV Provider Self-Registration Portal. You MUST have your Medicaid Provider Identification Number (MCD ID) to register. If you need help with identifying your MCD ID, please contact DMAP Provider Services from 8:00 AM ET to 4:30 PM ET at 1-800-999-3371, select option 0, option 4.

Once the registration process is complete, providers may begin accessing the Sandata training resources.

- Providers who are utilizing Sandata as their EVV solution: Sandata Learn.
- Providers utilizing an alternate EVV vendors: DE Aggregator Training.

Please contact the EVV Provider Service Team at DHSS_DMMA_EVV@delaware.gov if you have questions or require more information pertaining to acceptable EVV solutions.

Helpful Titles

- DMAP Provider Screening and Enrollment Frequently Asked Questions
- How-To View and Verify a Member's Eligibility through the Provider Portal
- How-To Utilize Treatment History Panels

Top Tips

- Provider Enrollment
- Provider Health Information Portability and Accountability Act

***Remittance Advice Reminder:** RAs are available on the Provider Portal every **Monday** after 12:00 noon ET.

Ambulatory-Free Standing Surgical Center Provider Specific: Revision Date – 02/01/2023: Sections Revised:

- In compliance with the registered trademark of the American Medical Association, added the ® symbol to each instance of CPT®.
- Updated manual title page and replaced references of client with member.

Clinic Provider Specific: Revision Date – 02/01/2023: Sections Revised:

- In compliance with the registered trademark of the American Medical Association, added the ® symbol to each instance of CPT®.
- Updated manual title page and replaced references of client with member.

Hospice Provider Specific: Revision Date – 02/01/2023: Sections Revised:

- In compliance with the registered trademark of the American Medical Association, added the ® symbol to each instance of CPT®.
- Updated manual title page and replaced references of client with member.

Independent Lab Provider Specific: Revision Date – 02/01/2023: Sections Revised:

- In compliance with the registered trademark of the American Medical Association, added the ® symbol to each instance of CPT®.
- Updated manual title page and replaced references of client with member.

Independent Therapist Provider Specific: Revision Date – 02/01/2023: Sections Revised:

- In compliance with the registered trademark of the American Medical Association, added the ® symbol to each instance of CPT®.
- Updated manual title page and replaced references of client with member.

Long Term Care Provider Specific: Revision Date – 02/01/2023: Sections Revised:

- Updated manual title page and replaced references of client with member.

NCPDP D.0 Claim Billing or Encounter Payer Sheet: Revision Date – 12/01/2022: Section Revised:

- Updated 1Ø4-A4 values.

Pharmacy Billing Manual: Revision Date – 12/01/2022: Section Revised:

- Section 4.0 – Removed obsolete wording.

General Policy Manual: Revision Date – 11/22/2022: Sections Revised:

- Section 1.38.2.2.1 – Updated section to include the disclosure of changes related to permits, certifications, and accreditations.
- Section 1.38.2.2.2 – Additional screening and enrollment clarification for high-risk provider types that are not recognized by Medicare for enrollment.
- Section 1.38.2.3.2 – Updated section to include the disclosure of changes related to permits, certifications, and accreditations.
- Section 1.38.2.3.3 – Additional screening and enrollment clarification for high-risk provider types that are not recognized by Medicare for enrollment.

Updated Electronic Claims Submission Requirements

Phase 3: CMS-1500 billing claims will be effective July 1, 2023, and DMAP will no longer accept CMS-1500 paper claims forms. The CMS-1500 is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers, durable medical equipment regional carriers (DMERCs), and some state agencies when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. For more information about the CMS-1500 form, visit the CMS website.

Effective July 1, 2023, all claims, both singles and their attachments, must be submitted electronically through an approved software vendor, clearinghouse, or through the DMAP Provider Portal. Any paper claims submitted after June 30, 2023, will not be processed, or returned.

You Ask, DMAP Answers (YADA)

How do I check member eligibility on the DMAP Portal?

1. Go to the Delaware Medical Assistance Portal and log into the Secure Portal.
2. From the homepage, click the **Eligibility** tab.
3. Select **Eligibility Verification**.
4. Enter the Member ID and the Effective Date.
    a. If the Member ID is not known, enter the Social Security Number (SSN) and birth date.
5. Click **Submit.**
6. The bottom portion of the panel displays the search results to link to the Eligibility Verification Coverage. There can be more than one type of coverage for each effective date.
7. Click on the coverage title for more information, including a more detailed description and the effective dates.
    a. If the member is enrolled in a Managed Care Oragnization (MCO), the panel may provide additional details.

For more information on how to view a member's eligibility on the DMAP Provider Portal, view How To View and Verify a Member's Eligibility through the Provider Portal on the DMAP Document Repository. For other How-To documents, visit the How-To Corner. **Note:** Managed Care Organization-Only Providers (MCOPs) should refer to their MCO Handbook for member eligibility verification instructions.

***YADA Disclaimer**: DMAP acknowledges that the YADA responses provided are general and are not intended to be a comprehensive listing of all of the possible answers pertaining to provider services. Please continue to send inquiries to the Provider Services Team.

Delaware Cancer Treatment Program

The Delaware Cancer Treatment Program (DCTP) is available to Delaware residents who:

- Were residents of Delaware when diagnosed with cancer,
- Were diagnosed with cancer on or after July 1, 2004,
- Have no comprehensive health insurance,
- Do not receive benefits through the Medicaid Breast and Cervical Cancer Treatment Program,
- Meet income guidelines (up to 650 percent of the Federal Poverty Level), and
- Are not eligible for health insurance.

The DCTP is also available to Delaware residents with comprehensive health insurance who:

- Were residents of Delaware when diagnosed with cancer,
- Were diagnosed with cancer on or after July 1, 2004,
- Do not receive benefits through the Medicaid Breast and Cervical Cancer Treatment Program,
- Meet income guidelines (up to 650 percent of the Federal Poverty Level), and
- Meet maximum out-of-pocket expense for health insurance of equal to more than 15 percent of their household income (does NOT include premiums) *.

***Applicant must submit documentation from their insurance carrier notating the maximum out-of-pocket expense in order to determine eligibility**.

The DCTP application is available online at healthydelaware.org. Please click HERE for more information and to download both the English and Spanish application packet. For more information on DCTP, please call 1-844-245-9580.

DCTP Prior Authorization

The DCTP follows current Medicaid guidelines regarding what is required for submission of a prior authorization form for approval for service. When completing DCTP prior authorization forms, please use your Medicaid ID / Location ID (MCD ID). This number is issued by the Delaware Medical Assistance Portal (DMAP) and is different from your National Provider Identifier (NPI) or Tax ID. The MCD ID will start with either a '25' for newly enrolled providers or a '20' for previously enrolled providers. If you are unsure of your MCD ID, it is displayed on the gray bar at the top of the page once you are logged in to the Provider Portal. ***Prior authorizations for DCTP are not to be submitted on the Portal.***

Please click HERE to access the form that **MUST** be utilized for all DCTP participant prior authorization requests. **Note:** The DCTP Prior Authorization form is different from other Prior Authorization forms. For more information about the DCTP program, including prior authorization of services for those in the DCTP program, please call 1-844-245-9580.

Managed Care Organizations (MCOs) for 2023

The Delaware Department of Health and Social Services (DHSS) has selected three managed care companies to operate its Medicaid Managed Care Program. Centene's Delaware First Health has joined Highmark Health Options Blue Cross Blue Shield, which began operating in Delaware in 2015, and AmeriHealth Caritas, which began in 2018.

The three managed care organizations will provide additional options for the approximately 300,000 Medicaid members statewide in Delaware. For information about provider enrollment, please reach out to the MCOs at the contact numbers below.

AmeriHealth Caritas
1-855-707-5818

Delaware First Health
1-877-236-1341

Highmark Health Options
1-844-325-6251

Medicaid Fraud Laws

Laws governing Medicaid fraud specify the criminal, civil, and administrative remedies the government may impose on individuals or entities that commit fraud and abuse in the Medicaid Program. Violating these laws may result in nonpayment of claims, Civil Monetary Penalties (CMPs), exclusion from all Federal health care programs, and criminal and civil liability.

Medicaid fraud laws include:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)

False Claims Act (FCA)

The civil FCA protects the government from being overcharged or sold substandard goods or services and imposes civil liability on any person who knowingly submits or causes the submission of a false or fraudulent claim to the government. The terms "knowing" and "knowingly" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. No proof of specific intent to defraud is required to violate the civil FCA.

Example: A physician knowingly submits claims to Medicaid for a higher level of medical services than actually provided or higher than the medical record documents.

Penalties: Civil penalties for violating the FCA may include recovery of up to three times the amount of damages sustained by the government as a result of the false claims, plus additional penalties per false claim filed. A criminal FCA statute exists by which individuals or entities submitting false claims may face fines, imprisonment, or both.

Anti-Kickback Statute (AKS)

The AKS makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a federal health care program. When a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the AKS.

Example: A provider receives cash or below fair market value rent for medical office space in exchange for referrals.

Penalties: Civil penalties for violating the AKS may include three times the amount of the kickback. Criminal penalties for violating the AKS may include fines, imprisonment, or both.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from referring certain designated health services payable by Medicaid to an entity in which the physician (or an immediate family member) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Example: A provider refers a beneficiary for a designated health service to a business in which the provider has an investment interest.

Penalties: Penalties for physicians who violate the Stark Law may include fines, Civil Monetary Penalties, repayment of claims, and potential exclusion from all federal health care programs.

If you have any further questions regarding fraud, waste, or abuse, please contact the DMMA SUR Unit at:

Toll-Free Telephone: 1-800-372-2022
Hotline (After-Hours Voicemail Only) 1-800-372-2022, select option #1
Email: SURreferrals@state.de.us

Current Drug Shortages

There is currently an ongoing Amoxicillin shortage. Providers may be contacted by a pharmacy if the prescribed product is not available. Please consider alternate dosage forms, alternate products, or compounded products where appropriate.

Current U.S. Food and Drug Administration (FDA) drug shortage background information, including news, reports, and extended use dates can be found online at: https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages.

A searchable database of current and resolved drug shortages and discontinuations reported to the FDA can be found online at: https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm.

FDA recommends avoiding use of NSAIDs in pregnancy at 20 weeks or later because they can result in low amniotic fluid.

The U.S. Food and Drug Administration (FDA) is warning that use of nonsteroidal anti-inflammatory drugs (NSAIDs) around 20 weeks or later in pregnancy may cause rare but serious kidney problems in an unborn baby. This can lead to low levels of amniotic fluid surrounding the baby and possible complications. NSAIDs are commonly used to relieve pain and reduce fevers. They include medicines such as aspirin, ibuprofen, naproxen, diclofenac, and celecoxib. After around 20 weeks of pregnancy, the unborn babies' kidneys produce most of the amniotic fluid, so kidney problems can lead to low levels of this fluid. Amniotic fluid provides a protective cushion and helps the unborn babies' lungs, digestive system, and muscles develop.

Although this safety concern is well known among certain medical specialties, we wanted to communicate our recommendations more widely to educate other health care professionals. This issue affects all NSAIDs that are available by prescription and those that can be bought over-the-counter (OTC) without a prescription.

Source:https://www.fda.gov/drugs/drug-safety-and-availability/fda-recommends-avoiding-use-nsaids-pregnancy-20-weeks-or-later-because-they-can-result-low-amniotic

FDA announces Evusheld is not currently authorized for emergency use in the U.S.

The U.S. Food and Drug Administration (FDA) revised the Emergency Use Authorization (EUA) for Evusheld (tixagevimab co-packaged with cilgavimab) to limit its use to instances in which the combined frequency of non-susceptible SARS-CoV-2 variants nationally is less than or equal to 90%. Based on this revision, Evusheld is not currently authorized for use in the U.S. until further notice by the FDA.

Data shows Evusheld is unlikely to be active against certain SARS-CoV-2 variants. According to the most recent CDC Nowcast data, these variants are projected to be responsible for more than 90% of current infections in the U.S. This means that Evusheld is not expected to provide protection against developing COVID-19 if exposed to those variants.

Source:https://www.fda.gov/drugs/drug-safety-and-availability/fda-announces-evusheld-not-currently-authorized-emergency-use-us

Help Us Get the Word Out

The following information is being provided to members as a reminder to update their contact information to avoid any interruption of medical services. For printable versions of the flyer/poster in Spanish and English, visit the DMAP Portal Document Repository. For more information about Delaware Medicaid PHE Unwinding: de.gov/medicaidrenewals.

Notable Dates and Information

Enrollment Fees

Effective **May 12, 2023**, institutional providers must submit an application enrollment fee of $688.00 at initial application, reactivation, revalidation, reenrollment, or addition of a new service location.

Provider Taxonomy Screening Level List

MCOP Taxonomy Screening Level List

1135 Waivers

The abbreviated processes for provider screening and enrollment that were approved during the COVID-19 PHE will end on May 11, 2023. Effective **May 12, 2023**, all program integrity requirements for provider screening and enrollment will resume.

HHS Transition Roadmap

Pharmacy Signatures

Effective **May 12, 2023,** pharmacy providers must obtain the written name and signature of the recipient or their representative upon receipt of a DMMA-covered medication.

Pharmacy Provider Manual

Children's Dental Program

The following are Dental Code changes for the Children's Dental Program only.

The following codes have been updated. The Children's Dental Policy Manual will be updated accordingly.

- **Effective 12/01/2022:** CDT code D2740 age limitation 14 – 20 years; Prior authorization required.
- **Effective 12/01/2022:** CDT codes D3110 and D3120 age limitation 0 – 20 years; Once per lifetime per tooth, primary and permanent.

Adult Dental Program

Dental providers currently enrolled in DMAP/Fee for Service (FFS) in the following taxonomies can provide services to eligible adult members enrolled in FFS. **Join us to meet the growing demands of the Adult Dental Program.** Dental providers who are not currently enrolled in DMAP/FFS with the taxonomies listed below must enroll with an MCO to provide services to eligible DMAP adult members.

Provider Description	Taxonomy Code	Enrollment Type (Group and/or Individual)
Dentist	122300000X	Both
Endodontics	1223E0200X	Individual
Periodontics	1223P0300X	Individual
Prosthodontics	1223P0700X	Individual
Oral & Maxillofacial Surgery	1223S0112X	Individual

Managed Care Organization (MCO) Enrollment

Dental providers who want to provide adult dental services to members in the Delaware Medicaid managed care population **must** enroll with an MCO. For additional information, please see the MCO contact information below.

- AmeriHealth Caritas: 1-855-707-5818
- Delaware First Health: 1-877-236-1341, Option 3, then Option 4
- Highmark Health Options: 1-844-325-6251; Secure Email

For additional information regarding the Division of Medicaid and Medical Assistance (DMMA) Adult Dental Program, click HERE.

DMAP Dental Manuals

The DMAP launched the Adult Dental Program Provider Specific Manual on 10/01/2020. The Dental Provider Specific Manual is now the Children's Dental Program Provider Specific Manual, effective 10/01/2020. The former Dental Provider Specific Manual has been archived for reference.

Early Periodic Screening, Diagnosis & Treatment Corner

Preventative Pediatric Health Care Updates

The purpose of Delaware's Children with Medical Complexity Advisory Committee (CMCAC) is to strengthen the system of care, increase the collaboration across agencies, encourage community involvement, and ensure that every child with a medical complexity has the opportunity to receive the adequate and appropriate health care services they need and deserve. One of the priorities identified by the CMCAC is to develop new and strengthen existing resources for parents/caregivers, providers, and the larger community involved in the care of children with medical complexity. The Children with Medical Complexity (CMC) Resource Page has resources for children with medical complexities, their families, providers, and other stakeholders.

New resources on the CMCAC website include:

- Children with Medical Complexities Durable Medical Equipment (DME) and Supplies Information Sheet / FAQ
  - DMEs and Supplies ordered by doctors include medical equipment and supplies that assist with daily activities. Examples of DMEs include hospital beds and ventilators. Examples of medical supplies include diapers and nutritional supplements.
- Children with Medical Complexities Pharmacy Products and Services Information Sheet / FAQ
  - Pharmacy Products and Services are ordered in a particular way by a doctor and may require special considerations for payment. Common types of pharmacy products and services include acute medications for short-term conditions and maintenance medications to treat chronic long-term conditions.

Families of children with medical complexities created these resources in collaboration with the Division of Medicaid and Medical Assistance (DMMA). Click the link below:

Resources for Families, Providers, and Others Involved in the Care of Children with Medical Complexity - Delaware Health and Social Services - State of Delaware

USPSTF Recommendations

Delaware Medicaid provides coverage and reimbursement of all preventative services assigned either grade A or B by the United States Preventive Services Task Force (USPSTF). Click HERE for the comprehensive listing of USPSTF recommendations.

Recommendations with a grade of either A or B

Topic	Description	Grade	Release Date of Current Recommendation
Syphilis Infection in Nonpregnant Adolescents and Adults: Screening: asymptomatic, nonpregnant adolescents and adults who are at increased risk for syphilis infection	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	A	September 2022*
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years.	B	October 2022
Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	B	October 2022*

*Previous recommendation was an “A” or “B.”

Reminder: DMMA Extended Preventative Coverage to Younger Delaware Medicaid Recipients to Align with USPSTF Recommendations for Colorectal Cancer Screenings

The United States Preventive Services Task Force (USPSTF) expanded the recommended ages for colorectal cancer screening from 50 to 75 years to now include ages 45 to 75 years. The USPSTF continues to recommend selectively screening adults aged 76 to 85 years for colorectal cancer.

This expansion covers adults 45 years and older who do not have signs or symptoms of colorectal cancer and who are at average risk for colorectal cancer (i.e., no prior diagnosis of colorectal cancer, adenomatous polyps, or inflammatory bowel disease; no personal diagnosis or family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer [such as Lynch syndrome or familial adenomatous polyposis]).

Managed Care Organization-Only Providers (MCOPs)

MCOP Screening and Enrollment Updates

In compliance with 42 CFR § 438.602, 42 CFR Part 455, subparts B and E, and the 21st Century Cures Act, Delaware Medicaid is required to screen and enroll all current and prospective Managed Care Organization-Only Providers (MCOPs).

In June 2022, the Delaware Medical Assistance Program (DMAP) sent registration letters to current In-Network MCOPs to initiate the screening and enrollment process. MCOPs with multiple National Provider Identifiers (NPIs) and taxonomies received separate letters. The letters indicated the unique ID / Medicaid Provider Identification Number (MCD ID) and address for each service location associated with the NPI and taxonomy combination. In some cases, duplicate unique IDs (MCD IDs) were assigned due to slight differences in reported addresses (ex. Suite vs STE). MCOPs must verify and enroll the correct unique ID (MCD ID) and address with DMAP to continue to receive Medicaid payments for services. Failure to successfully enroll with DMAP will result in termination of the Medicaid contract associated with each un-enrolled service location. Many providers have successfully completed the enrollment process and are approved to continue in the Delaware Medicaid program; however, some have not acted.

Due to the overwhelming response received from the provider community, DMAP has extended the date to complete the required MCOP Enrollment Application on the Provider Portal. DMAP has heard you and remains committed to adding new system capabilities, thus allowing more time for providers to complete the registration process.

The **new deadline** for all current MCOPs to complete the enrollment application is **September 30, 2023**. Please ensure that current contact information is up-to-date and be sure to register each service location. We hope that the system changes and deadline extension prove to be beneficial, and that the registration process is more streamlined. **DMAP would like to reiterate that providers that are currently engaged are not at risk of losing a suspended payment and/or termination from the Delaware Medicaid Program and Managed Care Organization (MCO) network participation. We encourage you not to wait and to enroll all service locations as soon as possible.**

To ensure that you receive all communications, please update your contact information with Highmark Health Options (HHO), AmeriHealth Caritas (AHC), and Delaware First Health (DFH) via your MCO Provider Portal now!
Contact information includes phone numbers, addresses (mailing, service location, billing, credentialing, and enrollment to include floor and suite numbers), point-of-contact names, and email addresses.

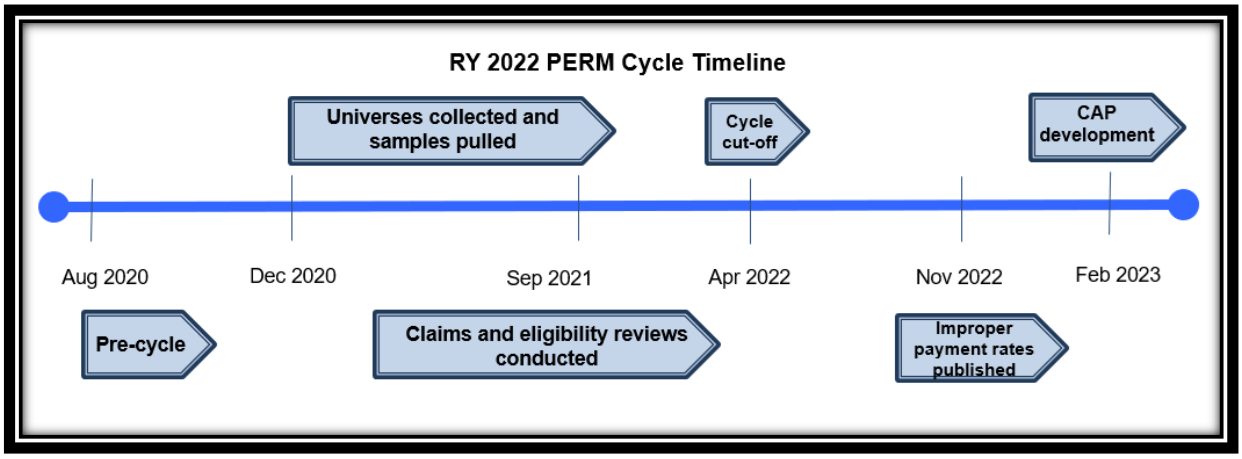
As a reminder, the Social Security Act § 1932(d)(6)(A) mandates that "*a state shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1902(kk) with the State agency administering the State plan under this title. Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.*"

For More Information:

- Read the Rule: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf
- Check out the Announcement Section on the DMAP Provider Portal for MCO Provider Screening and Enrollment updates.
- **To check on the status of your MCOP registration, provider enrollment application, or for assistance** contact DMAP Provider Services from 8:00 AM ET to 4:30 PM ET at 1-(800) 999-3371, select option 0, option 4.

PERM Cycle RY22 Updates

DMMA would like to thank all providers and staff that participated in the RY22 PERM cycle. Please see the RY 2022 PERM timeline below.



The Division of Medicaid and Medical Assistance (DMMA) has received the final errors and completed the final phase in the development and approval of the Corrective Action Plan (CAP). As taken from the CMS website (Corrective Action Plan (CAP) Process | CMS), a CAP is a "narrative of steps taken to identify the most cost-effective actions that can be implemented to correct errors causes." When DMMA receives the approved CAP, DMMA may reach out to you for assistance and requests that you respond promptly.

CMS will collect the Federal Financial Portion (FFP) back from the State for claims where proper documentation is not submitted by providers timely. Consequently, DMMA will recoup the payment from a liable party as a PERM Recovery.

IMPORTANT: Providers must submit proper medical record documentation supporting the paid claim(s) selected for the audit. The required documentation must include sufficient information to validate that provided services were medically necessary and were consistent with the specified diagnosis during the time of claim payment. If providers have questions regarding documentation, they should refer to the provider-specific policy manual. Additionally, providers must comply with all federal and state laws, regulations, and billing instructions provided under the Delaware Medicaid program pursuant to Section 1.6 Provider Contractual/Programmatic Responsibilities in the General Policy Manual.

- 1.6.1 states "A provider who signs a contract with the Delaware Medical Assistance Program (DMAP) is responsible to meet certain conditions in order to remain an eligible provider and receive payment for services rendered."
- 1.6.2 states "Providers are responsible for the accuracy, truthfulness, and completeness of all claims submitted to DMAP. The provider is further responsible for all costs associated with the preparation for the submission of claims, whether prepared or submitted by the provider or by an outside agency or service."
- Refer to Section 1.6 of the General Policy Manual for additional information regarding provider responsibilities.

CMS will collect the Federal Financial Portion (FFP) back from the State for claims where proper documentation is not submitted by providers timely. Consequently, DMMA will recoup the payment from a liable party as a PERM Recovery.

Questions?

If you have any questions or concerns regarding this program, please contact DeeGee Peterson at DeeGee.Peterson@delaware.gov, Alicia Seals at Alicia.Seals@delaware.gov, or Theodore R. Robinson, Chief of Program Integrity, DMMA, at Theodore.R.Robinson@delaware.gov.

Reminders

Vaccine for Children (VFC) – Encounter for Immunization

Diagnosis code Z23 (ENCOUNTER FOR IMMUNIZATION) may be used as a primary diagnosis code for immunizations in a physician setting when the member is in the VFC Program.

How To Update Provider Contact Information on the Provider Portal

Enrolled providers can update their contact information (i.e., phone number, mailing address) and demographic information (i.e., accepting new patients, language spoken, etc.) on the Provider Portal. Accurate contact and demographic information are invaluable to DMAP members in need of medical service.

1. Log into the Secure Portal.
2. Select Characteristics.
3. Select the plus sign (+) next to the address to be updated.
   a. The "Mail To", "Pay To", and "Home Address" can be updated on the Portal.
   b. If the Service Location changes, a new application will be required to enroll the new Service Location.
   c. The Contact Information can be updated on the Service Location.
4. Select Edit.
5. Make the necessary updates and select Save.
   a. Ensure the "Mail To" address is up to date to receive DMAP administrative notifications such as welcome letters, revalidation invitations, and administrative updates.

Delaware Medicaid Retroactive Coverage Fact Sheet

The Division of Medicaid and Medical Assistance (DMMA) has expanded the groups of individuals who are eligible for retroactive Medicaid coverage. Click HERE to view information detailing the definition of retroactive coverage, eligible members, effective dates, and reimbursement for providers.

Provider Disclosure

Sections 6401 and 6501 of the Affordable Care Act require states to incorporate additional program integrity provisions within Medicaid and the Children's Health Insurance Program (CHIP) to prevent fraud, waste, and abuse. In compliance with Title 42 CFR §455, Subpart B, providers must complete the online DMAP Disclosure Statement of Information by Providers and Fiscal Agents upon enrollment, revalidation, re-enrollment, reactivation, and within 30 days of any change contained in the enrollment application. For more information regarding the Disclosure of Information by Providers and Fiscal Agents Statement, see the General Policy Manual and How-To Disclosure Statement of Information to be Completed by Providers and Fiscal Agents.

Provider Security Awareness and HIPAA Tips

Providers and Trading Partners provide the first line of defense in securing member protected health information (PHI) and maintaining compliance with the Health Insurance Portability and Accountability Act (HIPAA). DMAP suggests the following security tips to prevent breaches and to combat fraud, waste, and abuse.

- Develop and maintain internal systematic training for staff regarding DMAP Portal registration privileges and HIPAA compliance.
- Review and monitor DMAP Portal user roles (administrator and delegates) and levels of access.
- Review DMAP Portal access for all employees who are on extended leave or have not logged in to the DMAP Portal within the last 180 days.
- Complete timely DMAP Portal deactivation and removal of staff access for employees who have separated employment.
- Complete annual HIPAA training for all providers and staff.
- Report ALL suspected PHI breaches and related incidents immediately via the Report Fraud SUR Referral Form link.

Need Assistance?

Phone & Fax Contacts

Provider Contacts

1-800-999-3371

Provider Pharmacy	**option 0, option 1** *****Fax 302-454-0224***
Provider Services	**option 0, option 2** (***1 – Member Eligibility; 2 – Claim Status***) *****Fax 302-454-7603***
Provider Incentive Program	**option 0, option 3** *****Fax 302-454-7603***
Provider Enrollment	**option 0, option 4** *****Fax 302-454-7603***

Member Contacts

1-800-996-9969

Health Benefits Manager

Delaware Cancer Treatment Program (DCTP)*

****Fax ONLY 302-454-0223***

Managed Care

Highmark Health Options

Members: 1-844-325-6251

Pharmacies: 1-844-325-6251

Providers: 1-844-325-6251

AmeriHealth Caritas Delaware

Members DSHP: 1-844-211-0966

Members DSHP Plus: 1-855-777-6617

Pharmacies DSHP: 1-855-251-0966

Pharmacies DSHP Plus: 1-888-987-6396

Providers: 1-855-707-5818

Prior Authorizations: 1-855-260-9544

Delaware First Health

Members: 1-877-236-1341

Pharmacies: 1-833-236-1887

Provider: 1-877-236-1341

Contact Us

Secure Correspondence

Log in to the Provider Portal

Email* Us

delawarepret@gainwelltechnologies.com

**Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox.*

Electronic Data Interchange (EDI) Department*

DelawareECSGroup@gainwelltechnologies.com

1-800-999-3371, Option 0, Option 2

Stop Medicaid Fraud Now!

To Submit Anonymously

Call 1-800-372-2022

Or click HERE

Stay Connected!

Sign up for **Notify Me** to receive e-mail notifications about mass adjustments, special program information, program reminders, policy updates, holiday closing, and inclement weather updates.

Click **HERE** to sign up for Provider notifications.

Click **HERE** to sign up for Member notifications.

NOTE: If you are a Registered Provider/Delegate/Trading Partner, log into the Portal to update your Notify Me Subscription.