DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Improving the Provider Enrollment Application Process

The Delaware Medical Assistance Program (DMAP) has implemented a new system change in response to feedback from providers. **Both Fee-For-Service (FFS) Providers and Managed Care Organization-Only Providers (MCOPs) can now reset an Application Tracking Number (ATN) on a previously "denied" or "not processed" Delaware Medicaid Provider Enrollment application.**

This update improves the registration process by automating the ATN reset process in the DMAP Provider Portal to help providers complete their enrollment applications.

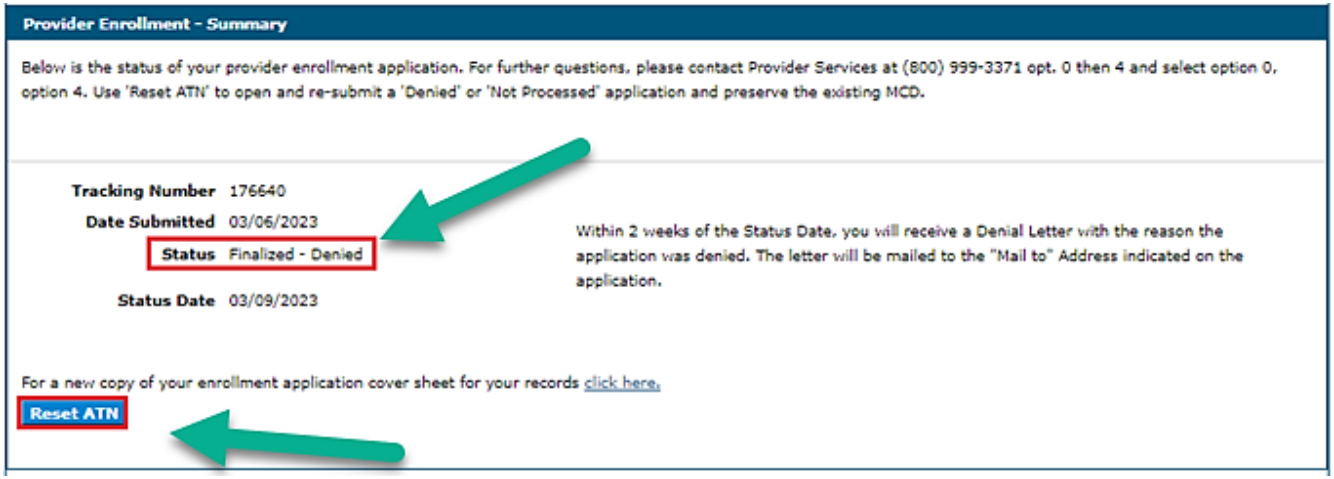
For more information on how to reset an ATN, go to page 2.

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.

Improving the Provider Enrollment Application Process (continued)



Effective immediately, all providers can utilize the DMAP Provider Portal to reset their Application Tracking Number (ATN) on applications with the status "Finalized - Denied" or "Not Processed". By resetting their ATN, providers can make corrections to applications with previously supplied incorrect information. To reset an ATN, Fee-For-Service (FFS) providers and Managed Care Organization-Only Providers (MCOPs) should log into the DMAP Provider Portal and click "Enrollment Status." Enter the ATN and either the provider's Social Security Number or Tax ID Number; then click "Search." The application status will display as shown above with the option to "Reset ATN."

- MCOPs can find more information on resetting an ATN and revising applications in the updated DMAP Provider Screening and Enrollment Frequently Asked Questions and in the new How-To: Reset an Application Tracking Number (ATN) - MCO-Only Provider Enrollment.
- FFS providers can find more information on resetting an ATN in the updated How-To: Reset an Application Tracking Number (ATN).

For more information on efforts to screen and enroll all current MCOPs in compliance with the 21st Century Cures Act, see Managed Care Organization-Only Provider (MCOPs) on page 13 of this DMAP Quarterly Bulletin.

Helpful Titles

- Request Assistance with Resetting Passwords
- How-To Submit a Pharmacy Prior Authorization Request through the 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.

Manuals & Forms Updates

Independent Laboratory Policy Manual: Revision Date – 06/28/2023: Sections Revised:

- Section 7.4, 7.5, 7.6, and 7.7 - Sections updated in alignment with references to the Current Procedural Terminology (CPT®) Manual for correct codes as published by American Medical Association (AMA).

Practitioner Provider Specific Policy Manual: Revision Date – 06/28/2023: Sections Revised:

- Section 27.4, 27.5, 27.6, and 27.7 - Sections updated in alignment with references to the Current Procedural Terminology (CPT®) Manual for correct codes as published by American Medical Association (AMA).

Federally Qualified Health Centers (FQHC) Manual: Revision Date – 06/16/2023: Section Revised:

- Section 2.6.1 - Section updated in compliance with the Delaware State Plan.

General Policy Manual: Revision Date – 06/16/2023: Section Revised:

- Section 1.7.1.1 - Section updated in compliance with the Delaware State Plan.

Adult Dental Program Provider Specific: Revision Date – 05/26/2023: Section Revised:

- Section 8.0 - Updated billing requirements for D9223 and D9243 effective 10/01/2020. Updated procedure descriptions for D9239 and D9243 to align with current CDT Manual

Children's Dental Program Provider Specific: Revision Date – 05/26/2023: Section Revised:

- Section 8.0 - Added CDT codes D2740, D3110, D3120 effective 12/01/2022. Added CDT codes D5511 and D5512 effective 01/01/2020. Removed CDT code D5510 effective 12/31/2019. Updated billing requirements for CDT codes D9223 and D9243 effective 10/01/2020. Updated restrictions for CDT codes D3351, D3352, D3353 effective 03/01/2022. Updated prior authorization requirement for CDT code D0322 effective 11/01/2022.

You Ask, DMAP Answers (YADA)

How do I know if I am required to submit an application fee?

The Centers for Medicare and Medicaid Services (CMS) requires institutional providers to submit an application fee. The application fee is for program integrity screening and enrollment purposes, and CMS updates the fee amount each year. CMS defines an institutional provider as any provider that submits the following forms for enrollment: CMS-855A, CMS-855B, CMS-855S, and associated Provider Enrollment, Chain and Ownership System (PECOS) enrollment applications.

Institutional providers who are enrolled in or have paid the application fee to Medicare or another state's Medicaid or Children's Health Insurance Program (CHIP) are exempt from paying an application fee to DMAP.

Providers who do not meet the exemption criteria must submit an application fee to DMAP at initial enrollment, re-enrollment, revalidation, reactivation, and when adding a new service location. Individual providers, professional provider groups and providers who have received approval for a Hardship Waiver Request are not required to pay the application fee.

Read the Laws: 42 CFR § 455.450 – Screening Levels for Medicaid Providers

42 CFR § 455.460 – Application Fee for Institutional Providers

Provider Taxonomy Screening Level List | MCOP Taxonomy Screening Level List

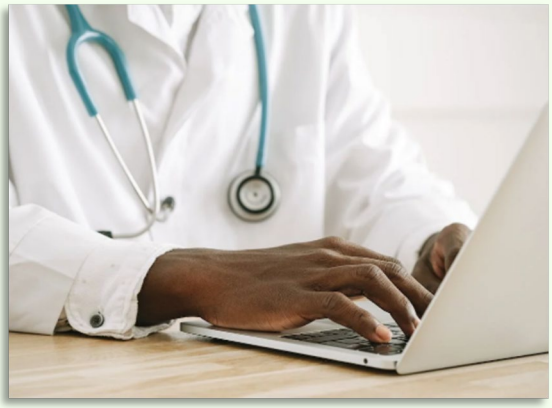
***YADA Disclaimer**: DMAP acknowledges that the YADA responses provided are general and are not intended to be a comprehensive listing of all of the possible answers pertaining to provider services. Please continue to send inquiries to the Provider Services Team.

Additional News

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 DMAP Go Green initiative. This includes Dental, UB-04, or CMS-1500 paper claims.



Any paper claims submitted after June 30, 2023, will not be processed nor will they be returned. All claims, both singles and attachments, must be submitted electronically through an approved software vendor, clearinghouse, or through the DMAP Provider Portal. Managed Care Only Providers (MCOPs) must submit encounter claims through their appropriate Managed Care Organization.

Providers, Delegates, and Trading Partners can register for access to the DMAP Provider Portal HERE. Contact Provider Services to request training on the DMES portal electronic claims submission process.

National Maternal Mental Health Hotline

The National Maternal Mental Health Hotline 1-833-TLC-MAMA (1-833-852-6262) is 24/7, free, confidential, and available in 60+ languages.

The Hotline provides emotional support and resources for pregnant and postpartum mothers and their loved ones who may be experiencing mental health challenges. The Hotline's support and resources are available via phone in over 60 languages, and via text in English and Spanish.

Parents and their loved ones who contact the Hotline will speak to professional counselors who provide immediate real-time support, information, and resources. Counselors are licensed or certified and have training in how to provide culturally appropriate and trauma-informed support. Counselors will also provide referrals to local or telehealth providers if a caller needs longer-term care and support. They will consider preferences for age, gender, ethnicity, and language-specific resources when providing referrals.

Learn more about the National Maternal Mental Health Hotline.

Delaware Cancer Treatment Program (DCTP)

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 Credit Balance Reporting (MCBR)

Online Medicaid Credit Balance Reporting (MCBR) Requirements

DMAP provider portal submission of the MCBR went live on April 1, 2021. Here are a few reminders:

- MCBRs must be submitted via the DMAP Provider Portal. No paper MCBR forms will be accepted.
- MCBRs are only required when the identified provider reaches the $10,000.00 threshold for the yearly quarter.
- The MCBR panel will display the quarters that require an MCBR.
- A separate MCBR submission is required for each service location.
- Providers are encouraged to contact Provider Services at 1-800-999-3371 for MCBR related questions.

Federal regulations require that all benefits available through other party payers be exhausted since the Medicaid Program is the payer of last resort.

The Centers for Medicare and Medicaid Services (CMS) conducts reviews in selected states to determine if federal requirements are being met. CMS has discovered instances where Medicaid funds were being retained by providers, even though other third-party payment sources had made payments for the same service. The reviews revealed that many patient records indicated credit balances in cases where the Medicaid Program was the secondary payer. In many cases, the provider billed the Medicaid Program and a third-party payer. Payments made by a third-party payer were credited to patient accounts, along with payments received from the Medicaid Program. However, the appropriate refunds were not made to the Medicaid Program.

When both a third-party payer and the Medicaid Program make payments to a provider, the provider is obligated to immediately refund the appropriate credit balances to the Medicaid state agency. To ensure that Delaware Medicaid properly recovers improper or excess program payments resulting from patient billing or claims processing errors, the Delaware Medical Assistance Program (DMAP) established an MCBR requirement. CMS has similarly mandated credit balance reporting requirements under the Medicare Program.

DMAP requires all in-state and out-of-state enrolled providers to submit a quarterly MCBR to the Delaware Medicaid Surveillance and Utilization Review (SUR) Unit via the DMAP Provider Portal. No paper MCBR forms will be accepted. This quarterly MCBR submission is a requirement for all in-state and out-of-state providers who were paid greater than $10,000 in the quarter (for either in-patient and/or outpatient services, in the case of hospital providers) by DMAP. Providers are responsible for identifying when the $10,000 payment threshold has been satisfied for each quarter. The MCBR must be submitted even when there are no credit balances on Medicaid accounts at the close of business in the reporting period.

Providers required to submit a quarterly MCBR include:

Acute Care Hospitals	282N00000X	Home Health Agencies	251E00000X
Rehabilitation Hospitals	283X00000X	Renal Dialysis Facilities	261QE0700X
Psychiatric Hospitals	283Q00000X	Intermediate Care Facilities	313M00000X
Specialty Hospitals	284X00000X	Rehabilitation Agencies	261QR0400X
Skilled Nursing Homes (SNF)	314000000X	Day Health and Rehabilitation Services	103TR0400X

A completed MCBR must be submitted via the DMAP Provider Portal at the end of each quarter, within 30 days after the close of each calendar quarter. Refer to the General Policy Manual for MCBR guidance.

If you have any further questions regarding fraud, waste, or abuse,
please contact the DMMA Surveillance Utilization and Review (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

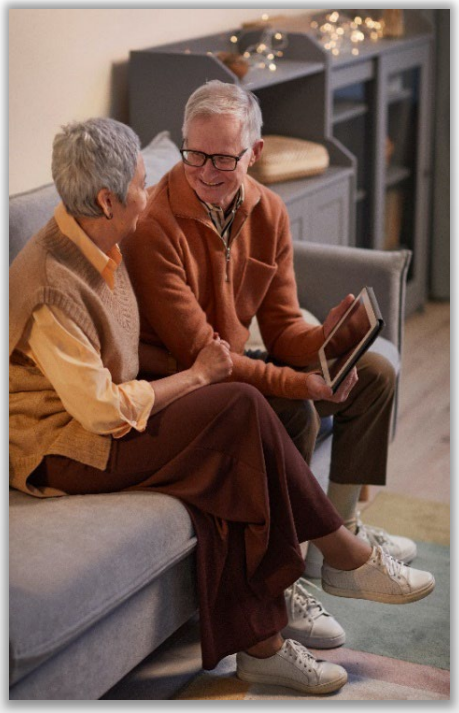
EVV Claims Validation Guidance for Providers using Sandata EVV Solution

The Delaware Medical Assistance Program (DMAP) will utilize a pre-adjudication claims validation process to match Electronic Visit Verification (EVV) claims to member visit data. At a future date, all payers must implement a hard edit in their claims systems that would deny a claim if a claim cannot be matched to a corresponding valid member visit. DMAP recognizes that payers, as well as Gainwell Technologies (DMMA's Fiscal Agent), are at different stages of "readiness" for this federal requirement. EVV will implement claims validation in 4 phases, as detailed below.

Phases of Implementation

Phase 1 – Current phase

- Capture member visits as they are currently.
- Process claims as they are currently.
- Post-payment review of member visits occurs for payers not doing pre-payment visit validation.



Phase 2 – Upcoming phase (targeted to begin July 2023*)

- Capture member visits as they are currently.
- Process claims as they are currently.
- Delaware First Health (DFH) will only do pre-payment review.
- Highmark Health Options (HHO) and AmeriHealth Caritas (AHC) will do post-payment review of member visits.
  *Start date is dependent on the ability to generate the claims/encounters file.

Phase 3 – Begins Fourth Quarter 2023

- Capture member visits as they are currently.
- Payers implement pre-payment validation of visits with soft edit. Soft edit will inform the provider when a claim subject to EVV would have been denied due to non-valid member visit.
- Post-payment review of visits occurs for payers not in Phase 3.

Phase 4 – Will only begin after all payers have completed Phase 3 and have had sufficient experience/notice; all payers will enter Phase 4 simultaneously.

- Capture member visits as they are currently.
- Payers turn on hard edit to deny claims subject to EVV that do not have corresponding valid member visits.

Pharmacy Corner

Current Drug Shortages

Currently, there is 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 drug shortages, resolved drug shortages, and discontinuations reported to the FDA can be found online at: https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm.

FDA Authorizes Changes to Simplify Use of Bivalent mRNA COVID-19 Vaccines

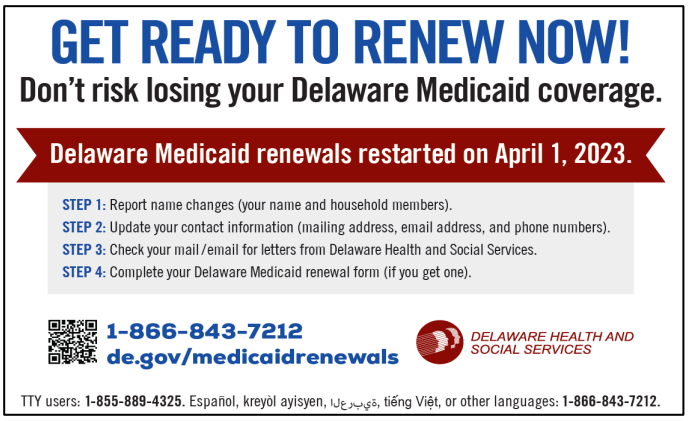
The U.S. Food and Drug Administration amended the emergency use authorizations (EUAs) of the Moderna and Pfizer-BioNTech COVID-19 bivalent mRNA vaccines to simplify the vaccination schedule for most individuals. This action includes authorizing the current bivalent vaccines (original and omicron BA.4/BA.5 strains) to be used for all doses administered to individuals 6 months of age and older, including for an additional dose or doses for certain populations. **The monovalent Moderna and Pfizer-BioNTech COVID-19 vaccines are no longer authorized for use in the United States.**

- **Most individuals, depending on age, previously vaccinated with a monovalent COVID-19 vaccine** who have not yet received a dose of a bivalent vaccine may receive a single dose of a bivalent vaccine.
- **Most individuals who have already received a single dose of the bivalent vaccine** are not currently eligible for another dose. The FDA intends to make decisions about future vaccination after receiving recommendations on the fall strain composition at an FDA advisory committee in June.
- **Individuals 65 years of age and older who have received a single dose of a bivalent vaccine** may receive one additional dose at least 4 months following their initial bivalent dose.
- **Most individuals with certain kinds of immunocompromise who have received a bivalent COVID-19 vaccine** may receive a single additional dose of a bivalent COVID-19 vaccine at least 2 months following a dose of a bivalent COVID-19 vaccine, and additional doses may be administered at the discretion of, and at intervals determined by, their healthcare provider. However, for immunocompromised individuals 6 months through 4 years of age, eligibility for additional doses will depend on the vaccine previously received.
- **Most unvaccinated individuals** may receive a single dose of a bivalent vaccine, rather than multiple doses of the original monovalent mRNA vaccines.
- **Children 6 months through 5 years of age who are unvaccinated** may receive a two-dose series of the Moderna bivalent vaccine (6 months through 5 years of age) OR a three-dose series of the Pfizer-BioNTech bivalent vaccine (6 months through 4 years of age). Children who are 5 years of age may receive 2 doses of the Moderna bivalent vaccine or a single dose of the Pfizer-BioNTech bivalent vaccine.
- **Children 6 months through 5 years of age who have received 1, 2 or 3 doses of a monovalent COVID-19 vaccine** may receive a bivalent vaccine, but the number of doses that they receive will depend on the vaccine and their vaccination history.

Source: https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-changes-simplify-use-bivalent-mrna-covid-19-vaccines

Help Us Get the Word Out

The following information is being provided to members to alert them that Delaware Medicaid renewals restarted on April 1, 2023. Members should update their contact information to avoid any interruption of medical services. For more information about Delaware Medicaid PHE unwinding efforts, providers and members can visit: de.gov/medicaidrenewals.



For printable versions of other PHE unwinding flyers/posters in Spanish and English, visit the DMAP Portal Document Repository.

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

Pharmacy and DPAP Copays

During the COVID-19 Public Health Emergency (PHE), Delaware Medicaid waived Pharmacy and Delaware Prescription Assistance Program (DPAP) copayments. The COVID-19 PHE ended May 11, 2023, but Pharmacy and DPAP copayments will restart **December 1, 2023**.

Pharmacy Provider Specific Policy Manual

Dental Copays

During the COVID-19 Public Health Emergency (PHE), Delaware Medicaid did not institute Adult Dental Program copayments. The COVID-19 PHE ended May 11, 2023, but Adult Dental Program copayments will start **December 1, 2023**.

Adult Dental Program Provider Specific Policy 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 has been updated as of 05/26/2023 to include these codes.

- **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

Early Periodic Screening, Diagnostic, and Treatment (EPSDT) and Delaware Healthy Children Program (DHCP) Program Compliance Update

Effective July 1, 2023, Delaware Medicaid and Medical Assistance (DMMA) will provide full EPSDT coverage for children enrolled in DHCP by adding Non-Emergency Medical Transportation (NEMT) and Prescribed Pediatric Extended Care (PPEC). NEMT and PPEC services will be provided to DHCP members even if they are not participants in the Children's Community Alternative Disability Program (CCADP).

Early Periodic Screening, Diagnostic, and Treatment (EPSDT) is a benefit for children and young adults under age 21 years who have Medicaid. The EPSDT benefit makes sure that children and young adults get access to complete preventive medical care.

Non-Emergency Medical Transportation (NEMT) is provided to and from medical and dental appointments for eligible Medicaid members only when a member has no other means of transportation. By adding the NEMT benefit, DMMA will increase the access to care for eligible children enrolled in the DHCP program.

Prescribed Pediatric Extended Care (PPEC) offers additional supports to institutionalization or community/home care for eligible DHCP children who may medically need the services. Members will contact their provider for more information about PPEC.

For more information, visit:

- Members can book a ride by logging into their ModivCare account or calling 1-866-412-3778
- Non-Emergency Medical Transportation (NEMT)
- Prescribed Pediatric Extended Care Provider Manual
- Care of Children with Medical Complexity

Additional information regarding these changes will be forthcoming and will be added to the following resource pages:
Delaware Medical Assistance Portal
Children with Medical Complexity Website

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
Latent Tuberculosis Infection in Adults: Screening: asymptomatic adults at increased risk of latent tuberculosis infection (LTBI)	The USPSTF recommends screening for LTBI in populations at increased risk. See the "Assessment of Risk" section for additional information on adults at increased risk.	B	May 2023
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

Task Force Issues Draft Recommendation Statement on Screening for Breast Cancer

The United States Preventive Services Task Force (USPSTF) posted a draft recommendation statement on screening for breast cancer. The Task Force now recommends that all women get screened for breast cancer every other year starting at age 40 years. This is a B grade. More research is needed on whether or not women with dense breasts should have additional screening with breast ultrasound or MRI, and on the benefits and harms of screening in women older than 75 years of age. These are I statements, meaning the balance of benefits and harms cannot be determined. The use of the term women in this draft recommendation includes cisgender women and other people assigned female at birth.

Breast cancer is the second most common cancer and the second most common cause of cancer death for women in the United States. While the Task Force has consistently recognized the lifesaving value of mammography, the previous recommendation was that women in their 40s make an individual decision about when to start screening based on their health history and preferences. In this new recommendation, the Task Force now recommends that all women get screened starting at age 40. This change could result in 19 percent more lives being saved.

Managed Care Organization-Only Providers (MCOPs)

The Division of Medicaid and Medical Assistance Reiterates that all Delaware Managed Care Only Providers Must Register with the Delaware Medical Assistance Program

Managed Care Organization-Only Providers (MCOPs) contracted with the Delaware, Division of Medicaid and Medical Assistance (DMMA) Managed Care Organizations (MCOs) must comply with the 21st Century Cures Act by registering with the Delaware Medical Assistance Program (DMAP). All providers are required to verify and enroll their correct ID and address in order to continue to receive Medicaid reimbursement for services. Failure to comply will result in them having their contracts with Medicaid terminated.

Although some provider locations have successfully completed the enrollment process and are approved to continue in the Delaware Medicaid program, a large number of providers have not registered and could be in jeopardy of having their Medicaid contract terminated. Currently, there are several providers engaged in the screening and enrollment process, and who are actively working to register their service locations. The State of Delaware continues to conduct outreach and mitigation efforts to discourage termination of provider contracts to ensure that Delaware maintains an optimum provider network to provide needed services to members.

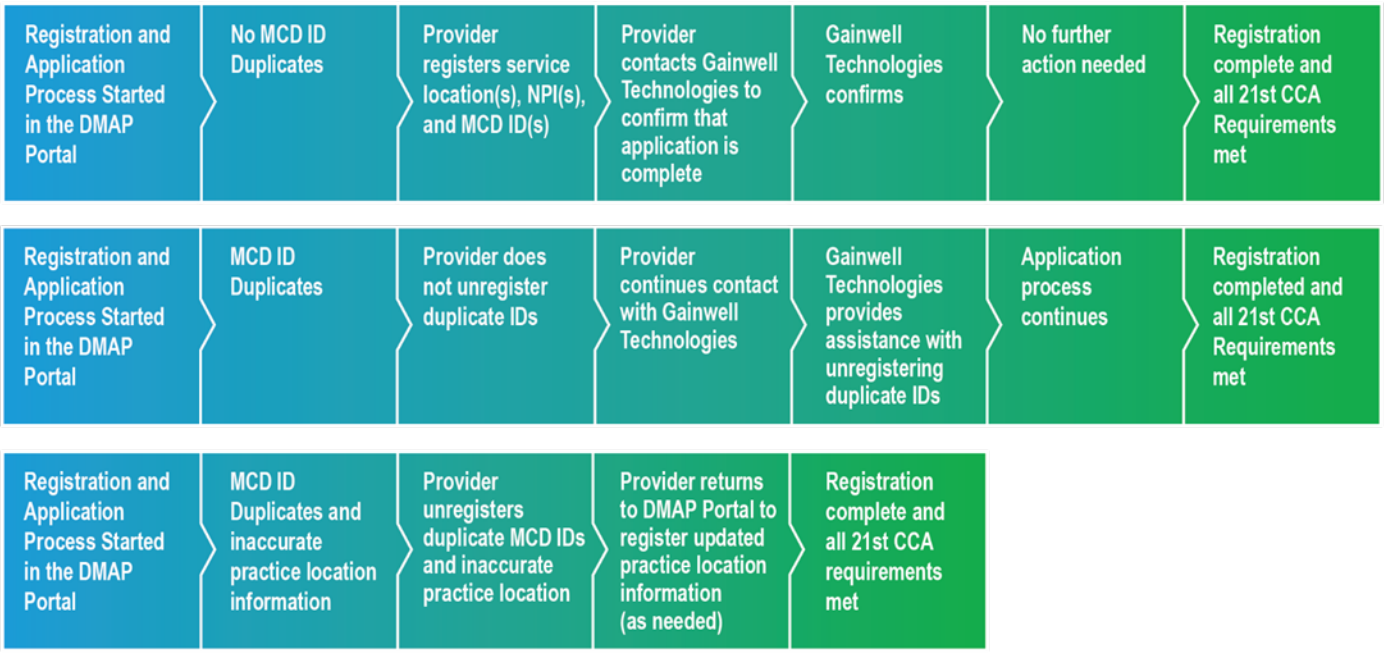
DMMA, the MCOs, and Gainwell Technologies (DMMA Fiscal Agent) Provider Services have received questions from providers regarding what is classified as engaged and whether or not they will be terminated. **DMMA wants to reiterate that Providers that are currently engaged with the DMAP screening and enrollment process are not at risk of suspended payment(s) and/or termination from the Delaware Medicaid Managed Care Organization (MCO) network participation.**

DMAP has extended the date to complete the required Enrollment Application on the DMAP Provider Portal until September 30, 2023. Providers that have failed to engage but have billed within the last two (2) years will receive an additional registration letter. **Providers are strongly encouraged to not wait and to enroll all their service locations immediately.**

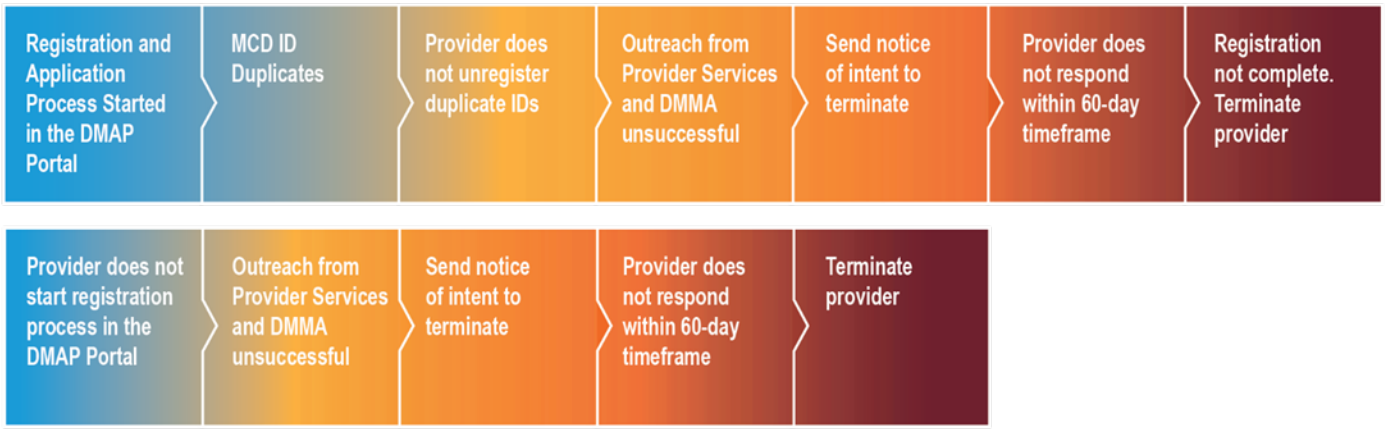
Managed Care Organization-Only Providers (MCOPs)

Paths of Engaged and Non-Engaged Providers

Engaged Providers



Non-engaged Providers

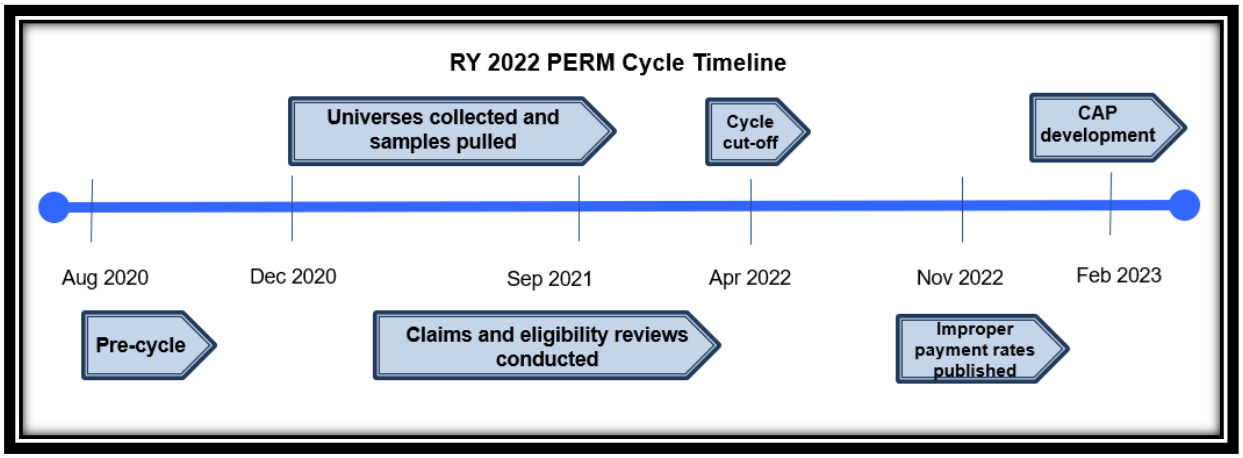


For More Information:

- Read the Rule: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf
- Please see the Announcement Section on the DMAP Provider Portal for MCO Provider Screening and Enrollment updates. https://medicaid.dhss.delaware.gov
- Contact DMAP Provider Services at (800) 999-3371; Option 0, then Option 4 or email at mailto:delawarepret@gainwelltechnologies.com

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.



DMMA has submitted the 2022 Corrective Action Plan (CAP) to the Centers for Medicare & Medicaid Services (CMS). Once CMS reviews the documents, they will provide the State with either an acceptance letter or a request for additional information. DMMA is responsible for implementing, monitoring, and evaluating the effectiveness of their CAP, with assistance and oversight from CMS. CMS will collect the Federal Financial Portion (FFP) back from the State for claims where proper documentation was 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 DMAP Provider Portal. Accurate contact and demographic information are invaluable to DMAP members in need of medical services.

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 for information about 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 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.