DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

DMMA Reminds Managed Care Organization-Only Providers (MCOPs) it is Never Too Late to Register with the Delaware Medical Assistance Program (DMAP)

Managed Care Organization-Only Providers (MCOPs) contracted with 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 their National Provider Identification (NPI) number, taxonomy, and practice location address and to enroll to receive Medicaid reimbursement for services. Providers that fail to comply will be subject to denial of payment.

For more information on the MCOP program, go to page 5.

In This Edition:

gainwell

How-To & What's New

New Pharmacy Prior Authorization Forms

Effective October 25, 2023, DMAP has updated all pharmacy prior authorization (PA) forms to a new format. Please be sure to use the most recent version of the PA form when uploading (via the DMAP Provider Portal) or faxing the prior authorizations. The updated PA forms can be found on the DMAP Pharmacy Corner page.

As a reminder, DMAP is not currently partnered with any outside entities to process prior authorization requests. To ensure you have the most up-to-date information and authorization requirements, please visit the DMAP Pharmacy Corner.

Payer ID for 837P and 837I in Loop 2010BB

Effective November 1, 2023, the Delaware Medical Assistance Program (DMAP) requires providers to enter a payer ID of 'DE_TXIX' for Fee For Service (FFS) or 'DSCYF' for Department of Services for Children, Youth, and their Families.

Providers who use Trading Partners/Clearinghouses to Submit Electronic Claims will need to update the Payer ID for 837P and 837I in Loop 2010BB. To learn more about Loop 2010BB - Element NM109 - 'DE_TXIX' and 'DSCYF', refer to the 837 DMES EDI Companion Guide.

Providers who utilize the DMAP Portal to Submit Electronic Claims will need to update the Claim Indicator field.

If you failed to make the update by November 1, 2023, claims will be denied with "EOB 1470 - Denied. Invalid/Missing Payer ID" on the Remittance Advice (RA).

Helpful Titles

- How-To Send Attachments with an 837 X12 Transaction through a Vendor or Clearinghouse
- How-To View a Member's Eligibility through the Provider Portal
- How-To Utilize Treatment History Panels
- How-To Restore Delegate Functionality

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.

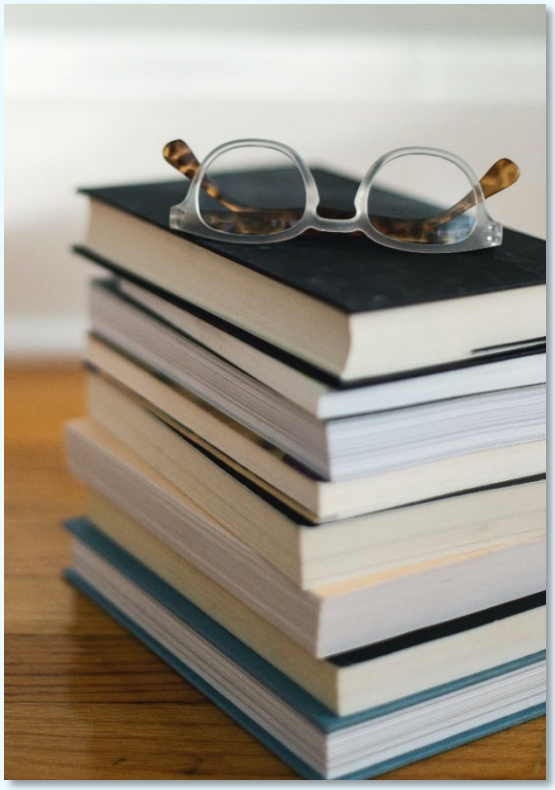
Manual & Form Updates

General Policy Manual: Revision Date – 12/12/2023: Sections Revised:

- Section 1.38.2.1 – Section updated to provide additional policy clarification for institutional providers regarding provider enrollment application fee hardship exception requests.

Children's Dental Program Provider Specific: Revision Date – 12/07/2023: Sections Revised:

- Section 3.2 – Updated section to reflect electronic claims filing requirements for Orthodontic Services.
- Section 3.2.4 – Updated section to require all prior authorization forms and supporting documentation be submitted via the DMAP Provider Portal. In addition, all models must be submitted digitally via the DMAP Provider Portal. DMMA will no longer accept mailed articulated or marked study models with wax bite.



Pharmacy Provider Specific: Revision Date – 11/30/2023: Sections Revised:

- Section 1.1.2.1 – Clarification added regarding recoupment of monies for drugs that are systematically prepared but not used by the member.
- Sections 3.1.1 & 4.1.4.2 – Updated language to change Wholesale Price (AWP) to Wholesale Acquisition Cost (WAC).
- Section 4.1.8 – Clarification added regarding DMAP coverage of Total Parenteral Nutrition under the medical benefit.
- Section 4.2.4.2 – Section updated in alignment with the State Plan regarding the expansion of post-partum coverage from 60 days to 12 months.
- Section 4.2.4.2.1 – Section updated in alignment with current ICD-10 diagnosis codes.
- Section 4.2.4.8 – Added smoking cessation products to copayment (copay) exclusions.
- Sections 5.3.2.4 & 5.3.2.4.1 – Added controlled substance dispensing requirement for claim payment.

Part C Birth to Three Provider Specific: Revision Date – 11/17/2023: Sections Revised:

- All – Updated DXC to Fiscal Agent
- Section 1.4 – Updated section to add Gainwell Technologies as the current Fiscal Agent and general responsibilities.

DMES EDI v5010 X12 834 Companion Guide: Revision Date – 11/15/2023: Sections Revised:

- Loop 2300 HD03 – Added LTC-Long Term Care
- Loop 2300 HD04 – Added RENEWAL, Added PLUS – Plus Diamond State Health Plan, DSHP – Diamond State Health Plan, DHCP – Delaware Healthy Children Program, DUAL – Dual Diamond State Health Plan, PACE – Program of all Inclusive Care for the Elderly, INCAR – Incarcerated, Removed LTC – Long Term Care

General Policy Manual: Revision Date – 10/16/2023: Sections Revised:

- Section 1.21 – Revised Section Numbering
- Section 1.21.7 – Added prior authorization for a new Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial in compliance with CMS regulation.
- Section 14.0 – Added new Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial in compliance with CMS regulation.

Coming Soon: Delaware Medicaid Retroactive Coverage Expansion

Revised: January 24, 2024

The Division of Medicaid and Medical Assistance (DMMA) is expanding the groups of individuals who are eligible for retroactive Medicaid coverage.

The Division of Medicaid and Medical Assistance (DMMA) will expand retroactive eligibility to all Diamond State Health Plan (DSHP) and Diamond State Health Plan-Plus (DSHP-Plus) participants who apply for and receive Medicaid coverage. DMMA is making this change in compliance with Federal Regulation 42 CFR §435.915 that requires states to provide three months of retroactive eligibility for Medicaid for eligible individuals. DMMA is currently updating systems to accommodate this new requirement and will provide additional information regarding the effective date to expand retroactive eligibility coverage when completed.

General Information

If an individual meets the general financial and technical eligibility requirements and receives Medicaid-covered services during the three months prior to becoming eligible, those services will be covered. Providers will be encouraged to return payment to members that were eligible for Delaware Medicaid Retroactive Eligibility Coverage if eligible services were provided during the retroactive eligibility period.

The additional expansion populations include:

- MAGI-based Adult Group
- Protected SSI Medicaid Group
- Children's Community Alternative Disability Program (CCADP)
- Long Term Care (LTC) Community Services Groups
- Former Foster Care Group
- The Incarcerated Group (MAGI and Non-MAGI)
- Emergency Services
- Labor and Delivery Services

Individuals eligible under the Delaware Healthy Children Program (DHCP) will **not** be eligible for retroactive Medicaid.

As a reminder, **Fee-for-Service (FFS) providers and Managed Care-Only Providers (MCOPs) must verify member eligibility prior to providing services.** Providers should also re-check member eligibility for retroactive Medicaid coverage. FFS providers can verify and re-check member eligibility via the DMAP Provider Portal. MCOPs should refer to their MCO provider portal handbook for information related to member eligibility verification.

- AmeriHealth Caritas: https://www.amerihealthcaritasde.com/provider/index.aspx
- Delaware First Health: https://www.delawarefirsthealth.com/providers.html
- Highmark Health Options: https://www.highmarkhealthoptions.com/providers.html

For additional information and updates, check the links below:

- Instruction document: How-To: View and Verify a Member's Eligibility through the Provider Portal
- Retroactive Medicaid coverage federal regulation: Social Security Act § 1115
- Delaware Diamond State Health Plan authority: Section 1115 Waiver Demonstrations

Managed Care Organization-Only Providers (MCOPs)

The Division of Medicaid and Medical Assistance Reminds Managed Care Organization-Only Providers (MCOPs) it is Never Too Late to 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 their National Provider Identification (NPI) number, taxonomy, and practice location address and enroll to receive Medicaid reimbursement for services. Providers that fail to comply will be subject to denial of payment.

The DMAP and various stakeholders continue to conduct outreach efforts to mitigate contract termination and denial of payments to providers and to ensure that Delaware maintains an optimum provider network to provide needed services to members. **Providers are strongly encouraged to act immediately to enroll all of their service locations to avoid denial of payment.**

The DMAP appreciates all efforts from providers to ensure we have a substantial network and would like to emphasize that it is never too late to complete the registration/enrollment process. Providers are encouraged to contact DMAP provider services for assistance with their registration and/or enrollment application. Providers should contact their managed care organization for assistance with claim denials.

Providers whose claims were suspended and/or denied can reset their terminated Medicaid Identification Number (MCD) at any time. For reset instructions, see How-To Submit a RESET Request for an Application Tracking Number (ATN).

For More Information:

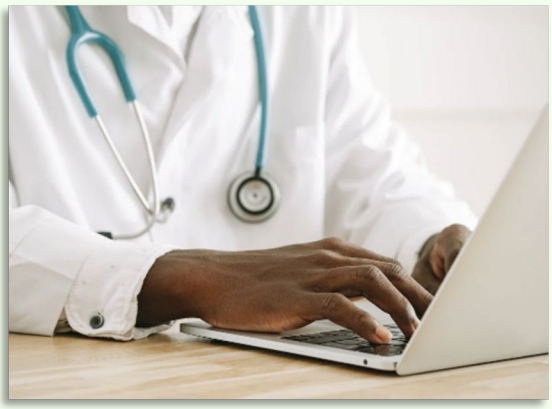
- Read the Rule: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf
- Check out the Announcement Section on the DMAP Provider Portal for MCO Provider Screening and Enrollment updates.
- **To check on the status of your MCOP registration, provider enrollment application, or for assistance**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

Additional News

Go Green with DMAP

Updated Electronic Claims Submission Requirements

Reminder: Effective **July 1, 2023**, the Delaware Medical Assistance Program (DMAP) requires all claims to be submitted electronically as part of the DMAP Go Green initiative. This includes Dental, UB-04, and 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 Organization-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.

You Ask, DMAP Answers (YADA)

If I unregistered a Managed Care Organization – Only Provider (MCOP) service location and now I need to register it again, what should I do?

Service Locations

Medicaid ID	Address ▲	Revalidation Date	Status	Action
001122334	380 MAIN STREET, WILMINGTON, Delaware 19084-1013	12/3/2022	Duplicate	
112233445	380 MAIN STREET, WILMINGTON, Delaware 19084-0000	9/30/2023	Duplicate	
223344556	380 MAIN STREET, WILMINGTON, Delaware 19084-1013	12/3/2022	Registered	
334455667	123 APPLE ROAD, SMYRNA, Delaware 19977-1479	5/19/2023	Unregistered	Reset
445566778	1234 STREET ROAD, SUITE 0000, CITY, Delaware 19977-0000	12/3/2022	Registered	
556677889	1234 ST RD, SUITE 0, CITY, Delaware 19977-0000	12/3/2022	Duplicate	

A service location which has been unregistered can be reset, as long as it is not a duplicate, to allow the provider to rework the existing Registration Application. Under Enrollment Application, enter the National Provider Identifier (NPI) and taxonomy, and click **Search** to find practice locations available. Click **Reset** next to the unregistered location.

A new password must be created each time an Application Tracking Number (ATN) is reset. Review the Password Assistance box for password requirements. Enter and Confirm a password, and then click **Submit**.

The selected location will show a status of "Pending" and will show *Resume Enrollment* next to the in-progress application. Click **Resume Enrollment** to reopen the application and continue.

***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 (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 equal to or 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 (TTY 711).

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 DMAP Provider Portal.***

Please click HERE to access the form that **MUST** be utilized for all DCTP participants 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 (TTY 711).

Managed Care Organizations (MCOs) for 2024

The Delaware Department of Health and Social Services (DHSS) has selected three managed care companies to operate its Medicaid Managed Care Program. Highmark Health Options Blue Cross Blue Shield began operating in Delaware in 2015. AmeriHealth Caritas started in 2018. Centene's Delaware First Health joined the DHSS family in 2023.

The three managed care organizations 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

Provider Review / Audits

Medicaid programs are devoting more resources to program integrity, which means providers are more likely than ever to be audited.

All DMAP providers are subject to **routine review and/or audit** by authorized representatives of the DMAP such as, but not limited to, the Surveillance and Utilization Review (SUR) staff, the Medicaid or Independent Professional Review Team, Utilization Review Team, DMAP Fraud Control Unit, or independent audit firms.

Before the Review Audit

Always Be Prepared for an Audit. Providers should do the following to make sure they are prepared for a review audit:

- Emphasize to staff the importance of proper documentation,
- Be familiar with the manuals and regulations, and
- Perform routine self-audits to ensure that staff is maintaining proper documentation.

For a Desk Audit, a "Review Audit Letter" will arrive in the mail to request that the provider makes certain records available. Please try to meet the requested deadline for submitting the records. If it is not possible to produce all the requested records in the timeframe specified, please contact the DMAP SUR Unit via phone, email, or letter to request a reasonable extension.

After the Review Audit

DMAP will send a "Findings Letter" to the provider explaining what was discovered during the review audit.

The Findings Letter will identify any of the following:

- Any alleged errors or deficiencies found by the Reviewer.
- Amount of Questioned Costs identified by the Reviewer. Questioned Costs represent the dollar value of the claims for services that the Reviewer determined were not appropriately documented or correctly billed.
- Provider's Redetermination or Appeal Rights for any alleged overpayment identified in the review audit.

Do not ignore the Findings Letter and just think that the review audit will go away. Respond to the Findings Letter within the specified timeframe with a payment to satisfy the overpayment. Alternatively, the provider can file a Request for Redetermination to provide additional documentation. If a provider files a Request for Redetermination, he/she will receive a response via a "Redetermination Findings Letter" explaining if the SUR Unit agrees or disagrees with the provider's additional documentation.

The last important step is to address the Reviewer's findings. For example, for documentation findings, the provider could change their procedures or the utilized documents. For billing findings, the provider could increase billing oversight. It is important to always address the review audit findings. Addressing the findings can reduce the likelihood that the finding will reoccur in the event of another audit. Also, addressing the findings will help prevent more serious actions, such as a suspension from DMAP or a referral to the Attorney General or the Office of Inspector General. For more information, please visit the DMAP Provider Portal and read the General Policy Manual (Sections 1.11, 1.12, and Appendix A).

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@delaware.gov

All Aboard the EVV Train!

The EVV implementation is chugging along! As noted in previous editions of this newsletter, at a future date there will be a pre-adjudication process which will include a "hard edit" where claims will be denied without a valid visit authorization. The pre-adjudication process has not yet been implemented. The EVV Team will notify providers well in advance of its implementation so there is time to prepare.

The EVV Team continues to provide education and assistance to help make sure the pre-adjudication "hard edit" process is clear. Currently, our Managed Care Organizations (MCOs) and Gainwell Technologies (DMMA Fiscal Agent) are at different stages of "readiness." Until the pre-adjudication process is implemented, there will be a post-adjudication process. The post-adjudication process will include a "soft edit" and alert. Many thanks to our partners for their continued patience and cooperation!

EVV Highlights for Q4:

- 102 unique providers who provide services subject to EVV have registered with Sandata.
- 349,752 visits from 60 different providers are reflected in the production environment. Of these, 312,417 (89%) are in a verified status.
- There has been a continued increase in the number of providers who do not have unverified visits over the past few months.
- With the 10/1 date for compliance with 21st Century Cures Act mandates having now passed, we expect to see issues arise with some EVV providers.
- The EVV team's targeted collaboration sessions with our provider partners have continued to address both common and unique concerns/issues.

Provider Reminders:

The EVV Team would like to remind our provider partners that the EVV requirement is federally mandated. All PCS and HHCS providers **MUST** register with our EVV vendor Sandata. Please 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 vendor: DE Aggregator Training

Join Us:

Attend our monthly EVV provider forums. The EVV Team changed the format of the meeting to more of a Q&A session for our provider partners to have their questions answered/concerns addressed. Please look out for invites and join us if your time/schedule permits. For more information, visit the DMMA EVV webpage.

Contact Us:

For questions or more information, contact the EVV Provider Service Team at DHSS_DMMA_EVV@delaware.gov.

Pharmacy Corner

Pharmacy Program Changes for 2024

	Eligible OTC Medications	Preferred Diabetic Supplies	Oral Oncology
Changes	Only rebate-eligible over-the-counter (OTC) medications will be preferred. Non-preferred OTC medications will not pay without an approved override. The member will be required to try and fail two of the preferred brands before an override will be considered.	New brands of diabetic supplies will be preferred. Non-preferred brand OTC medications will not pay without an approved override. The member will be required to try and fail two of the preferred brands before an override will be considered.	Members starting **NEW** oral oncology therapies with AB-rated generics must attempt a 30-day supply of the generic before brand name medications will be considered. *Members already on oral oncology therapies will not be impacted.*
Effective Date	January 1, 2024	January 1, 2024	January 1, 2024
Reference Document	Delaware OTC Rebate List	Preferred Diabetic Supplies	Generic Oral Oncology Medications

COVID-19 Vaccine Recommendations

As of **September 11, 2023**, the bivalent Pfizer-BioNTech and Moderna COVID-19 vaccines are no longer available for use in the United States.

As of **September 12, 2023**, the 2023–2024 updated Pfizer-BioNTech and Moderna COVID-19 vaccines were recommended by CDC for use in the United States.

As of **October 3, 2023**, the 2023-2024 updated Novavax vaccine was recommended by CDC for use in the United States.

The 2023–2024 updated COVID-19 vaccines more closely target the XBB lineage of the Omicron variant and could restore protection that may have decreased over time against severe COVID-19. There is no preferential recommendation for the use of any one COVID-19 vaccine over another when more than one licensed or authorized, recommended, and age-appropriate vaccine is available.

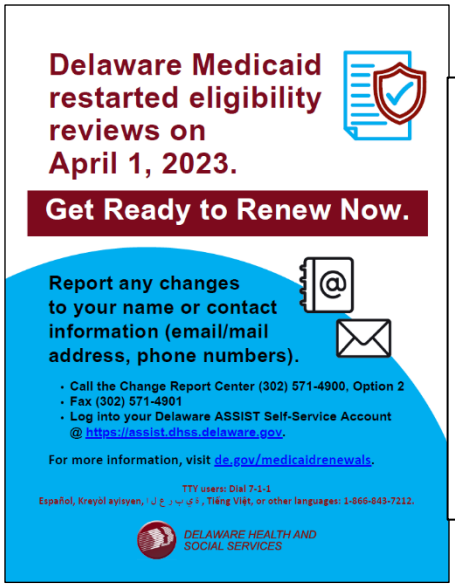
Everyone aged 5 years and older should get 1 dose of an updated COVID-19 vaccine to protect against serious illness. Children aged 6 months to 4 years need multiple doses of COVID-19 vaccines to be up-to-date, including at least 1 dose of an updated COVID-19 vaccine. People who are moderately or severely immunocompromised may get additional doses of the updated COVID-19 vaccine.

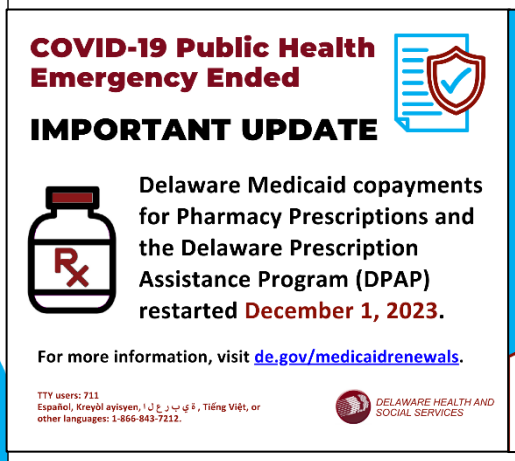
For more information, visit the Centers for Disease Control and Prevention COVID-19 Vaccination Clinical & Professional Resources page.

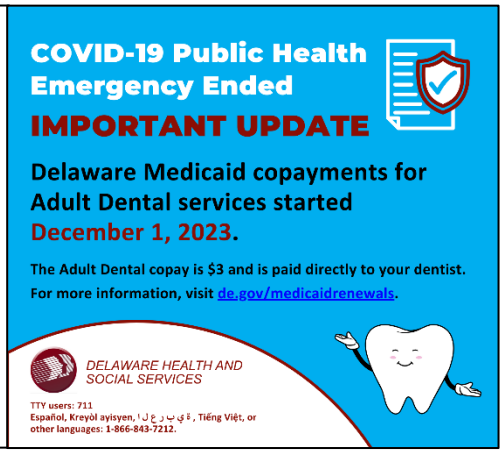
Help Us Get the Word Out

The following posters will be provided to providers and community partners to remind members that Delaware Medicaid renewals restarted on April 1, 2023, Pharmacy and Delaware Prescription Assistance Program (DPAP) (Medicare Part D) copays restarted on December 1, 2023, and Adult Dental copays started December 1, 2023. 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, visit the DMAP Portal Document Repository.







Notable Dates and Information

Member Eligibility

Delaware Medicaid renewals restarted **April 1, 2023**. FFS providers and MCOPs must verify member eligibility prior to providing services. FFS providers can review How-To: View and Verify a Member's Eligibility through the Provider Portal.

MCOPs should refer to their MCO provider portal handbook for information related to member eligibility verification.

Pharmacy and DPAP Copays

During the COVID-19 Public Health Emergency (PHE), Delaware Medicaid waived Pharmacy and Delaware Prescription Assistance Program (DPAP) copayments. Pharmacy and DPAP (Medicare Part D) copayments restarted **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. Adult Dental Program copayments for most members over the age of 21 years started **December 1, 2023**.

Adult Dental Program Provider Specific Policy Manual

Enrollment Fees

Effective **January 1, 2024**, institutional providers must submit an application enrollment fee of $709.00 at initial application, reactivation, revalidation, reenrollment, or addition of a new service location.

Provider Taxonomy Screening Level List

MCOP Taxonomy Screening Level List

Children's Dental Program

The following are changes to the Children's Dental Program:

The Children's Dental Program Provider Specific Policy Manual has been updated to reflect the requirement that **all claims, prior authorization forms, and supporting documentation for Orthodontic Services must be filed electronically via the DMAP Provider Portal**.

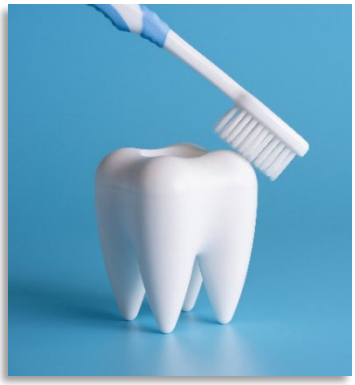
In addition, all models must be submitted digitally via the DMAP Provider Portal. **Mailed articulated or marked study models with wax bite are no longer accepted.** Any articulated or marked study models mailed will be returned to sender. DMAP will contact providers over the next few months to pick up models that are currently in the possession of the Division of Medicaid and Medical Assistance (DMMA).

For more information, see the Children's Dental Program Provider Policy Manual.

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. 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 (EPSDT) Corner

Children with Medical Complexity – New Brochure: "What to Expect when Your Child's Medical Equipment or Supplies Change"

The Children with Medical Complexity (CMC) Workgroup, in partnership with the Division of Medicaid and Medical Assistance (DMMA), developed a brochure with information on how to navigate changes to a child's medical equipment or supplies. The **"**What to Expect when Your Child's Medical Equipment or Supplies Change**"** brochure provides tips and resources for parents/caregivers, families, care coordinators, providers, and advocates.

Many thanks to the CMC Workgroup members for their work to develop and share this valuable resource!

To download the brochure or for more information, visit the Care of Children with Medical Complexity: https://dhss.delaware.gov/dhss/dmma/cmc_resources.html.

New Year, New Updates

The Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care, also known as the "Periodicity Schedule," is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.

With the new year, new updates are likely. Don't forget to regularly check the Periodicity Schedule to ensure your youngest patients are on track for a happy and healthy year.

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
Hypertensive Disorders of Pregnancy: Screening: asymptomatic pregnant persons	The USPSTF recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy.	B	September 2023
Folic Acid Supplementation to Prevent Neural Tube Defects: Preventive Medication: persons who plan to or could become pregnant	The USPSTF recommends that all persons planning to or who could become pregnant take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid.	A	August 2023
Prevention of Acquisition of HIV: Preexposure Prophylaxis: adolescents and adults at increased risk of HIV	The USPSTF recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV.	A	August 2023

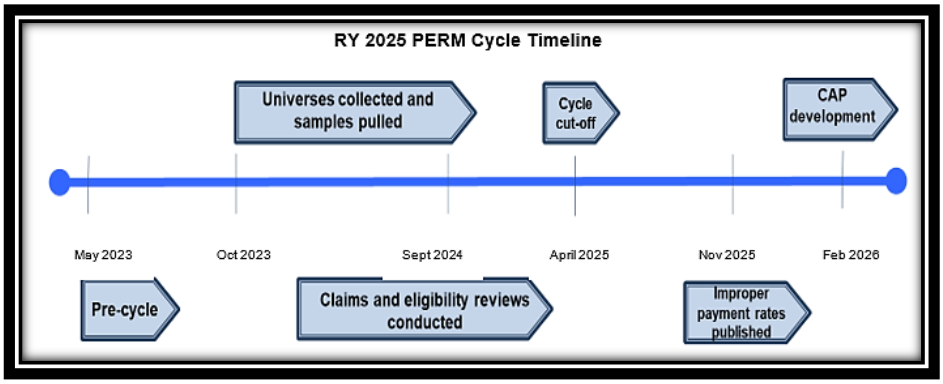
USPSTF Issues Draft Recommendation Statement on Screening for Breast Cancer

The USPSTF posted a draft recommendation statement on screening for breast cancer. The USPSTF 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 deaths for women in the United States. While the USPSTF 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 USPSTF now recommends that all women get screened starting at age 40. This change could result in 19% more lives being saved.

PERM Cycle RY25 Updates

The State is still in the process of providing the three PERM contractors their requested documentation. During this process of gathering all documentation, claims and eligibility reviews are conducted, universes collected, and samples pulled. CMS provides the states with RY 2025 PERM Cycle 1 calls, and Regular State Check-In calls.



PERM Cycle Progression

- The process of sampling, reviewing payments, calculating, and reporting improper payment rates takes more than 2 years.
- Fee-for-service (FFS) claims and managed care capitation payments are collected for a full year: July 1, 2023, through June 30, 2024.
    - Payments will receive a Data Processing (DP) Review, a Medical Review (MR), and/or an Eligibility Review.
    - Findings will be used to calculate improper payment rates.
- Delaware will develop the corrective action plan (CAP) based on the findings.

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. Contact Information can be updated for a 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 notifications, 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 members' 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.