DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Coming Soon:

Redesign of the DMAP Portal Pharmacy Corner

The Delaware Medical Assistance Program (DMAP) will be modernizing the Pharmacy Corner pages of the Delaware Medical Assistance Portal.

New enhancements include an updated provider Pharmacy Corner and a member Pharmacy Corner. The redesigns will promote easier navigation of the DMAP Pharmacy Corner pages for provivders and members. The updates will include:

- **NEW** Landing Page
- **NEW** Scrolling Announcement Banner
- **NEW** and Updated Resource Links, and
- **NEW** and Updated Contact Information for members.

In This Edition:

gainwell

How-To & What's New

Action Required: Durable Medical Equipment (DME) Prior Authorization

Any prior authorization (PA) requests for medically necessary supplies and durable medical equipment (DME) **must be submitted electronically through the DMAP Provider Portal**.

The following requirements must be met:

- PA must be submitted 2 weeks prior to the scheduled date of service.
- PA must be obtained prior to the delivery of the DME item or supplies.
- Members must be eligible for benefits at the time of service.
- Providers must seek authorization from all other insurance prior to submitting to Medicaid.
- Remittance information from other insurances must be submitted when filing a claim with DMAP.

For more information regarding this change and for the form itself, see the Durable Medical Equipment Provider Specific Policy Manual.

DHSS and DHCC Launch Benchmark Trend Report Dashboard

The Delaware Department of Health and Social Services (DHSS) and the Delaware Health Care Commission (DHCC) have launched the Benchmark Trend Report Dashboard to further support the State's efforts to improve health care quality for all residents, while simultaneously working to monitor and reduce the economic burden of health care spending.

This dashboard provides an interactive view of Delaware's health care spending and quality data across multiple years. Users can directly interact with the data and visualizations, allowing a customizable journey through the dashboard. Information is broken down by state-, market- and insurer-level spending, as well as type of insurance and total health care enrollment.

The spending and quality benchmarks were originally developed to support Governor John Carney's vision for the state. In November 2018, Governor Carney signed Executive Order 25, establishing a state health care spending benchmark, an annual per-capita-rate-of-growth benchmark for health care spending, and multiple health care quality measures that are to be evaluated and adjusted every three years. The benchmarks were subsequently codified in August of 2022 through House Bill 442.

For more information, see the full news release at: https://news.delaware.gov/2024/02/12/dhss-and-dhcc-launch-benchmark-trend-report-dashboard/.

Helpful Titles

- How-To Send Attachments with an 837 X12 Transaction through a Vendor or Clearinghouse
- How-To View and Verify 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

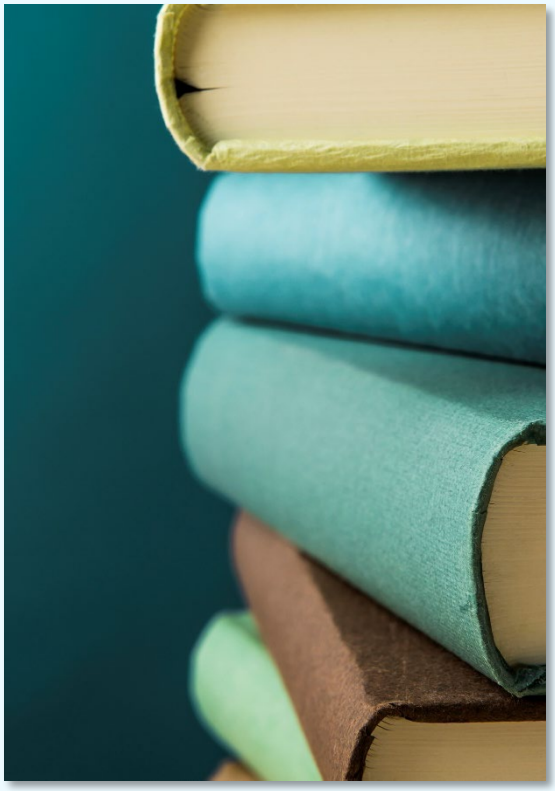
***Remittance Advice Reminder:** RAs are available on the Provider Portal every **Monday** after 12:00 noon ET.

Durable Medical Equipment Provider Specific: Revision Date – 02/26/2024: Sections Revised:

- Section 3.1.2 – Updated with the requirement that all prior authorization requests be submitted via the DMAP portal.
- Section 8.0 – Added the DMAP portal link for electronic submission of supply prior authorization requests.
- Section 9.0 – Updated Appendix B – Medicaid Certificate of Medical Necessity to reflect the requirement that the form be submitted via the DMAP portal.

Practitioner Provider Specific: Revision Date – 01/12/2024: Sections Revised:

- Section 1.0 – Updated section in compliance with current provider descriptions and policy requirements.
- Section 17.0 – Added specific criteria for annual behavioral health well check in compliance with 24 Del Admin. Code Title 31 Chapter 5 §531.



General Policy Manual: Revision Date – 12/12/2023: Section 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.

Coming Soon: Delaware Medicaid Retroactive Coverage Expansion

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 when the updates are completed.

General Information

If an individual meets the general financial and technical eligibility requirements, and if the individual 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 who 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) are **not** 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 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)

ACT NOW TO AVOID PAYMENT SUSPENSION OR TERMINATION

In compliance with 42 CFR § 438.602 and 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 support of Delaware's Managed Care Program, **DMAP has extended the deadline for all engaged MCOPs to complete the enrollment application to September 30, 2024**. DMMA has been in constant communication with providers and has had an overwhelming response from providers, expressing concern and offering suggestions and solutions. DMMA has heard you and remains committed to our provider community.

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*."

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

Electronic Claims Submission Requirements

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 submitted paper claims will not be processed or 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)

What should I do if I unregistered a Managed Care Organization-Only Provider (MCOP) service location, but I need to re-register it?

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 that was unregistered can be re-registered by resetting the Application Tracking Number, as long as it is not a duplicate service location. Resetting the service location allows the provider to rework the existing Registration Application.

To reset the Application Tracking Number, go to the DMAP Portal, click the “Provider Enrollment” link, and click the “MCO-Only Provider Enrollment Application” link. Log in using your NPI and Taxonomy, and click **Search**. A panel will open with a list of each state-assigned Medicaid ID (MCD ID) and the associated Provider Practice / Service Location. Click **Reset** next to the unregistered service location that you want to re-register. On the “Provider Enrollment: Reset ATN” page, create a new password, and then click **Submit**. (Remember to write down and save the password that you create. No one has access to this password, and the password cannot be reset if forgotten.) The selected service location will change to a status of “Pending”. Click **Resume Enrollment** and update the application for that service location.

For more information and specific instructions, see How-To Reset an Application Tracking Number.

***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

Criminal Health Care Fraud Statute

The following excerpts are provided from the Medicare Fraud & Abuse: Prevent, Detect, Report (2021) from the Centers for Medicare & Medicaid Services (CMS).

The Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute, 18 U.S. Code § 1347 prohibits **knowingly and willfully** executing, or attempting to execute, a scheme or lie in connection with the delivery of, or payment for, health care benefits, items, or services to either:

- Defraud any health care benefit program, or
- Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program.

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary claims for power wheelchairs.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Exclusion Statute

The Exclusion Statute, 42 U.S. Code § 1320a-7, requires the Office of Inspector General (OIG) to exclude individuals and entities convicted of any of the following offenses from participation in all federal health care programs:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid,
- Patient abuse or neglect,
- Felony convictions for other health care-related fraud, theft, or other financial misconduct, or
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances.

The OIG also may impose permissive exclusions on other grounds, including:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud, or misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances,
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity,
- Providing unnecessary or substandard services,
- Submitting false or fraudulent claims to a federal health care program,
- Engaging in unlawful kickback arrangements, or
- Defaulting on health education loan or scholarship obligations.

Excluded providers may not participate in the federal health care programs for a designated period. If you are excluded by OIG, then federal health care programs, including Medicare and Medicaid, will not pay for items or services that you furnish, order, or prescribe. Excluded providers may not bill directly for treating Medicare and Medicaid patients, and an employer or a group practice may not bill for an excluded provider's services. At the end of an exclusion period, an excluded provider must seek reinstatement; reinstatement is not automatic. The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE).

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

Sailing into the EVV Open Sea…

We are now in the Deep Blue Sea of EVV! As mentioned in our previous editions, the State will be utilizing a post-adjudication process initially, which will include a "soft edit" and alert that, once pre-adjudication begins, a visit in question may be rejected. This process has not been implemented yet; however, the EVV team anticipates that soft edit notifications will begin for some providers in the second quarter of 2024. At an as-yet undetermined future date, the pre-adjudication process will begin, which will include a "hard edit" where claims will be denied without a valid claims match. Because our MCO and fiscal agent partners are at varying stages of readiness, the EVV team is providing as much education/assistance as required so that the hard edit process is as smooth as possible. Please continue to stay tuned for further guidance from the EVV team as we move closer to this milestone. Again, thanks to our partners for their continued patience and cooperation!

EVV Highlights for Q1:

- 115 unique MCD IDs where services are subject to EVV have been registered with Sandata.
- 643,975 visits are present in system.
- There has been a continued increase in the number of providers who do not have unverified visits over the past few months.
- The EVV team's targeted collaboration sessions with our provider partners have continued to address both common and unique concerns/issues.
- The EVV team continues to work diligently with our provider and MCO partners to iron out issues related to MCD IDs and the overlap with the 21st Century Cures Act's guidelines.
- The EVV team's targeted collaboration sessions with our provider partners have continued as needed/requested, with the intention 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 Personal Care Services (PCS) and Home Health Care Services (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 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

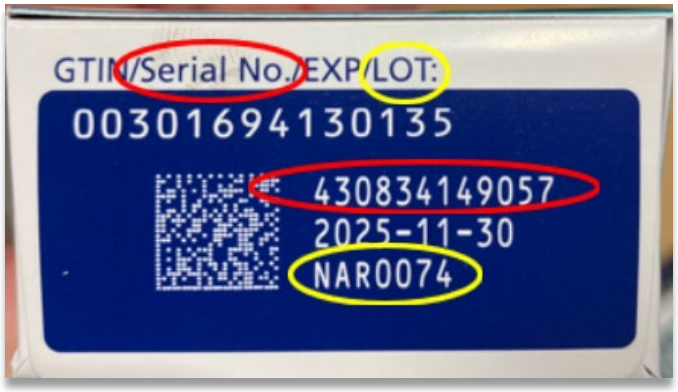
Important Discontinuation Information

See below for recently or soon-to-be discontinued medications by manufacturers.

Brand Name	Drug Name	NDC	Discontinuation Date
Combivir Tablets 150mg/300mg	Lamivudine and Zidovudine	49702-0202-18	January 1, 2024
Epizcom Tablets 600mg/300mg	Abacavir and Lamivudine	49702-0206-13	January 1, 2024
Lexiva Tablets 700mg	Fosamprenavir Calcium	49702-0207-18	January 1, 2024
Lexiva Oral Suspension	Fosamprenavir Calcium	49702-0208-53	January 1, 2024
Levemir FlexPen 100 iU/1 mL	Insulin Detemir Injection	00169-6432-10	April 1, 2024
Glucagen Injection 1mg/1mL	Glucagon Hydrochloride	00169-7065-15	July 1, 2024
Levemir Vial 100 iU/1 mL	Insulin Detemir Injection	00169-3687-12	December 31, 2024

More information about current and resolved drug shortages and discontinuations reported to the FDA can be found on the U.S. Food & Drug Administration (FDA) Drug Shortages Page.

Counterfeit Ozempic (semaglutide)



Recently, there have been reports of counterfeit Ozempic (semaglutide) injection 1 milligram (mg) being delivered to legitimate U.S. drug supply chains. The FDA has already seized thousands of units of the product. The FDA advises wholesalers, retail pharmacies, health care practitioners, and patients to check the product they have received and to not distribute, use, or sell products labeled with lot number NAR0074 and serial number 430834149057. Some counterfeit products may still be available for purchase.

The FDA and Novo Nordisk (manufacturer of Ozempic) are testing the seized products and do not yet have information about the drugs' identity, quality, or safety.

Additional analysis found that the needles from the samples are also counterfeit. Accordingly, the sterility of the needles cannot be confirmed, which presents an increased risk of infection for patients who use the counterfeit products. Based on analyses completed to date, other confirmed counterfeit components within the seized products are the pen label, accompanying health care professional and patient information, and carton.

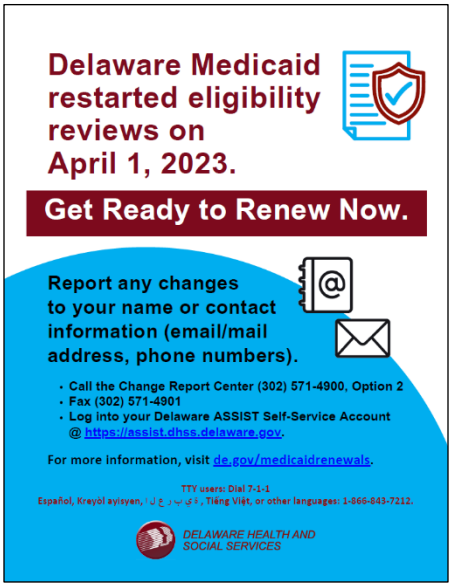
Source: https://www.fda.gov/drugs/drug-safety-and-availability/fda-warns-consumers-not-use-counterfeit-ozempic-semaglutide-found-us-drug-supply-chain

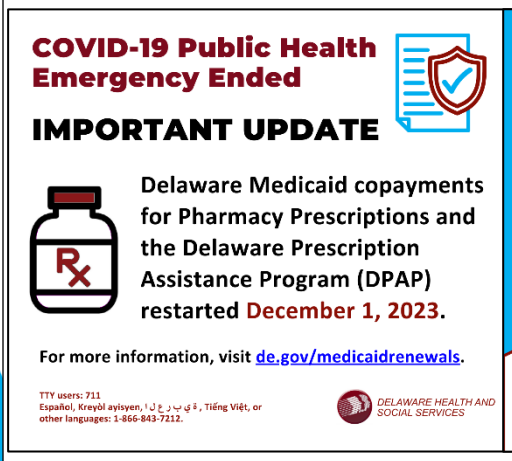
Public Health Emergency (PHE) Unwinding Updates

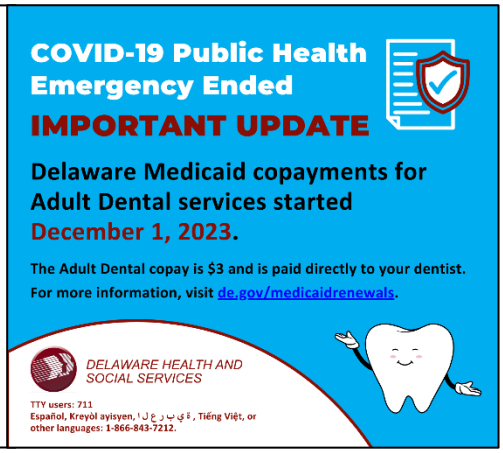
Help Us Get the Word Out

The following posters are available to remind members that Delaware Medicaid renewals restarted on April 1, 2023; Pharmacy and Delaware Prescription Assistance Program (DPAP) 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 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.

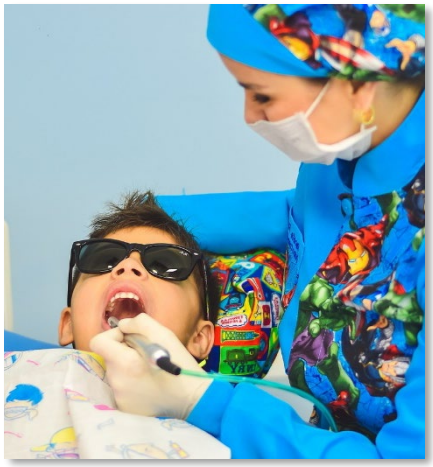
Provider Taxonomy Screening Level List

MCOP Taxonomy Screening Level List

Be on the Lookout

The 2024 Dental Fee Schedule will soon post to the DMAP Document Repository. The effective date of the Dental Fee Schedule will be **April 1, 2024**.

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.** Managed Care Organization-Only Providers (MCOPs) must submit encounter claims through their appropriate managed care organization.

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.

Early Periodic Screening, Diagnosis & Treatment (EPSDT) Corner

Vision Services

Many children across the country experience uncorrected vision issues and may not have eyeglasses they need to see a class board, read a book, or participate in a school setting. Using funds from the Health Service Initiative, Delaware offers vision services in the school setting through the Vision To Learn program. Trained eye care professionals provide vision screenings and eye exams to students and, if appropriate, the students are then able to choose from a variety of glasses in multiple styles, colors, and size. These services are offered free of charge regardless of insurance coverage, immigration status, or family income.

Alongside the Vision to Learn program services, the Delaware Medical Assistance Program (DMAP) performs outreach by supplying brochures and information about the Delaware Healthy Children Program (DHCP) and other Delaware Medicaid and Medical Assistance (DMMA) programs.

DMAP members under the age of 21 are eligible for the following vision benefits:

- One routine eye exam, including refraction, annually (unless a medical condition warrants a higher frequency).
- Lenses and/or frames to be dispensed when medically necessary.
    - DMAP will cover replacement of damaged lenses and/or repair of broken frames.
- Coverage of deluxe frames for special needs children, infant eye size under 42mm, child eye size over 58mm, and for special reasons may be covered with prior authorization.

Review the Practitioner Provider Specific Policy Manual for more information on coverage offered to DMAP members.

For more information on the impact of the Vision To Learn program in Delaware, visit the Vision To Learn 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
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 Interventions for High Body Mass Index in Children and Adolescents

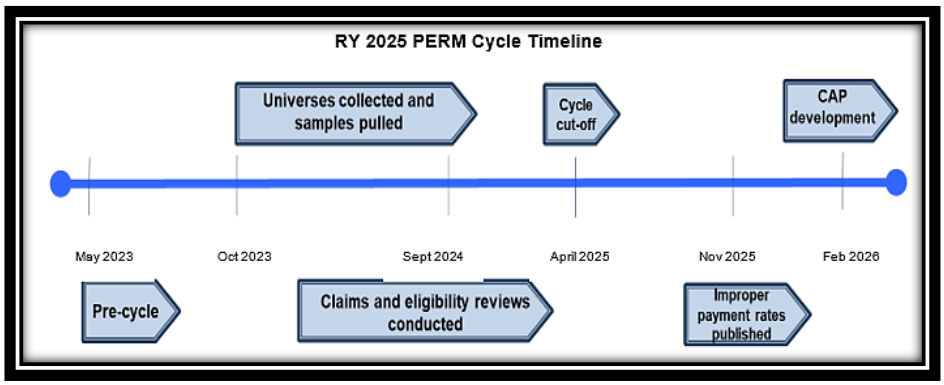
The USPSTF posted a draft recommendation statement on interventions for high body mass index (BMI) in children and adolescents. The USPSTF recommends physicians provide or refer children and teens with a high BMI to intensive, comprehensive behavioral interventions. **This is a B grade**.

This recommendation applies to children and adolescents ages 6 years and older with a high BMI. Nearly 20% of children and teens in the United States have a high BMI, sometimes referred to as having obesity. BMI is calculated from a child's height and weight and is plotted on a growth chart. Obesity is defined as a BMI at or above the 95th percentile for age and sex on the growth chart.

Comprehensive, intensive behavioral interventions may include education about healthy eating habits, counseling on behavioral change techniques, such as goal setting and problem solving, and supervised exercise sessions. Effective interventions include at least 26 or more hours with a healthcare professional over one year, which requires commitment from children and their families.

For more information, click here to see the draft recommendation.

PERM Cycle RY25 Updates



The state continues to provide the three PERM Contractors their requested documentation. During this process of gathering all documentations, claims and eligibility reviews are conducted, universes collected, and samples pulled. CMS provides the states with RY25 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 or Alicia Seals at Alicia.Seals@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.