DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Delaware Medicaid Supports New Initiatives for Annual Behavioral Health Services

In alignment with Delaware legislation and recommendations from the U.S. Preventive Services Task Force (USPSTF), effective January 1, 2024, the Delaware Medical Assistance Program (DMAP) updated their system to ensure all Medicaid members have access to an annual behavioral health well check. The goal is to promote health and foster the coordination of screening and preventive mental health services. Providers must use the diagnosis code "annual behavioral health well check", and these services can only be provided by a licensed mental health clinician (Nurse Practitioner or Licensed Behavioral Health Practitioner/ Clinician) who has, at minimum, a master's-level degree. The well check must include but is not limited to the following:

- Review of medical history,
- Evaluation of adverse childhood experiences,
- Use of a group of developmentally appropriate mental health screening tools, and
- Anticipatory behavioral health guidance congruent with stage of life.

For more information, see the Practitioner Provider Specific Policy Manual and the legislation.

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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

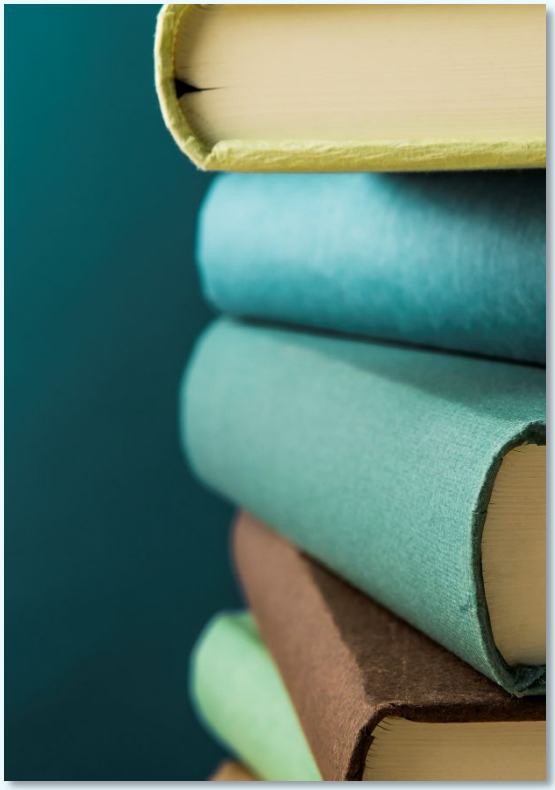
***Remittance Advice Reminder:** RAs are available on the Provider Portal every **Monday** after 12:00 noon ET.

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 working to expand the groups of members who are eligible for retroactive Medicaid coverage.

In compliance with Federal Regulation 42 CFR §435.915, the DMMA is working to 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 currently updating systems to accommodate these changes. Once updates are completed, additional information will be provided regarding the effective date and updated policies.

General Information

Once the system changes are completed, Medicaid-covered services will be covered for members if they meet the general financial and technical eligibility requirements, and if they receive Medicaid-covered services during the three months prior to becoming eligible. Providers will be encouraged to return payments 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 will 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
- Incarcerated Group (MAGI and Non-MAGI)
- Emergency Services
- Labor and Delivery Services

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

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

ALERT for Providers

School Based Health Services Providers: Payment Error Rate Measurement (PERM) RY 2022 CHIP Corrective Action Plan (CAP) Update

Providers of school-based health services must comply with General Conditions for Participation (Section 1.5) and Provider Participation Requirements (Section 2.0) detailed in the School Based Health Services Provider Specific Policy Manual. Providers are strongly encouraged to review Section 1.5.3 regarding documentation, medical record authentication, and provider signatures.

Please remember that medical record entries for services provided/ordered must be authenticated by the author using a handwritten or electronic signature. Signatures using an "auto-authentication"/"auto-signature" system (i.e., "signed but not read") or a stamp are not acceptable.

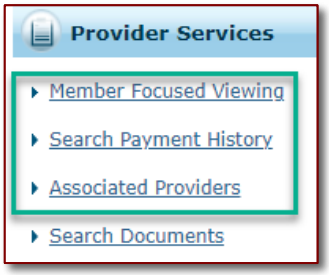
You Ask, DMAP Answers (YADA)

How do I know if I am using a Fee-for-Service (FFS) master account or a Managed Care Organization-Only Provider (MCOP) master account on the DMAP Portal?

There are four types of DMAP Portal provider accounts: FFS master account, FFS delegate account, MCOP master account, and MCOP delegate account. Each type of account has a different level of access in the DMAP Portal. The provider's master account sets the level of access for any delegate accounts affiliated with the provider.

To identify whether you have a master account or delegate account, log into the DMAP Portal and navigate to the **Home** tab. Master user accounts will only have **"Provider Name"** in the upper left-hand area. Delegate accounts will have **"Delegate for"** and **"Provider Name"** in the upper left-hand area.

FFS Master Account Example



FFS and MCOP providers have different options under the **Provider Services** section. Both have the option for **Search Documents**. However, only FFS providers have options for **Member Focused Viewing, Search Payment History,** and **Associated Providers.**

If you believe you have the wrong type of account, please contact DMAP Provider Services from 8:00 AM ET to 4:30 PM ET at 1-800-999-3371 (TTY 711), select option 0, option 4 or email at delawarepret@gainwelltechnologies.com.

***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	Delaware First Health	Highmark Health Options
1-855-707-5818	1-877-236-1341	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) Unit staff, the Medicaid or Independent Professional Review Team, Utilization Review Team, DMAP Fraud Control Unit, or independent audit firms.

Always Be Prepared for an Audit

The most important things providers can do before a review audit are the following:

- Make sure documentation is correct, organized, and accessible.
- Train staff and emphasize the importance of proper documentation.
- Ensure staff are familiar with manuals and regulations.
- Routinely perform self-audits to ensure that staff are maintaining proper documentation.

Review and/or Audit Process

If a provider is chosen for a review and/or audit, they will receive a review audit notification letter in the mail to request that they make certain records available. The notification letter will include a requested deadline for submitting the records. If it is not possible to submit all the requested records by the deadline specified in the letter, the provider should contact the DMAP SUR Unit staff via phone, email, or letter to request a reasonable extension (see below for contact information).

When the review and/or audit is completed, the provider will receive a "Findings Letter" that explains the Nurse Reviewer's findings. The Findings Letter will identify any alleged errors or deficiencies and will identify the amount of questioned costs identified in the review and/or audit. Questioned costs represent the dollar value of the claims for services that the Nurse Reviewer determined were not appropriately documented or correctly billed. The Findings Letter will also outline the 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 letter by the deadline specified in the letter with a payment to satisfy the overpayment or file a Request for Redetermination to provide additional documentation. If a provider files a Request for Redetermination and provides additional documentation, the provider will receive a response via a Redetermination Findings Letter that will explain the SUR Unit's decision regarding the provider's additional supporting documentation.

The last, but perhaps most important, step after a review and/or audit is to **address any problems specified in the Findings Letter**. For example, if there were problems with documentation, the provider could address the concerns by changing the procedures performed or the documents utilized. Another example, if there were problems with billing, the provider could increase oversight of the billing process.

It is important to address the review audit findings. First, addressing the review audit findings makes it more likely that the finding will not recur if the provider is chosen for another review audit in the future. Second, addressing the findings will reduce the likelihood of more serious actions from happening, such as a suspension or referral to the Attorney General or Office of Inspector General (OIG).

More information: Please refer to Section 1.11, Section 1.12, and Appendix A of the General Policy Manual.

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

EVV is Trucking Along!

DMMA was pleased to host Sandata EVV team members for a site visit and meet and greet on April 17, 2024. The session provided valuable insights on the past, present, and future trajectory of the project, as well as beneficial face-to-face communication. The DMMA team looks forward to continuing to grow our relationship with Sandata as we progress with EVV full integration.

The pre-adjudication process on the horizon, a tentative date of January 1, 2025, will include a "hard edit" where claims will be denied without a valid authorization/visit match. As we approach this milestone, the EVV team is continuing to offer/provide as much education and assistance as required so that the hard edit process is as smoothly understood and avoidable as possible. We will be utilizing a post-adjudication process until the January 1, 2025, target date, 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 but is expected to begin this summer. As always, the EVV Team will notify providers well in advance so there is time to prepare. We would like to again extend a huge thank you to our partners for their continued patience and cooperation!

EVV Highlights for Q2:

- 105 unique providers who provide services subject to EVV have registered with Sandata.
- 826,574 visits from 69 different providers are reflected in the production environment. Of these, 783,539 (95%) are in a verified status (claims with visits matched).
- There has been steady progress over the past few months in engaging with providers and our MCO partners in resolving issues related to EVV, including Medicaid Provider Identification Number (MCD ID) alignment, proper Sandata registration, and data testing.
- 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 21st Century Cures Act's guidelines.
- New Taxonomy crosswalk and Frequently Asked Questions (FAQ) documents have been added to the EVV website for convenience.
- The EVV team's targeted collaboration sessions with our provider partners have continued, with the intention to address both common and unique concerns/issues. We would like to again send many thanks for the continued cooperation!

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 (TTY 711), 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.

Update on FDA Evaluation of Suicidal Thoughts or Actions in GLP-1 RA Patients

Over the last several months, the U.S. Food and Drug Administration (FDA) has received reports in the FDA Adverse Event Reporting System (FAERS) of suicidal thoughts or actions in patients treated with a class of medicines called glucagon-like peptide-1 receptor agonists (GLP-1 RAs). GLP-1 RAs medicines are used to treat people with type 2 diabetes or help those with obesity or who are overweight to lose weight. The FDA has been evaluating and conducting detailed reviews of these reports.

The preliminary evaluation has not found evidence that use of these medicines causes suicidal thoughts or actions. Because the information provided was often limited and because these events can be influenced by other potential factors, the FDA determined that the information in these reports did not demonstrate a clear relationship with the use of GLP-1 RAs. Similarly, the reviews of the clinical trials, including large outcome studies and observational studies, did not find an association between use of GLP-1 RAs and the occurrence of suicidal thoughts or actions.

However, because of the small number of suicidal thoughts or actions observed in both the group of people using GLP-1 RAs and in the comparative control groups, the FDA cannot definitively rule out that a small risk may exist; therefore, the FDA is continuing to look into this issue.

Source: https://www.fda.gov/drugs/drug-safety-and-availability/update-fdas-ongoing-evaluation-reports-suicidal-thoughts-or-actions-patients-taking-certain-type

Counterfeit Botox (onabotulinumtoxinA)

The U.S. Food & Drug Administration (FDA) is alerting health care professionals and consumers that unsafe counterfeit versions of Botox (onabotulinumtoxinA) have been found in multiple states and administered to consumers for cosmetic purposes.

FDA is aware of adverse events linked to the counterfeit Botox, including hospitalizations. Symptoms included blurred or double vision, difficulty swallowing, dry mouth, constipation, incontinence, shortness of breath, weakness, and difficulty lifting one's head following injection of these products. These symptoms are similar to those seen when botulinum toxin spreads to other parts of the body.

The counterfeit product includes counterfeiting of the outer carton and vial. The counterfeit product may be identified by one or more of the following:

- The outer carton and vial contain lot number C3709 C3.
- The outer carton displays the active ingredient as "Botulinum Toxin Type A" instead of "OnabotulinumtoxinA".
- The outer carton and vial indicate 150-unit doses, which is not a unit made by AbbVie or Allergan.
- The outer carton contains language that is not English.

Example of Counterfeit Botox

Source: https://www.fda.gov/drugs/drug-safety-and-availability/counterfeit-version-botox-found-multiple-states

Member Eligibility Renewals Update

In compliance with the Consolidated Appropriations Act, 2023, **Delaware Medicaid restarted eligibility renewals on April 1, 2023. Renewal processing is ongoing and is expected to be completed by August 31, 2024.** During the renewal process, some members may experience gaps or changes in their coverage, including possibly losing their Delaware Medicaid.

As a reminder, DMAP providers must verify member eligibility prior to providing services. For rules and requirements, please refer to section 3.4 of the General Policy Manual. FFS providers are encouraged to review the step-by-step instruction document How-To: View and Verify a Member's Eligibility in the Manuals, Bulletins, and Forms link on the DMAP Provider Portal.

Managed Care Organization-Only Providers (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

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

2024 Dental Fee Schedule

The 2024 Dental Fee Schedule is on the DMAP Document Repository. Effective date is **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 prior authorization forms, claims, 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. **DMAP no longer accepts mailed articulated or marked study models with wax bite.** Any articulated or marked study models mailed to DMAP 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

Reminder: Adult Dental Co-payments Started December 1, 2023

Adult Dental copayments started **December 1, 2023**. Adult Medicaid individuals, with some exclusions, are responsible for paying a $3 copay for each dental visit. Dental services may not be refused if the beneficiary is unable to pay the copay. For more information about the copay and individuals excluded from the copay requirement, please refer to Section 6.2 of the Adult Dental Program Policy Manual.

Join us to meet the growing demands of the 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. For additional information regarding the DMMA Adult Dental Program, click HERE.

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

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 sizes. 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
Falls Prevention in Community-Dwelling Older Adults: Interventions: community-dwelling adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	B	June 2024
Breast Cancer: Screening: women aged 40 to 74 years	The USPSTF recommends biennial screening mammography for women aged 40 to 74 years.	B	April 2024
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

USPSTF Issues Draft Recommendation Statement on Interventions for High Body Mass Index in Children and Adolescents

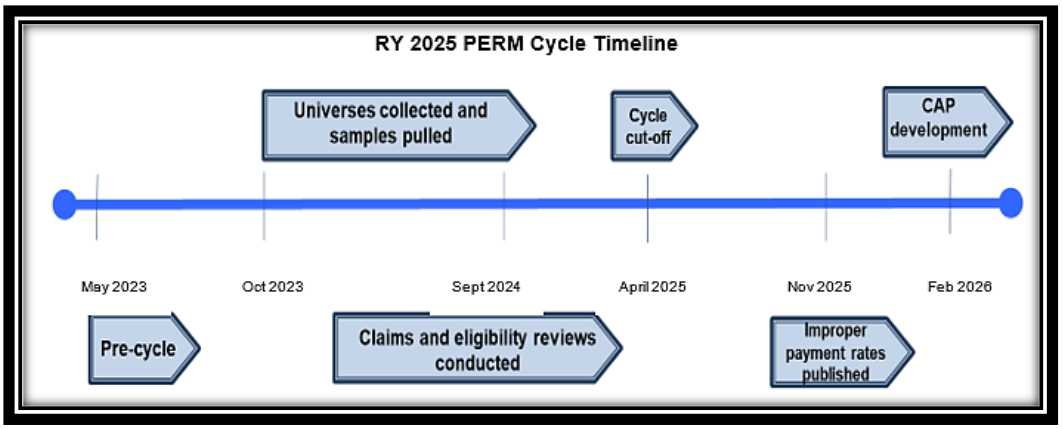
The USPSTF posted a draft recommendation statement on interventions for high body mass index (BMI) in children and adolescents. The USPSTF recommends physicians provide or refer children and teens with a high BMI to intensive, comprehensive behavioral interventions. **This is a B grade**.

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 CMS PERM Review Contractors have begun sending the First Initial Request Letters for Medical records. It is important that the providers thoroughly examine the letter. To comply with the request, providers should:

1. Review the attached Claim Summary page that identifies the specific patient, date of service, and the service(s) selected for review.
2. Gather the documents shown on the attached Cover Sheet which are generally those needed to support the billed service(s).
    a. Please be sure that documentation (Notes, Plan of Care, etc.) issued from electronic records are signed and dated (electronic signature acceptable if permitted by state regulations).
3. Once the documents are gathered, please choose ONE of the methods to submit the records/documentation to the PERM Review Contractor.

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

Updates to 12-month Postpartum Coverage

The Division of Medicaid and Medical Assistance (DMMA) extended Medicaid postpartum coverage to 12 months for eligible members, effective July 1, 2022. **If your member is enrolled in Delaware Medicaid, please remind them to contact their local office or the Change Report Center (302-571-4900, Option 2 (TTY 711)) with any changes in their pregnancy, if they have a newborn, or if they have changes to their postpartum status.** They may also be eligible for retroactive coverage for pregnancy and birth services.

The following updates to Delaware Medicaid postpartum coverage were made:

- Postpartum coverage was extended from 60 days to 12 months per pregnancy, regardless of the reason the pregnancy ended;
- Postpartum coverage begins on the day the pregnancy ends, and continues through the last day of the month in which the 12-month period ends; and
- Eligible members will remain eligible for ongoing postpartum healthcare coverage, even if there are changes that may affect their eligibility (ex: change in income, change in household/family unit).

However, the 12-month postpartum benefits are not available to the following individuals:

- Members who received only emergency labor and delivery services; or
- Members who are not otherwise eligible for Medicaid (i.e., they cannot apply and be found eligible for Medicaid for the postpartum period alone).

Click HERE for more information.

Delaware Medicaid Retroactive Coverage Fact Sheet

The Division of Medicaid and Medical Assistance (DMMA) expanded the groups of individuals who are eligible for retroactive Medicaid coverage. Individuals eligible under the Delaware Healthy Children Program (DHCP) are not eligible for retroactive Medicaid. Click HERE for information about retroactive coverage, eligible members, effective dates, and reimbursement for providers.

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: Subscribe to Provider Notify Me E-Mail Notifications

For providers who have NOT enrolled for an account on the Delaware Medical Assistance Portal:

1. Go to the Delaware Medical Assistance Portal: https://medicaid.dhss.delaware.gov/.
2. Select the "Notify Me" link in the left panel.
3. Enter and confirm your e-mail address. Choose which types of notifications you want to receive via e-mail.
4. When you receive a confirmation e-mail, click on the link in the e-mail to finish subscribing.

For providers who HAVE enrolled for an account on the Delaware Medical Assistance Portal:

1. Go to the Delaware Medical Assistance Portal: https://medicaid.dhss.delaware.gov/.
2. Log into the Provider Portal using your User ID and Password.
3. After signing in, users with an unverified e-mail address will be directed to the "Subscribe for E-mail Notifications" panel. A confirmation dialog box prompt will appear. Click OK.
4. Verify that the e-mail address on record is correct. If desired, add additional types of notifications.
5. When you receive a confirmation e-mail, click on the link in the e-mail to finish subscribing.

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.