DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Delaware Medical Assistance Program (DMAP) Complies with the 21st Century Cures Act Requirement (Managed Care Rule)

DMAP would like to thank Managed Care Organization-Only Providers (MCOPs) for their participation in the registration/enrollment process by the September 30, 2024, deadline!

By completing the registration/enrollment process, providers assisted in ensuring that DMAP has a substantial and updated network for our members. As part of the 21st Century Cures Act compliance efforts, more than 6,500 new managed care organization provider applications were successfully completed, and more than 2,300 existing Medicaid Identification Numbers (MCDs) were confirmed and registered with DMAP.

For MCOPs who started the registration/enrollment process but were **not** able to finish by the deadline, *it's never too late!* You can reset your current Application Tracking number (ATN) to continue the process. MCOPs who have not yet started the registration/enrollment process, please start a new MCOP enrollment application. DMAP must screen and enroll all current and prospective MCOPs in compliance with 42 CFR § 438.602 and 42 CFR § Part 455, subparts B and E, and the 21st Century Cures Act.

For important updates regarding enrollment application requirements for non-billing MCOPs, please go to page 4.

In This Edition:

gainwell

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)) if there are any changes in the pregnancy, if the pregnancy ends for any reason, 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 has been 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 remain eligible for ongoing postpartum healthcare coverage, even if there are changes that may affect their Medicaid eligibility (ex: change in income, change in household/family unit).

However, 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.

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.

Coming Soon: Delaware Medicaid Retroactive Coverage Expansion

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

In compliance with Federal Regulation 42 CFR § 435.915, Delaware Medicaid 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. Delaware Medicaid 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.

Effective **January 1, 2025**, the additional expansion populations will include:

- Modified Adjusted Gross Income (MAGI)-based Adult Group
- Protected Supplemental Security Income (SSI) Medicaid Group
- Long Term Care (LTC) Community Services Groups
- Former Foster Care Group
- Incarcerated Group (MAGI and Non-MAGI)
- Emergency Services
- Labor and Delivery Services

Individuals covered under the Delaware Healthy Children Program (DHCP) will 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

Update: Enrollment Application Requirements for Non-Billing MCOPs

The deadline for all engaged MCOPs to complete their registration/enrollment application was extended to September 30, 2024. For those who started the process but were not able to finish by the deadline, *it is never too late!* You can reset your current Application Tracking number (ATN) to continue the process. If you have not yet started the registration/enrollment process, please start a new MCOP enrollment application. The Delaware Medical Assistance Program (DMAP) must screen and enroll all current and prospective MCOPs in compliance with 42 CFR § 438.602 and 42 CFR Part 455, subparts B and E, and the 21st Century Cures Act.

As part of DMAP's commitment to our provider community, an update has been made to reduce the quantity of applications that need to be submitted to DMAP. Effective immediately, Non-Billing MCOPs only need to register each NPI and Taxonomy combination at their main practice location.

- For registration purposes only, DMAP defines a "Non-Billing" provider as a rendering/attending/performing or ordering/referring/prescribing provider listed on a claim.
- Non-Billing MCOPs who have already registered additional service locations, do not need to take any action at this time.

No update is being made for Billing MCOPs. Billing MCOPs are still required to register each service location where services are rendered.

- For registration purposes only, DMAP defines "Billing" provider as the group or business entity being reimbursed for services rendered to the member.

MCOPs 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).

MCO providers who have not yet started the registration/enrollment process can start at any time. For new application instructions, see How-To Enrollment Guide for New MCO Network Providers.

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

For More Information:

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

Additional News

ALERT for Providers

School-Based Health Services Providers: Payment Error Rate Measurement (PERM) RY 2022 Children's Health Insurance Program (CHIP) Corrective Action Plan 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.

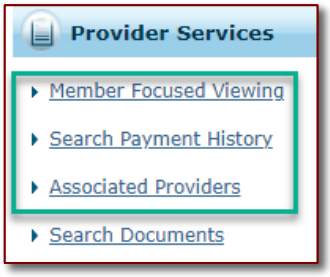
You Ask, DMAP Answers (YADA)

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.

Managed Care Organization (MCO) Member Open Enrollment for 2025

The Delaware Department of Health and Social Services (DHSS) selected three managed care companies to operate its Medicaid Managed Care Program. **Members have the opportunity to enroll in their choice of MCO coverage for 2025 from October 1 – October 31, 2024.** For more information or to enroll with an MCO, members should login to their DMAP Member Portal or call the Health Benefits Manager at 1-800-996-9969 (TTY 771) (M-Th 8AM – 6PM; F 8AM – 5PM).

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	delaware first health	HIGHMARK HEALTH OPTIONS
AmeriHealth Caritas	**Delaware First Health**	**Highmark Health Options**
1-855-707-5818	1-877-236-1341	1-844-325-6251

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).

Utilization Review

Utilization review ensures that services are reasonable, medically necessary, and of optimum quality and quantity, while making sure payments are appropriate according to the coverage policies established by the Division of Medicaid and Medical Assistance (DMMA). The Surveillance and Utilization Review (SUR) Unit of the Division of Medicaid & Medical Assistance (DMMA) conducts required utilization review activities through a series of monitoring systems. Delaware Medical Assistance Program (DMAP) members and providers are both subject to utilization review.

Utilization control procedures safeguard against the following situations:

- Unnecessary care and services;
- Inappropriate services or poor quality of service, monitored in accordance with SUR Unit guidelines; and
- Inappropriate payments, as defined by the DMMA.

Utilization review activities ensure the efficient and cost-effective administration of the DMAP by monitoring the following areas:

- Billing and coding practices
- Diagnosis-related group (DRG) validations
- Documentation
- Medical necessity
- Misuse and overuse
- Other administrative findings
- Quality of care
- Reasonableness of prior authorization (PA)

The utilization review process assists the SUR Unit to make important policy decisions, identify areas of policy that require clarification or change, and help shape policy guidelines to ensure that services are provided in an efficient and effective manner.

Abuse and Fraud Defined

Abuse: Incidents or practices of Medicaid providers that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices can result in unnecessary costs to the DMAP, improper payment, or payment for services that fail to meet recognized standards of care or are medically unnecessary.
The following are some examples of abuse:

- Billing and receiving payment from a member over and above the DMAP reimbursement for the service.
- Billing the DMAP at a higher fee than for private-pay patients.
- Submitting claims for services not medically necessary in relation to a member's diagnosis.
- Excessive charges for services or supplies.
- Violation of any of the provisions of the provider agreement.

Fraud: An intentional deception or misrepresentation of a provider or a member that could result in unauthorized benefit(s).
The following are some examples of fraud:

- Altering a member's medical records to generate fraudulent payments.
- Billing for group visits (such as a provider billing for members of the same family in one visit, although only one family member was seen).
- Billing for services or supplies that were not rendered or provided.
- Misrepresenting services provided (such as billing a covered procedure code and providing a non-covered service).
- Soliciting, offering, or receiving a kickback, bribe, or rebate.
- Submitting claim forms that have been altered or manipulated to obtain higher reimbursement.

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 (TTY 711)
Hotline (After-Hours Voicemail Only): 1-800-372-2022, select option 1.
Email: SURreferrals@delaware.gov

Prepare for Landing!

As of July 31, 2024, the "soft edit" part of the pre-adjudication process for EVV paid claims has been initiated. Providers subject to the EVV mandate will begin to receive a rejection warning alert that, once pre-adjudication begins, a visit in question will be rejected. The "soft edit" will continue to be rolled out over the next few weeks until all encounter and FFS claims are post-adjudicated. The final "hard edit" part of the pre-adjudication process has a tentative implementation date of January 1, 2025. For the "hard edit", claims will be denied if they do not have a valid authorization/visit/paid claims match.

The EVV team continues to offer and provide as much education and assistance as possible so the "hard edit" process is easily understood, and issues can be avoided. Providers who receive claim rejection warning(s) should be diligent and expedient in contacting their Managed Care Organization (MCO) partners, Sandata, and/or the State (where appropriate) to help the process be as smooth as possible. As always, the EVV team will notify providers well in advance of the "hard edit" full implementation so there is time to prepare. We extend a huge thank you to our partners for their continued patience and cooperation!

EVV Highlights for Q2:

- 112 unique providers who provide services subject to EVV have registered with Sandata.
- 1,017,435 visits from 63 different providers are reflected in the production environment. Of these visits, 977,525 (96%) are in a verified status (claims with visits matched).
- Provider and MCO partner engagement progress continues in resolving issues related to EVV, including MCDID alignment, proper Sandata registration, and data testing over the past few months.
- The EVV team continues to work diligently with our provider and MCO partners to iron out issues related to MCDIDs and the overlap with 21st Century Cures Act guidelines.
- Outreach to providers who are at high-risk for claims matching issues is increasing.

Provider Reminders:

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 or an alternate EVV vendor of their choosing. To register with 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.

Safety Alert: Dosing Errors Associated with Compounded Injectable Semaglutide Products

The U.S. Food and Drug Administration (FDA) has received reports of adverse events, some requiring hospitalization, that may be related to overdoses due to dosing errors associated with compounded semaglutide injectable products. Dosing errors have resulted from patients measuring and self-administering incorrect doses of the drug and health care providers miscalculating doses of the drug.

Many of the patients who received vials of compounded semaglutide lacked experience with self-injections, according to the adverse event reports. Unfamiliarity with withdrawing medication from a vial into a syringe and confusion between different units of measurement (e.g., milliliters, milligrams, and “units”) may have contributed to dosing errors.

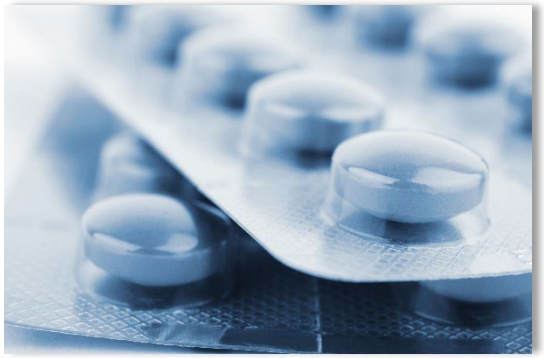
The FDA encourages health care providers and compounders to provide patients with the appropriate syringe size for the intended dose and counsel patients on how to measure the intended dose using the syringe.

Additionally, health care providers should be vigilant when prescribing and administering compounded semaglutide, as there may be different concentrations available. If uncertain, health care providers should contact the compounder about calculating the correct dose of medication to prescribe or administer.

For more information: https://www.fda.gov/drugs/human-drug-compounding/fda-alerts-health-care-providers-compounders-and-patients-dosing-errors-associated-compounded

CDC Releases Updated Recommendations for Contraceptive Use

The 2024 U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR) addresses a selected group of common, yet sometimes complex, issues regarding initiation and use of specific contraceptive methods. These recommendations for health care providers were updated by the Centers for Disease Control and Prevention (CDC) after review of the scientific evidence and a meeting with national experts in Atlanta, Georgia, during January 25–27, 2023. The information in this report replaces the 2016 U.S. SPR.



Notable updates include:

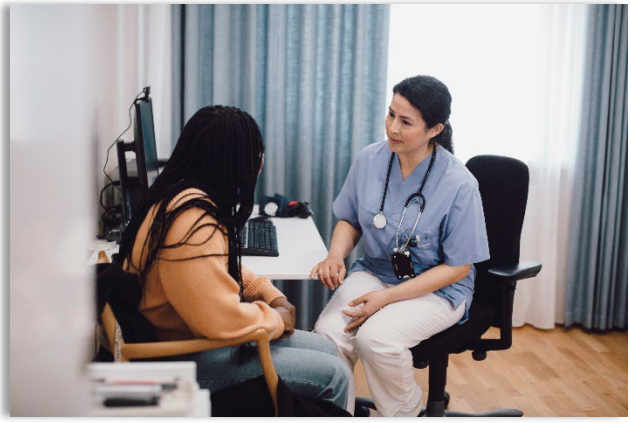
1. Updated recommendations for provision of medications for intrauterine device placement.
2. Updated recommendations for bleeding irregularities during implant use.
3. New recommendations for testosterone use and risk for pregnancy.
4. New recommendations for self-administration of injectable contraception.

The recommendations in the report are intended to serve as a source of evidence-based clinical practice guidance for health care providers. The goal of the recommendations is to remove unnecessary medical barriers to accessing and using contraception, and to support the provision of person-centered contraceptive counseling and services in a noncoercive manner. Health care providers should always consider the individual clinical circumstances of each person seeking contraceptive services.

For the full report, visit: http://dx.doi.org/10.15585/mmwr.rr7303a1

Member Eligibility Renewals Update

In compliance with the Consolidated Appropriations Act, 2023, **Delaware Medicaid restarted sending eligibility renewals on April 1, 2023 and ended as of August 31, 2024.** During the renewal process, some members may have experienced 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. Fee-for-service (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

Update to COVID-19 OTC Tests for At-Home Use

Effective **October 1, 2024**, DMAP will no longer cover over-the-counter (OTC) COVID-19 at-home test kits. Previously, DMAP covered four (4) OTC COVID-19 at-home test kits per rolling 30 days per member.

After September 30, 2024, providers will not be able to bill claims for OTC COVID-19 at-home test kits through pharmacy benefits.

Coming soon, members will be able to order four (4) free COVID-19 at-home tests per household from the U.S. government. Visit COVIDtest.gov for more information.

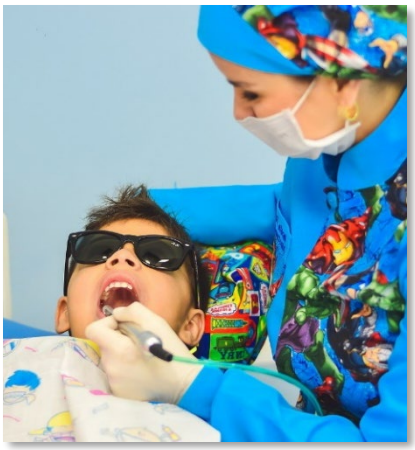
The Centers for Disease Control and Prevention (CDC) also has the Increasing Community Access to Testing (ICATT) program. The ICATT program provides no-cost COVID-19 testing and vaccines for those who are uninsured or underinsured until December 31, 2024. Visit the No-Cost COVID-19 Testing Locator to find current community and pharmacy partners in the ICATT program.

There are currently no changes to treatments, vaccinations, or laboratory testing coverage.

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

Recognizing National Suicide Prevention Month

Suicide is one of the leading causes of death among young people between ages 10-24 years, according to the Centers for Disease Control and Prevention (CDC) NCHS Data Brief No. 471 (June 2023) and the Centers for Medicare & Medicaid Services (CMS) Informational Bulletin published August 18, 2022. CMS also noted a decline in access to mental health services for children after the onset of the COVID-19 pandemic.

As a result of these concerns, CMS reminds providers that EPSDT services include screenings and medically necessary treatment for children's behavioral health, mental health, and substance use disorders. CMS encourages the following strategies to improve health outcomes in the above-mentioned areas:

1. Improve prevention, early identification, and engagement in treatment;
2. Increase access to treatment across the continuum of care;
3. Expand provider capacity; and
4. Increase integration of behavioral health and primary care.

For health screenings for individuals under 21 years of age, DMAP encourages providers to continue to follow the American Academy of Pediatrics' (AAP) Bright Futures Periodicity Schedule.

For information about Delaware 988 (Delaware's suicide and crisis lifeline) and on how Delaware recognized National Suicide Prevention Month, please click here: DHSS Observes National Suicide Prevention Month.

Quick Stats source: Youth Brisk Behavior Survey Date Summary & Trends Report.

Quick Stats

4 in 10 high school students experience persistent feelings of hopeless or sadness.

In 2023, **29%** of high school students experienced poor mental health during a 30-day period.

2 in 10 students seriously considered attempting suicide.

In 2023, **16%** of high school students made a suicide plan.

1 in 10 students attempted suicide.

2% of students were injured, poisoned, or overdosed during a suicide attempt.

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
High Body Mass Index in Children and Adolescents: Interventions	The USPSTF recommends that clinicians provide or refer children and adolescents 6 years or older with a high body mass index (BMI) (≥95th percentile for age and sex) to comprehensive, intensive behavioral interventions.	B	June 2024
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

USPSTF Issues Draft Recommendation Statement on Osteoporosis Screenings to Prevent Fractures

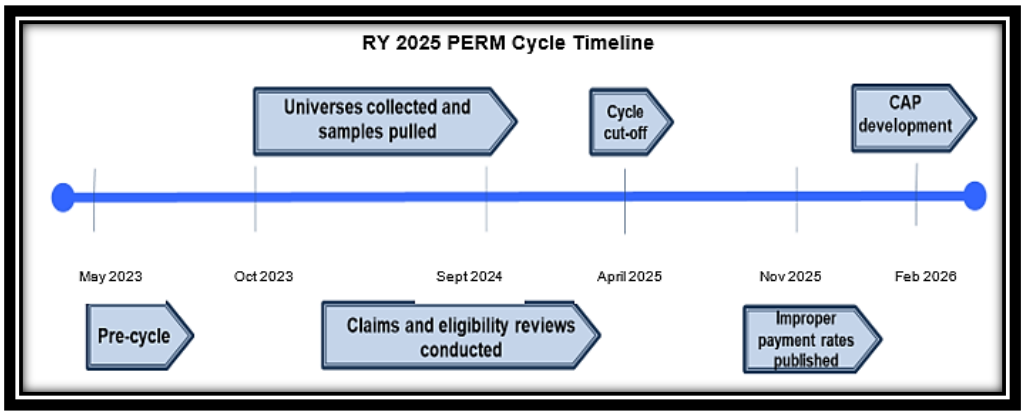
The USPSTF posted a draft recommendation statement on screening for osteoporosis to prevent osteoporotic fractures. They recommend screening for osteoporosis to prevent osteoporotic fractures in women aged 65 years or older. The USPSTF also recommends screening for osteoporosis to prevent osteoporotic fractures in postmenopausal women younger than age 65 years who are at increased risk for an osteoporotic fracture as estimated by clinical risk assessment. **Both recommendations are B grade**.

This recommendation applies to adults aged 40 years or older without known osteoporosis or history of fragility fractures. It does not apply to persons with secondary osteoporosis due to an underlying medical condition (e.g., cancer, metabolic bone diseases, or hyperthyroidism) or chronic use of a medication (e.g., glucocorticoids) associated with bone loss.

When deciding which postmenopausal women younger than age 65 years to screen, the USPSTF recommends first determining the presence of risk factors for osteoporosis and fracture. These include menopausal status, low body weight, parental history of hip fracture, cigarette smoking, and excess alcohol consumption.

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

PERM Cycle RY25 Updates



The CMS PERM Review Contractors (RC) have been sending request letters for medical records to some providers. During the two-week period ending July 25, 2024, the CMS PERM RC sent 222 letters to DE providers. **It is important for the provider to thoroughly examine any letter received from the CMS PERM RC and submit the requested information. If a provider does not submit the requested information, it will result in a Medical Review 1 (MR1) or Medical Review 2 (MR2) error. If the request is past-due, it may already be an MR1 or MR2 error.** To comply with the letter from CMS PERM RC, providers should:

1. Review the Claim Summary page attached to the letter 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 RC.

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

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.

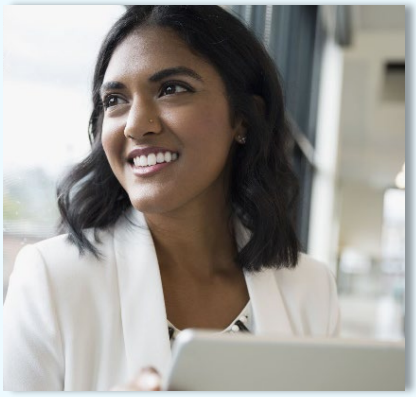
Delaware Medicaid Retroactive Coverage Fact Sheet

The Division of Medicaid and Medical Assistance (DMMA) 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.