DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

The DMAP Pharmacy Corner has a NEW LOOK!

Check out the new Delaware Medical Assistance Program (DMAP) Pharmacy Corners for Members and Providers. New enhancements include an updated Provider Pharmacy Corner and a new Member Pharmacy Corner. The websites are easier to navigate, highlight important information, and provide additional resources for both providers and members.

The Pharmacy Corner updates include:

- **NEW** Landing Page
- **NEW** Scrolling Announcement Banner
- **NEW** and Updated Resource Links
- **NEW** and Updated Contact Information

Visit the new DMAP Pharmacy Corner page today!

In This Edition:

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How-To & What's New

New: Children's Dental Program Moving to Managed Care Benefit

Effective January 1, 2025, the Children's Dental Program will move from Fee-for-Service to Managed Care. Children's dental services will be provided through a network of contracted dentists through each Managed Care Organization's (MCO) Dental Benefit Manager. ***Special Note:** Newly enrolled members will have access to dental services during a brief (30 – 60 day) fee-for-service (FFS) period prior to their enrollment in an MCO.

Dental providers who want to provide children's dental services must be enrolled in the Delaware Medical Assistance Program (DMAP) prior to credentialing with an MCO. Dental providers who already provide Adult Dental Services do not need to re-enroll with DMAP or be re-credentialed with the MCOs. Dental providers not yet enrolled in DMAP must submit a provider application through the DMAP Provider Portal. Please see How-To documents for enrollment instructions: How-To: Enrollment Guide for New MCO Network Providers or How-To: Enrollment Guide for Current In-Network MCO Providers. Visit the Dental News section for more information.

New: Optional Medicare Prescription Payment Plan

Starting **January 1, 2025**, all Medicare prescription drug plans will offer a new *optional* payment plan for out-of-pocket prescription drug costs. The new **Medicare Prescription Payment Plan** option allows the individual to pay out-of-pocket prescription drug costs in the form of monthly payments, instead of paying a copayment (copay) to the pharmacy at each visit. Individuals enrolled in any Medicare prescription drug plan, including both standalone Medicare prescription drug plans and Medicare Advantage plans (Medicare Part C), can opt into the new plan.

The new **optional** Medicare Prescription Payment Plan **does not** save members money or lower their drug costs. Members will continue to be responsible for monthly premiums, and they will receive a separate monthly bill for copays. Members enrolled in the Delaware Prescription Assistance Program (DPAP) **can** enroll in the Medicare Prescription Payment Plan. If a DPAP member chooses to enroll in the optional Medicare Prescription Payment Plan, their DPAP coverage will apply to the payment plan, and the member will receive a separate bill for their copays from the Medicare Prescription Payment Plan.

***Note:** Drugs that are excluded from Medicare Part D coverage are not part of the Medicare Prescription Payment Plan. Exclusions include vitamins, cough and cold medications, and non-prescription drugs. For medications excluded from Medicare Part D coverage, members will be required to pay their copay when picking up from the pharmacy.

For more information about the Medicare Prescription Payment Plan, visit CMS.gov.

Helpful Titles

- How-To: Submit a Pharmacy Prior Authorization Request through the Portal
- How-To: View and Verify a Member's Eligibility through the Provider Portal
- How-To: Utilize Treatment History Panels
- How-To: Provide a Third-Party Liability Lead through the Portal

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.

Delaware Medicaid Retroactive Coverage Expansion

Effective January 1, 2025, Delaware Medicaid is expanding the groups of members who are eligible for retroactive Medicaid coverage.

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

General Information

Medicaid-covered services will be covered for members if they meet the eligibility requirements, and if they receive Medicaid-covered services during the three months prior to becoming eligible. If eligible services were provided during the retroactive eligibility period, providers will be encouraged to return payments to members who were eligible for Delaware Medicaid Retroactive Eligibility Coverage.

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

As of September 30, 2024, the Delaware Medical Assistance Program (DMAP) is compliant with the requirement to have all engaged MCOPs screened and enrolled. For providers who started the process but were not able to finish their application by September 30, 2024, *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. 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 check the status of a prior authorization on the DMAP Provider Portal?

Prior authorization requests for Fee-for-Service Medical, Dental, Hospice, and Pharmacy must be submitted electronically through the DMAP Provider Portal. Instructions for how to submit a prior authorization can be found in the DMAP How-To Corner. For information about prior authorization requests to Managed Care Organizations (MCO), see the MCO's provider manual.

After submitting a prior authorization request, providers can check the status by returning to the "Care Management" tab. To check the status of your prior authorization requests:

1) Go to the Delaware Medical Assistance Provider Portal Page.
2) Log in by entering your User ID, Challenge Question, and Password.
3) From the Home Page, click the *Care Management* tab, and then click *View Authorization Status*.
4) The first tab, *Prospective Authorizations*, will show the first 20 authorizations that have you listed as the requesting or servicing provider, beginning on the current day or earlier.
5) If the prior authorization you're looking for is not there, click the *Search Options* tab.
6) From the *Search Options* tab, enter the authorization, member, and provider information. Click Search.
7) Click on the prior authorization number for more information.

If you have additional questions, please call the Provider or Pharmacy Provider call centers. Phone numbers and extensions are located on the Need Assistance page of this bulletin.

***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 Organizations (MCOs) for 2025

The Delaware Department of Health and Social Services (DHSS) 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

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).

Technical Denial

What is a technical denial?

A technical denial is issued when a provider fails to respond to a Division of Medicaid and Medical Assistance (DMMA) Surveillance Utilization Review (SUR) Unit request for information. The information is used to substantiate the care provided to a member. A technical denial results in the recoupment of the entire paid amount of funds paid for the claim.

Reasons for a technical denial include:

- Failure to provide the entire medical record,
- Failure to provide parts of the medical record required to conduct a review, or
- Failure to respond to a request to conduct a Self-Audit.

What happens if a provider fails to respond to a DMMA SUR documentation request?

If the requested records are not received within 45 days by the DMMA SUR Unit and the provider has not contacted the SUR Unit regarding a delay, the SUR Unit will attempt to contact the provider. The attempt will be made to the phone number or e-mail on file associated with the billing NPI. If this additional contact attempt is unsuccessful, the claims involved in the audit will be subject to a technical denial, and the claims will be recouped within 7 days.

What happens when a technical denial is issued?

Technical denials are issued when there is a failure to provide requested information. Technical denials result in the recoupment of the funds paid for the claim. The provider has ten (10) days from the date of the technical denial letter to provide the missing/incomplete documentation. If the requested documentation is received after the technical denial is issued, medical records and/or related documentation may be reviewed on a case-by-case basis as outlined in the DMMA Provider Post-Payment Audit Policy.

Upon completion of the technical denial review, a findings letter will be issued. Information on how to request a timely Re-Determination Review is located in Appendix A of the DMAP 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 (TTY 711)
Hotline (After-Hours Voicemail Only): 1-800-372-2022, select option 1.
Email: SURreferrals@delaware.gov

Smooth Sailing with EVV

As of July 31, 2024, the Delaware EVV program has partially implemented **soft edits** for EVV paid claims. Providers subject to the EVV mandate have started to receive alerts on remittance advices (RAs) to indicate that a visit will be denied once the **hard edit** starts. This process has rolled out incrementally over the past few months, and soon, all encounters and FFS claims will be part of the **soft edit**. The next phase, pre-adjudication, is on the horizon.

Beginning tentatively in Q1 2025, the **hard edit** will replace the **soft edit,** where claims will be denied without a valid authorization, visit, or paid claims match. As we quickly approach this date, the EVV team continues to provide education and assistance. Our aim is for the hard edit process to be easily understood and for denied claims to be avoided as much as possible. It is strongly encouraged that providers receiving claim rejection warning(s) be diligent and expedient in contacting their MCO partners, Sandata, and the State (where appropriate) to avoid complications. The EVV team will notify providers well in advance so there is time to prepare. Again, we extend a huge thank you to our partners for their continued patience and cooperation!

EVV Highlights from Q3:

- 107 unique providers who provide services subject to EVV have registered with Sandata.
- 1,210,854 visits from 66 different providers are reflected in the production environment. Of these, 1,176,951 (97%) are in a verified status (claims with visits matched)
- Major concerns the EVV team continues to observe include MCD ID alignment, proper Sandata registration, misaligned prior authorizations, and data testing. Please reach out if you are encountering such issues.
- The EVV team's targeted collaboration sessions with our provider partners have continued and are bearing fruit. The EVV team endeavors to address both common and unique concerns/issues. We would like to again send many thanks for the continued cooperation!
- The EVV team is also looking to increase targeted outreach to providers we have identified as **having claims-matching issues.**

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.

New PDL and Morphine Milligram Equivalent Limits

Effective January 6, 2025, the Delaware Medical Assistance Program (DMAP) will utilize the 2025 Preferred Drug List (PDL).

Along with the new 2025 PDL, there will be a change to decrease the maximum daily morphine milligram equivalent (MME) to 50 MME from 90 MME to align with Centers for Disease Control and Prevention (CDC) opioid prescribing recommendations.

The *CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022* states that many people do not experience benefit in pain or function from doses exceeding 50 MME/day and are exposed to progressively increasing risk as dosage increases. All members on doses equal to or exceeding 50 MME/day will require a prior authorization.

For Fee-for-Service (FFS) members, prior authorization requests must be submitted electronically via the DMAP Provider Portal with a completed FDA MedWatch Form 3500. For Managed Care Organization (MCO) members, please refer to the MCO's prior authorization criteria and requirements.

See the updated Provider Pharmacy Corner Portal for helpful resources and links.

Opioid Analgesic Risk Evaluation and Mitigation Strategy (OA REMS) Update

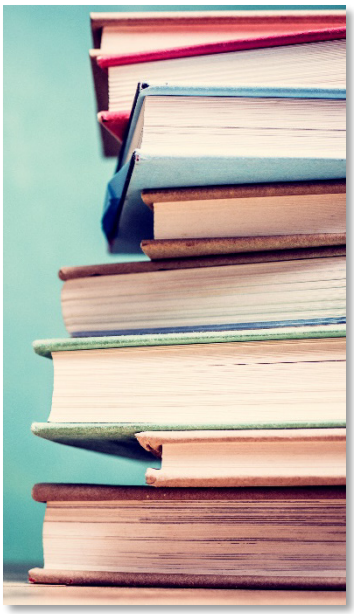
On October 31, 2024, the U.S. Food & Drug Administration (FDA) approved a modification to the Opioid Analgesic Risk Evaluation and Mitigation Strategy (OA REMS). The modification requires manufacturers of opioid analgesics dispensed in outpatient settings to provide pre-paid drug mail-back envelopes (MBEs) upon request to pharmacies and other dispensers of OAs.

The manufacturers have developed a Patient Education Sheet for patients on safe disposal of opioid analgesics, which is included with each MBE. They also developed an updated Patient Guide that health care providers can use to counsel patients on the options for safe disposal of unused opioid analgesics. MBE ordering will become available by March 31, 2025.

Refer to the OA REMS website for additional information.

Practitioner Policy Specific: Revision Date – 12/20/2024: Section Revised:

- Section 1.0 - Updated section in compliance with current provider descriptions and policy requirements for Certified Registered Nurse Anesthetist (CRNA) providers.
- Section 2.6 - Updated section to align with Delaware Medical Assistance Portal administrative language.



General Policy Manual: Revision Date – 12/20/2024: Section Revised:

- Table of Contents Section 1.34 and Sections 1.21.6.14, 1.34, & 2.1.10.2.19 - Extended services for pregnant women (Smart Start) language removed in compliance with the Delaware State Plan.
- Sections 2.2, 2.2.1.7, & 2.2.4.4 - Updated to remove premium language for the Delaware Healthy Children Program in compliance with the Delaware State Plan.

Children's Dental Program Provider Specific Policy Manual: Revision Date – 12/20/2024: Section Revised:

- Section 3.2.4.4 - Updated to remove premium language for the Delaware Healthy Children Program in compliance with the Delaware State Plan.

Clinic Provider Specific Policy Manual: Revision Date – 12/20/2024: Section Revised:

- Section 4.5.1 - Removed Smart Start language in compliance with the Delaware State Plan.

Dental Provider Specific Policy Manual: Revision Date – 12/20/2024: Section Revised:

- This manual has been archived; refer to the Adult Dental Program Provider Specific Manual and the Children's Dental Program Provider Specific Manual.

Extended Pregnancy Provider Specific Policy Manual: Revision Date – 12/20/2024: Section Revised:

- This Extended Pregnancy Services Provider Specific Manual (Smart Start) has been archived in compliance with the Delaware State Plan.

Member Eligibility Reminder

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.

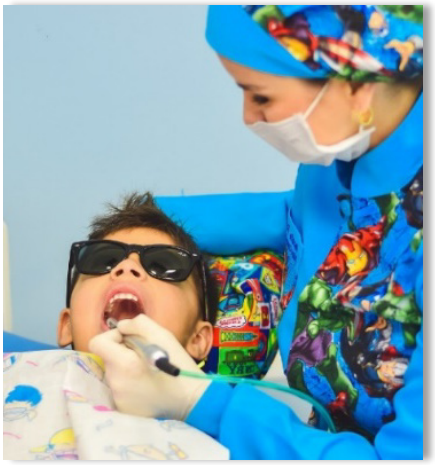
Managed Care Organization-Only Providers (MCOPs) should refer to their MCO provider portal handbook for information related to member eligibility verification.

- 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

Dental Fee Schedule

The Dental Fee Schedule is on the DMAP Document Repository.
Effective date is **April 1, 2024**.

Children's Dental Program



Effective **January 1, 2025**, the Division of Medicaid and Medical Assistance (DMMA) has contracted with Managed Care Organizations (MCOs) to provide dental services to children. Listed below is the Dental Benefit Manager (DBM) for each MCO:

- AmeriHealth Caritas: DentaQuest
- Delaware First Health: Envolve Dental
- Highmark Health Options: United Concordia

Dental providers wishing to provide dental services to children must enroll in DMAP prior to credentialing with an MCO using the taxonomies below**:**

Provider Description	Taxonomy Code	Enrollment Type (Group and/or Individual)
Dentist	122300000X	Both
Endodontics	1223E0200X	Both
General Practice	1223G0001X	Both
Oral & Maxillofacial Pathology	1223P0106X	Both
Oral & Maxillofacial Surgery	1223S0112X	Both
Orthodontics and Dentofacial Orthopedics	1223X0400X	Both
Pediatric Dentistry	1223P0300X	Both
Periodontics	1223P0300X	Both
Prosthodontics	1223P0700X	Both

Adult Dental Program

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

Managed Care Organization (MCO) Enrollment

Dental providers wishing to provide adult dental services **must** be enrolled in DMAP and must credential with an MCO. See MCO contact information below:

- AmeriHealth Caritas: 1-855-707-5818 or delawareprovidernetwork@amerihealthcaritas.com
- Delaware First Health: 1-877-236-1341 or DE_ProviderEngagement@delawarefirsthealth.com
- Highmark Health Options: 1-844-325-6251 or HHO-ProviderRelations@highmark.com

Early Periodic Screening, Diagnosis & Treatment (EPSDT) Corner

Coming Soon: Updated Frequently Asked Questions (FAQs) for Self-Directed Attendant Care (SDAC) and Respite Services

DMMA, in partnership with the Children with Medical Complexity (CMC) workgroup, has updated the FAQs for SDAC and Respite Services. The FAQs are a valuable resource for families of children with medical complexities, caregivers, and entities that work with children with medical complexities and their families. DMMA is working towards making the FAQs available on the CMC website by January 1, 2025: https://dhss.delaware.gov/dhss/dmma/cmc_resources.html. Thank you to the CMC workgroup participants who assisted in the creation of these valuable resources.

For more information about SDAC and Respite Services, visit the Children with Medical Complexity website: https://dhss.delaware.gov/dmma/children_with_medical_complexity.html.

New Year, New Updates

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

With the new year, new updates are likely. Remember to regularly check the Periodicity Schedule to ensure your youngest patients are on track for a happy and healthy year.

USPSTF Recommendations

Delaware Medicaid provides coverage and reimbursement of all preventative services assigned either grade A or B by the United States Preventive Services Task Force (USPSTF). Click HERE for the comprehensive listing of USPSTF recommendations.

Recommendations with a grade of either A or B

Topic	Description	Grade	Release Date of Current Recommendation
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

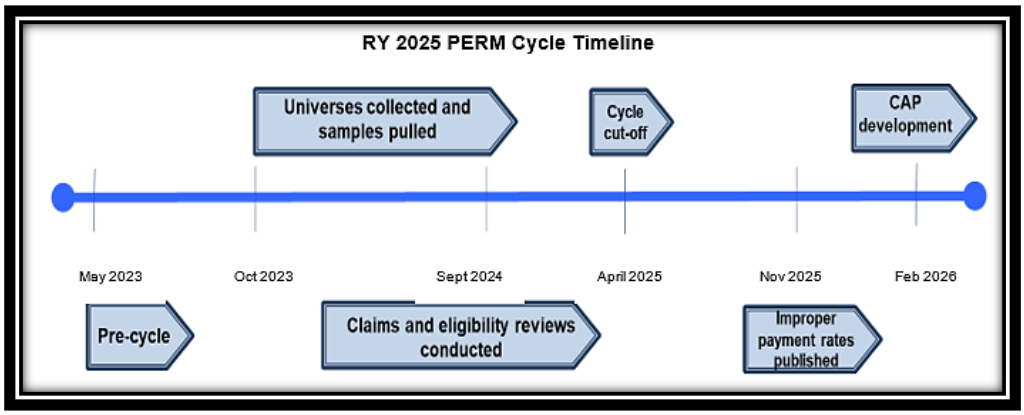
USPSTF Issues Draft Recommendation Updates for Behavioral Counseling Interventions in Breastfeeding.

The association between breastfeeding and health benefits in children is well established; health benefits have also been found for lactating persons. However, breastfeeding rates in the United States are relatively modest. 59.8% of infants at 6 months of age are breastfed, and 27.2% of infants at that age are exclusively breastfed. Breastfeeding rates differ according to race, age, level of education, and other sociodemographic factors. Variables associated with lower breastfeeding rates include Black race, being younger than age 30 years, participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), being unmarried, living in a nonmetropolitan area, or having high school as the highest education level achieved.

The USPSTF concludes with moderate certainty that behavioral counseling interventions to support breastfeeding in pregnant and postpartum persons have a moderate net benefit. Therefore, clinicians should provide pregnant and postpartum persons with behavioral counseling interventions to support breastfeeding or refer them to appropriate healthcare professionals.

Read the full update draft on the USPSTF website.

PERM Cycle RY25 Updates



The CMS PERM Review Contractors (RC) have been sending request letters for medical records to some 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 Joel Riley at Joel.Riley@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.

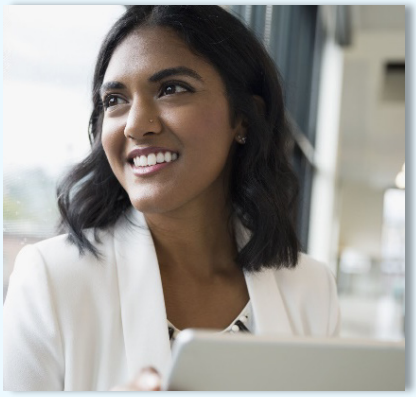
Delaware Medicaid Retroactive Coverage Fact Sheet

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
Dental Benefit Manager:
United Concordia: 1-800-372-2024

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
Dental Benefit Manager:
DentaQuest: 1-800-372-2022
or 1-877-378-5295
Prior Authorizations: 1-855-260-9544

Delaware First Health

Members: 1-877-236-1341
Pharmacies: 1-833-236-1887
Dental Benefit Manager:
Envolve Dental: 1-833-236-1886
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.