DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

The New Member Services Platform is Available!

The Delaware Medical Assistance Program (DMAP) is excited to announce the new DMAP Online Member Portal and the new **FREE MyDEMedicalAssistance** mobile app where members can access their medical coverage information in one secure place! Members are able to:

- **Check Eligibility and Coverage:** Members can quickly check their eligibility and coverage for themselves and their dependents.
- **Look Up Healthcare Provider Information:** Members can search for providers, access detailed provider information, and even get directions.
- **Manage Health Data:** Members can log in, manage, and update their personal health and clinical history, track claims, and more.
- **Get Support:** Live chat with the Member Portal Support Team is available from 8:00 AM – 4:30 PM, Monday – Friday.

For more information, click here.

In This Edition:

gainwell

How-To & What's New

Verify Your Notify Me Subscription Today!

We are updating our DMAP Email Notification System (Notify Me). If you are currently subscribed to receive email notifications from the Delaware Medical Assistance Program (DMAP), you must verify your email address by **May 31, 2025**.

If you do not verify your email address by **May 31, 2025**, you will no longer receive emails about DMAP updates, holiday/weather closures, and provider resources.

- For users who want to verify and *have* a Provider Portal login, click HERE to log in to your account.
- For users who want to verify but *do not have* a Provider Portal login, click HERE to enter your email address.

Click HERE to check out the new How-To on how to subscribe and verify your email.

You Ask, DMAP Answers (YADA)

What do providers do when they register their Medicaid Identification Number (MCD) and are designated as NonPar (Non-Participating)?

If a Managed Care Organization-Only Provider (MCOP) is identified as an Unregistered/NonPar Provider, the provider will need to reset their application on the DMAP Provider Portal with the most recent information. Providers can also contact the MCOs directly to be converted to a participating provider, as long as the MCOs have record of the MCD and the information is accurate for billing purposes.

Billing providers must register every service location and obtain a unique MCD for each one.

*__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.

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 Insurance 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 expanded the groups of members who are eligible for retroactive Medicaid coverage.

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

If members meet eligibility requirements, and if they receive Medicaid-covered services during the three (3) months prior to becoming eligible, Medicaid-covered services will be covered. If eligible services were provided during the retroactive eligibility period, providers are encouraged to return payments to members who were eligible for Delaware Medicaid Retroactive Eligibility Coverage.

Individuals in the groups below may be eligible for Retroactive Coverage:

- Modified Adjusted Gross Income (MAGI)-based Adult Group
- Protected Supplemental Security Income (SSI) Medicaid Group
- 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

Managed Care Organization-Only Providers (MCOPs)

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.

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
DentaQuest: 1-800-372-2022

Delaware First Health
1-877-236-1341
Centene Dental: 1-833-236-1886

Highmark Health Options
1-844-325-6251
United Concordia: 1-800-372-2024

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).

Medicaid Fraud Laws

Laws governing Medicaid fraud specify the criminal, civil, and administrative remedies the government may impose on individuals or entities that commit fraud and abuse in the Medicaid Program. Violating these laws may result in nonpayment of claims, civil monetary penalties (CMPs), exclusion from all federal health care programs, and criminal and civil liability.

Medicaid fraud laws include:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)

False Claims Act (FCA)

The civil FCA protects the government from being overcharged or sold substandard goods or services and imposes civil liability on any person who knowingly submits or causes the submission of a false or fraudulent claim to the government. The terms "knowing" and "knowingly" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. No proof of specific intent to defraud is required to violate the civil FCA.

Example: A physician knowingly submits claims to Medicaid for a higher level of medical services than actually provided or higher than the medical record documents.

Penalties: Civil penalties for violating the FCA may include recovery of up to three times the amount of damages sustained by the government as a result of the false claims, plus additional penalties per false claim filed. A criminal FCA statute exists by which individuals or entities submitting false claims may face fines, imprisonment, or both.

Anti-Kickback Statute (AKS)

The AKS makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a federal health care program. When a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the AKS.

Example: A provider receives cash or below fair-market value rent for medical office space in exchange for referrals.

Penalties: Civil penalties for violating the AKS may include three times the amount of the kickback. Criminal penalties for violating the AKS may include fines, imprisonment, or both.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from referring certain designated health services payable by Medicaid to an entity in which the physician (or an immediate family member) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

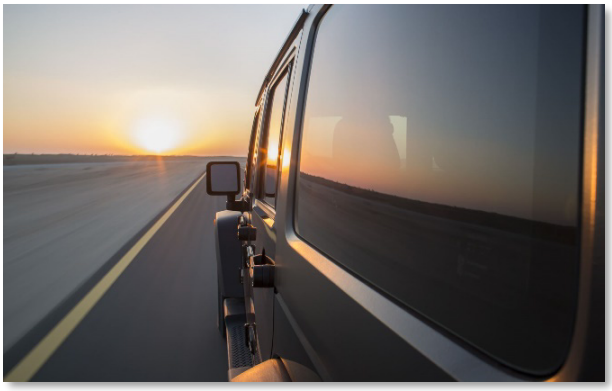
Example: A provider refers a beneficiary for a designated health service to a business in which the provider has an investment interest.

Penalties: Penalties for physicians who violate the Stark Law may include fines, civil monetary penalties, repayment of claims, and potential exclusion from all federal health care programs.

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

The Final Step is on the Horizon!

As 2025 begins, we are well into the "soft edit" phase for EVV paid claims. Providers have been receiving remittance advices (RAs) noting that non-matching claims will be rejected once the "hard edit" phase begins. Under the hard edit process, beginning **July 1, 2025**, claims without a valid authorization/visit/paid claims match will be denied.



The EVV team continues to communicate with providers and MCOs well in advance so there is time to prepare. The EVV team is also working diligently with our provider partners to offer education and assistance.

All providers receiving claim rejection warning(s) should contact their MCO partners, Sandata, and/or the State (where appropriate) to avoid any abrasion. Many thanks to our partners for their continued patience and cooperation!

EVV Highlights from Q4:

- 114 unique providers who provide services subject to EVV have registered with Sandata.
- 1,319,263 visits from 77 different providers are reflected in the production environment. Of these 977,525 (93%) are in a verified status (claims with visits matched)
- Progress continues in engaging with providers and our MCO partners with resolving issues related to EVV, including MCD ID alignment, proper Sandata registration, and other EVV hangups
- The EVV team continues work with our provider and MCO partners to iron out issues related to MCD ID's and the overlap with 21st CCA guidelines
- The EVV team's collaboration sessions with our MCO partners have continued, with the intention to address both common and unique concerns/issues and coordinate effective provider outreach
- The team has also continued our targeted outreach to providers whom we have identified as high-risk for claims matching issues. We would like to again send many thanks for the continued cooperation!

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.

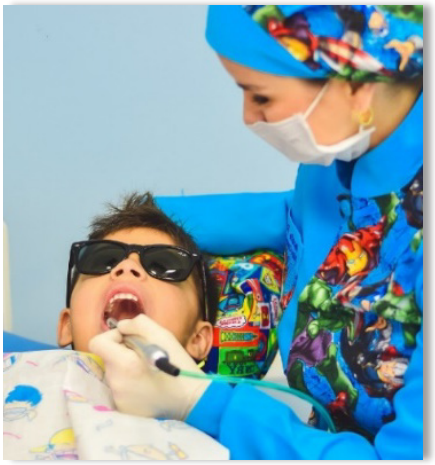
Contact Us:

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

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: 1-800-372-2022 or 1-877-378-5295
- Delaware First Health:
  - Centene Dental: 1-833-236-1886
- Highmark Health Options:
  - United Concordia: 1-800-372-2024

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
Dental Anesthesiologist	1223D0004X	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	1223P0221X	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. Dental providers wishing to provide adult dental services **must** be enrolled in DMAP and must credential with an MCO.

Provider Description	Taxonomy Code	Enrollment Type (Group and/or Individual)
Dentist	122300000X	Both
Dental Anesthesiologist	1223D0004X	Both
Endodontics	1223E0200X	Individual
Oral & Maxillofacial Surgery	1223S0112X	Individual
Periodontics	1223P0300X	Individual
Prosthodontics	1223P0700X	Individual

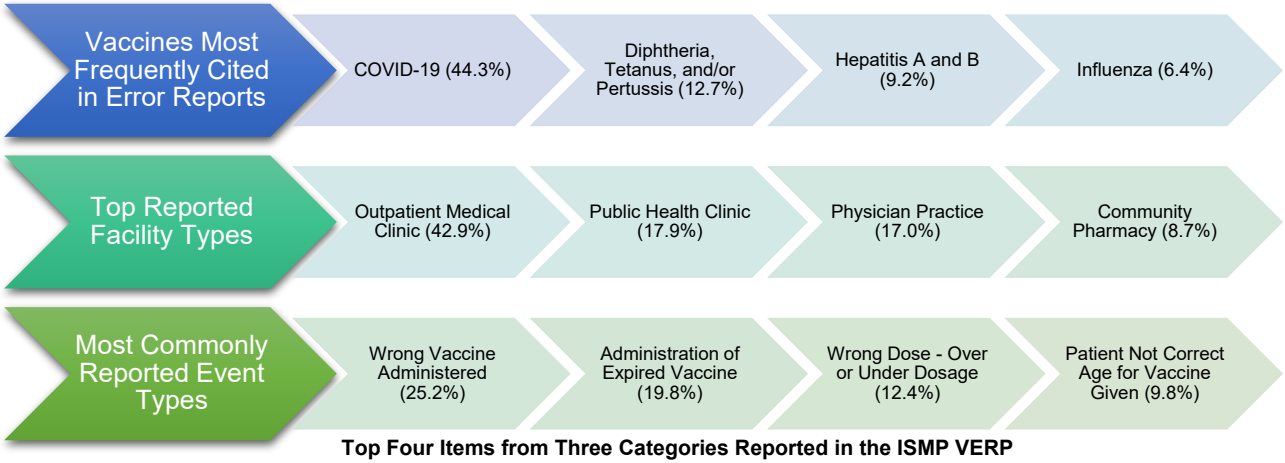
ISMP Report Reveals Top Errors in New Vaccine Administration

The Institute for Safe Medication Practices (ISMP) National Vaccine Errors Reporting Program (ISMP VERP) has released their biannual report analyzing 1,987 voluntary error event reports from January 1, 2022, through December 31, 2023.

The report details information about most common contributing factors, gives examples of how errors occurred, and discusses a multitude of strategies for risk reduction.

To download and read the entire report: https://home.ecri.org/blogs/ismp-resources/vaccine-bi-annual-report

To report an error: https://home.ecri.org/pages/ecri-ismp-error-reporting-system



Top Four Items from Three Categories Reported in the ISMP VERP

FDA Adds Boxed Warning About Anaphylaxis with the Multiple Sclerosis Medicine Glatiramer Acetate (Copaxone, Glatopa)

The U.S. Food and Drug Administration (FDA) is warning about the risk of a rare but serious allergic reaction with the medicine glatiramer acetate (Copaxone, Glatopa), which is used to treat patients with multiple sclerosis (MS). This serious allergic reaction, called anaphylaxis, can occur at any time while on treatment, after the first dose or after doses administered months or years after starting the medicine. For most patients who experienced anaphylaxis with glatiramer acetate use, the symptoms appeared within one hour of injection. In some cases, anaphylaxis resulted in hospitalization and death.

The initial symptoms of anaphylaxis can overlap with those of a common reaction called immediate post-injection reaction that is temporary and can start soon after a shot is given. While immediate post-injection reaction is common, anaphylaxis is rare and its symptoms are typically more severe, worsen over time, and require treatment. Patients experiencing a reaction after the medicine is administered should seek immediate medical attention if the symptoms are more than mild, get worse over time, or do not go away within a brief time. The FDA is adding a new boxed warning about this risk to the glatiramer acetate prescribing information and patient medication guide.

The full safety communication from the FDA can be found at: https://www.fda.gov/drugs/drug-safety-and-availability/fda-adds-boxed-warning-about-rare-serious-allergic-reaction-called-anaphylaxis-multiple-sclerosis

Early Periodic Screening, Diagnosis & Treatment (EPSDT) Corner

Children with Medical Complexity (CMC) New Initiative: ENFit Supplies

Over the past year, CMC families have expressed concerns around the transition to the new ENFit supplies, which are used for feeding and medication distribution. Because of the significance of these concerns, DMMA formed a task force to address these issues. DMMA, the ENFit Task Force, and the Children with Medical Complexity Advisory Committee (CMCAC) have worked together in obtaining information and completing research on issues related to these concerns. Through these collaborative efforts, it was concluded that the problem was due to a supply chain issue.

As a result of this determination, DMMA is working on the implementation of resolutions such as:

- Requesting that pharmacies carry these supplies
  - Starting April 1, 2025, DMAP will begin to cover ENFit pharmacy bottle medication adapters and syringes. Pharmacies will be able to provide the items to members in need of the items with a valid prescription.

The primary goal of these resolutions is to provide CMC families with greater accessibility to these vital supplies. DMMA would like to thank all participants of the CMCAC for their assistance in these efforts!

All of the Children with Medical Complexity Advisory Committee (CMCAC) meetings are open to the public. If you would like to join the next one, all meeting dates, times, and locations are posted on the State's public meeting calendar at https://publicmeetings.delaware.gov/.

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
Osteoporosis to Prevent Fractures: Screening: women 65 years or older	The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in women 65 years or older.	B	January 2025
Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years with 1 or more risk factors for osteoporosis	The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk for an osteoporotic fracture as estimated by clinical risk assessment.	B	January 2025
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

Opportunities for Public Comment

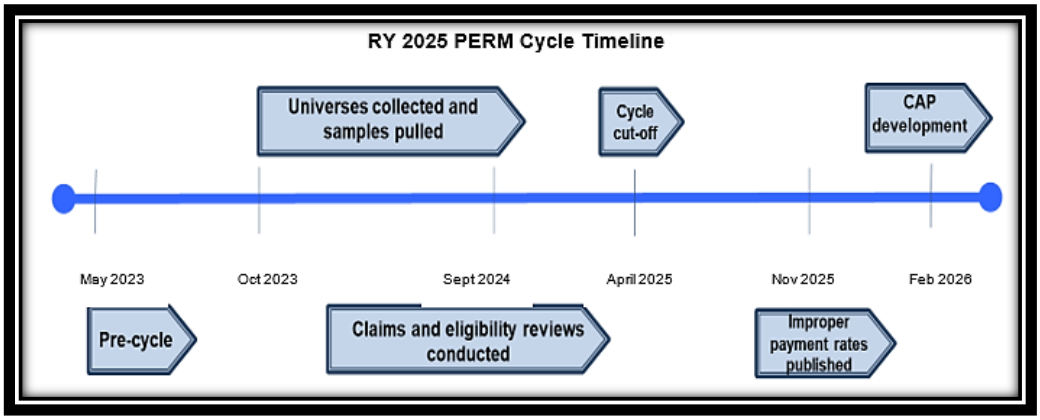
The U.S. Preventive Services Task Force (USPSTF) provides healthcare providers with an opportunity to influence the future of preventive care through its public comment process. Provider firsthand clinical experience and expertise are vital in ensuring that recommendations are evidence-based, practical, and applicable to diverse patient populations. The process begins when the USPSTF publishes a draft recommendation statement, accompanied by an evidence review. These drafts are made available for a defined public comment period, typically lasting a few weeks. During this time, providers and other stakeholders can submit feedback through the USPSTF website. Comments can address potential gaps, raise implementation concerns, or offer suggestions to enhance the recommendations' relevance and effectiveness.

After the comment period closes, all input is reviewed and carefully considered by the Task Force before finalizing the recommendation. This collaborative process allows healthcare providers to advocate for their patients and contribute to shaping guidelines that impact clinical practice nationwide.

Stay informed about open comment periods through the USPSTF website and take advantage of the opportunity to strengthen preventive care and shape health policy.

Payment Error Rate Measurement (PERM)

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 providers 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), Medical Review 2 (MR2), or Medical Review 3 (MR3) error. If the request is past-due, it may already be an MR1, MR2, or MR3 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.

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.

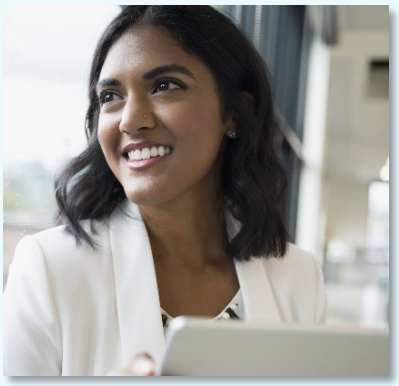
How-To: Subscribe to Provider Notify Me E-Mail Notifications

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.



Remember to verify your Notify Me Subscription by May 31, 2025!

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:
Centene 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.