



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF MEDICAID &
MEDICAL ASSISTANCE

Delaware Medical Assistance Program



It's Here!

The Division of Medicaid and Medical Assistance (DMMA) Announces the New Adult Dental Program October 1, 2020

See the [Dental News Corner](#) for participation information regarding the following:

- DMAP/Fee-for-Service (FFS) currently enrolled providers
- Managed Care Organization (MCO) enrolled providers
- Non-enrolled DMAP/FFS & MCO providers

In this Edition:

Front Page News See [Adult Dental Program](#)

How-To Corner: Tips to Help You See [How-To Recent Titles and Provider Announcements](#)

Promoting Interoperability News See [Program Year 2020 Attestations](#)

Manual & Forms Updates See [Manual & Forms Updates](#)

Reminders See [Provider Communications \(Notify Me\)](#)

DCTP See [Eligibility Criteria and Prior Authorization](#)

Vaccines for Children See [HPV Training and Education](#)

Program Integrity See [Provider Utilization Review](#)

Pharmacy Corner See [Naloxone Coverage and NCPDP](#)

MCO Corner See [Resources](#)

What's New See [Provider Appeals, Member Eligibility, and Prior Authorization](#)

PERM See [New Payment Error Rate Measurement Cycle](#)

Dental News See [Adult Dental Program](#)

EPSDT See [Flu Season](#)

EVV See [Electronic Visit Verification](#)

Need Assistance? See [Phone & Fax Contacts & Secure Correspondence](#)

What's New: From the Provider Portal homepage, click [How-To Corner](#) to open the pathway to Provider Guides. Review documents related to your interests.

Recent Titles

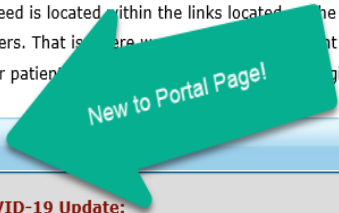
- [How-To Send Attachments with an 837 X12 Transaction through a Vendor or Clearinghouse](#)
- [How-To Disclosure Statement of Information to be Completed by Providers and Fiscal Agents](#)
- [How-To View a Member's Eligibility through the Provider Portal](#)
- [How-To Navigate the Delaware Medical Assistance Provider Portal Document Repository](#)



DMAP Introduces Provider Announcements

Welcome to the Delaware Medical Assistance Portal for Providers

This portal provides important information to health care providers about the Delaware Medical Assistance Program (DMAP). All of the information you need is located within the links located on the left side of this page. Looking for an important program update, check out our banners. That is where you will find information that is new to the program. If you would like to see your patient information, click on the login button on the left side of this page.



Announcements

DMMA Coronavirus COVID-19 Update:
[Click Here](#) for information related to Coverage, Copays, Coding, Pharmacy, Telehealth and More.

Coronavirus Disease (COVID-19) Update:
[Click Here](#) for information regarding Delaware's response to Coronavirus.

The Division of Medicaid and Medical Assistance has eliminated co-pays for Naloxone for Medicaid beneficiaries.
[For more information click here](#)

The Announcement Section contains the most up-to-date information regarding Delaware Medical Assistance Program (DMAP) changes.

DMAP has introduced a new folder to the Provider Portal Document Repository: [Coronavirus COVID-19 Updates](#), which contains a cumulative list of all of the Division of Medicaid and Medical Assistance (DMMA) COVID-19 Bulletin communications. Providers are able to access this folder via Provider Announcements DMMA Coronavirus COVID-19 Update.

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

Promoting Interoperability Program News

Promoting Interoperability Program

The Delaware Medicaid Promoting Interoperability Program's Medical Assistance Provider Incentive Repository (MAPIR) portal has been updated to align with Program Year 2020 requirements. We are currently accepting Program Year 2020 Attestations. Click [HERE](#) to access what's new in Program Year 2020 information for the Promoting Interoperability Program.



As a reminder, all returning providers will be required to attest to Stage 3 Meaningful Use (MU) – [CMS 2020 Program Requirements](#), and must use 2015 Certified EHR Technology (CEHRT) for the selected 90-day MU period. For more information, please contact the Delaware PIP Team at delawarepipteam@dxc.com or 1.800.999.3371 – option 0, option 3.

Manuals & Forms Updates

[General Policy Manual: Revision Date – 9/15/2020: Sections Revised:](#)

- 1.21.2.1 – Prior Authorization Policy updated to require all prior authorization requests to be submitted via the DMAP Portal.
- 8.0 – Manual updated to remove prior authorization forms to align with update to require Portal submission.

[General Policy Manual: Revision Date – 9/1/2020: Sections Revised:](#)

- 1.22.1.2.28 – Added Lung Cancer Screening as a covered Medicaid service.
- 6.0 – Section updated to announce new mailbox for the submission of Provider Enrollment Appeals

[Outpatient Provider Specific Policy Manual: Revision Date – 2/21/2020: Sections Revised:](#)

- All – In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.

[Dental Provider Specific Policy Manual: Revision Date – 2/21/2020: Sections Revised:](#)

- All – In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.

[Practitioner Provider Specific Policy Manual: Revision Date – 2/21/2020: Sections Revised:](#)

- All – In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.

[Durable Medical Equipment Provider Specific Policy Manual: Revision Date – 2/15/2020: Sections Revised:](#)

- 1.0 - Updated medical necessity and face-to-face requirements for DME and supplies in compliance with 42 CFR 440.70.
- 1.2 - Section updated to align with 42 CFR 414.202 and 42 CFR 440.70.
- 1.3 - Updated section in accordance to 42 CFR 414.202 and 42 CFR 440.70.
- 3.1.5 - Added face-to-face requirement policy in accordance to 42 CFR 440.70.
- 3.1.12 - Section updated to permit limited exceptions on a case-by-case basis in compliance with medical necessity.
- 3.3 - Language updated to align with Long Term Care Community Support Services (LTCCSS) Program.
- 4.0 - Clarification added regarding payment for inpatient services. Clarification added regarding Place of Service billing requirements.
- 4.2 - Section updated to permit limited exceptions on a case-by-case basis in compliance with medical necessity.
- 5.20.3 - Removal of language to align with the Long Term Care Community Support Services (LTCCSS) Program.
- 5.11.1.6 - Section updated to permit limited exceptions on a case-by-case basis in compliance with medical necessity.
- 7.1 - Updated section in accordance to 42 CFR 414.202 and 42 CFR 440.70.
- 8.0 - Clarifications added regarding the prior authorization requirement for non-listed billing codes. Added code A4226 with PA.

[Home Health Provider Specific Policy Manual: Revision Date – 2/15/2020: Sections Revised:](#)

- 1, 3, 5, 6 and 7 - Sections updated in compliance with 42 CFR 440.70 including clarifications regarding place of service, prior authorization, face-to-face encounters, qualified practitioners, and durable medical equipment and supplies requirements.
- 2.1 - Section updated in accordance with 42 CFR 484.102 to require Home Health Agencies to comply with all Federal, State and local emergency preparedness statutes as a condition of participation in the DMAP.
- All - In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.

[General Policy Manual: Revision Date – 2/10/2020: Sections Revised:](#)

- All – In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.
- 1.38.2 – Section updated in compliance with 42 CFR 455 Subpart B to allow for timely disclosure of information by providers and fiscal agents.

Reminders

Vaccine for Children (VFC) – Encounter for Immunization

Diagnosis code Z23 (ENCOUNTER FOR IMMUNIZATION) may be used as a primary diagnosis code for immunizations in a physician setting when the member is in the VFC Program.

ICD-10 Diagnosis Codes Update

The following values for diagnosis codes have been updated: O3680X0–O3680X5 and O3680X9 (Pregnancy with Inconclusive Fetal Viability); Z110–Z1389 (Encounter for Screening). These codes can be used as a primary diagnosis in accordance with the timely filing guidelines. Refer to section 1.19, **Claims Submission-Timeliness**, in the [General Policy Manual](#) for specific requirements regarding timely claims submission filing.

Delaware Medicaid Retroactive Coverage Fact Sheet

The Division of Medicaid and Medical Assistance (DMMA) has expanded the groups of individuals who are eligible for retroactive Medicaid coverage. Click [HERE](#) to view information detailing: the definition of retroactive coverage, eligible members, effective dates, and reimbursement for providers.

Specified Low-Income Qualified Medicare Beneficiary (SLMB)

You may have received the denial **Explanation of Benefits 2521** – *client is only eligible for payment of Medicare premiums and is not eligible for Medicaid services. This claim will not be paid.* This means the member is a SLMB. You may find more information by clicking [HERE](#) regarding this denial.

Master Pre-Admission Evaluation Form

Click [HERE](#) to view DMAP's fillable Master Pre-Admission Evaluation form. Once it has been determined that there is a need for a referral to the Division of Medicaid and Medical Assistance (DMMA) for Long-Term Care services, all applicants/members must have a completed Pre-Admission Evaluation (PAE) Tool and supporting data submitted to the DMMA Central Intake Unit (CIU). For more details regarding pre-admission evaluation instruction, please click the following link: [LTC Instructions Pre-Admission Evaluation Form](#).

Provider Disclosure

Sections 6401 and 6501 of the Affordable Care Act require states to incorporate additional program integrity provisions within Medicaid and the Children's Health Insurance Program to prevent fraud, waste, and abuse. In compliance with Title 42 CFR §455, Subpart B, providers must complete the online DMAP Disclosure Statement of Information by Providers and Fiscal Agents upon enrollment, revalidation, re-enrollment, reactivation, and within 30 days of any change contained in the enrollment application.

For more information regarding the Disclosure of Information by Providers and Fiscal Agents Statement, see the [General Policy Manual](#) and [How-To Disclosure Statement of Information to be Completed by Providers and Fiscal Agents](#).

Provider Security Awareness and HIPAA Tips

Providers and Trading Partners provide the first line of defense in securing member Protected Health Information (PHI) and maintaining HIPAA compliance. DMAP suggests the following security tips to prevent breaches and to combat fraud, waste, and abuse.

- Develop and maintain internal systematic training for staff regarding DMAP Portal registration privileges and [HIPAA](#) compliance.
- Review and monitor DMAP Portal user roles (administrator and delegates) and levels of access.
- Review DMAP Portal access for all employees who are on extended leave or have not logged in to the DMAP Portal within the last 180 days.
- Timely DMAP Portal deactivation and removal of staff access that have separated employment.
- Annual HIPAA training for all providers and staff.
- Report ALL suspected PHI breaches and related incidents immediately via the [Report Fraud link](#).

Delaware Cancer Treatment Program

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)
- are not eligible for health insurance

The DCTP is also available to Delaware residents with comprehensive health insurance who meet the following eligibility criteria:

- 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)
- maximum out-of-pocket expense for health insurance is equal to more than 15 percent of their household income (does NOT include premiums)*

***Applicant is required to 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.

Prior Authorization

The DCTP follows current Medicaid guidelines regarding what requires submission of a prior authorization form for approval for service. When completing DCTP prior authorization forms, please use your Medicaid ID / Location ID (MCD). 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 will start with either a '25' for newly enrolled providers or a '20' for previously enrolled providers. If you are unsure of your MCD, it is displayed on the gray bar at the top of the page once you are logged in to the provider portal.

Please click [HERE](#) to access the form that **MUST** be utilized for all DCTP participant prior authorization requests. For more information about the DCTP program, including prior authorization of services for those in the DCTP program, please call 1-844-245-9580.



Vaccines for Children (VFC) Program Provider HPV Training & Education

HPV vaccination coverage continues to lag behind coverage for the other vaccines recommended for preteens. High rates of Tdap and meningitis vaccination demonstrate that preteens are seeing clinicians and getting vaccinated, but they do not always receive HPV vaccine.

- The Centers for Disease Control and Prevention (CDC) recommends HPV vaccination for girls and boys at ages 11 or 12 years to protect against cancers caused by HPA infections. (Vaccination can be started at age 9.)
- CDC encourages clinicians to recommend HPV vaccination in the same way and on the same day that they recommend other routinely recommended vaccines for patients at age 11 or 12 years (<https://www.cdc.gov/hpv/hcp/for-hcp-tipsheet-hpv.html>).
- CDC suggests effectively recommending HPV vaccination by bundling the recommendation for all vaccines for preteens, with HPV vaccine in the middle.

If your immunization rates are below the national average, you will be contacted by Quality Insights about participating in this training. Although this training is not mandatory and not all initiatives are required to participate, **it is strongly recommended for all VFC providers.**

Please contact Jim Talbott, Immunization and Vaccines for Children Director, with questions (james.talbott@delaware.gov) 1-800-282-8672

DMAP Provider Utilization Review

Utilization Review

Utilization review guards against unnecessary medical care and services, and it ensures that payments are appropriate according to the coverage policies established by the Division of Medicaid and Medical Assistance (DMMA). The DMMA Surveillance and Utilization Review (SUR) Unit conducts required utilization review activities through a series of monitoring systems developed to ensure that services are reasonable, medically necessary, and of optimum quality and quantity. Both Delaware Medical Assistance Program (DMAP) members and providers are 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
- Inappropriate payments, as defined by DMMA

Utilization review activities ensure the efficient and cost-effective administration of 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 in making important policy decisions. In addition, utilization review activities can identify areas of policy that require clarification or change. It is a valuable tool in shaping policy guidelines to ensure that services are provided in an efficient and effective manner.

Abuse and Fraud Defined

The term abuse describes 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 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 is an intentional deception or misrepresentation, made by the provider or member, which could result in an unauthorized benefit, such as an improper payment being made to a Medicaid provider.

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 is an intentional deception or misrepresentation, made by the provider or member, which could result in an unauthorized benefit, such as an improper payment being made to a Medicaid provider.

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

Reporting Fraud, Waste, and Abuse

Healthcare fraud, waste, and abuse affects everyone. The State relies on the healthcare provider community to actively participate in the detection and deterrence of DMAP fraud, waste, and abuse. Report any suspected fraud, waste, or abuse by members or providers to the DMMA Program Integrity SUR Unit:

DMMA Program Integrity SUR Unit
Herman Holloway Campus
1901 N. DuPont Highway
New Castle, DE 19720
Toll-Free Telephone: 1-800-372-2022
Hot Line (After Hours Voice Mail Only) 1-800-372-2022 select option #1
Email: SURreferrals@delaware.gov



Need Assistance?

Surveillance Utilization Review Unit @ 302-255-9500

Option 0

Medicaid Credit Balance Reporting (MCBR)
Herman Holloway Campus
1901 N. DuPont Highway
New Castle, DE 19720
eFax: 602-736-9168
email: SUR_MCBR@delaware.gov

Pharmacy Update

Medicaid Coverage of Naloxone No Cost to DMAP Members

This is a reminder that naloxone opioid overdose rescue medications can be obtained two ways:

- With a prescription from a Physician, or
- Without a prescription – Naloxone can be dispensed using the standing order issued by the Division of Public Health (DPH). Clinical judgment should be applied to determine need, based on daily Morphine Milliequivalent value, per Center for Disease Control and Prevention (CDC) guidelines at daily doses greater than 90MME. Pharmacies should submit a claim electronically—as they would a prescription—using the Director of the Delaware DPH as the prescribing practitioner and the appropriate National Drug Code (NDC) for the drug product.

Effective July 1, 2018, the Division of Medicaid and Medical Assistance (DMMA) removed the copayment fee requirement for naloxone opioid overdose rescue medications for all Delaware Medicaid fee-for-service and managed care (MCO) members.

Covered products are listed below:

- NARCAN 2MG Nasal Spray
- NARCAN 4MG Nasal Spray
- Naloxone 2MG/2ML Syringe

ATTENTION ALL PROVIDERS!

[NCPDP VD 0 Billing Request Layout](#)

On January 24, 2020, the Department of Health and Human Services (HHS) published a final rule Administrative Simplification: *Modification of the Requirements for the Use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) national Council for Prescription Drug Programs (NCPDP) D.0 Standard (CMS-0055-F)*.

CMS-0055-F makes a regulatory change under HIPAA, modifying the requirements for the use of the NCPDP Telecommunication Standard Implementation Guide, Version D.0, August 2007. This final rule requires the use of the **Quantity Prescribed (460-ET) field** to identify incremental fills for Schedule II drugs. The compliance date was **September 21, 2020**.

Please refer to the NCPDP VD 0 Billing Request Layout PDF (above) located on the [Provider Portal](#) Document Repository.

Click [HERE](#) to learn more about the CMS-0055-F final rule.

Pharmacy Corner



Welcome to the Pharmacy Corner

The pharmacy program in Delaware is operationally administered through the Delaware Medical Assistance Program (DMAP) Staffing for the Pharmacy Program includes a Pharmacy Director in conjunction with the DXC Pharmacy Team. The objective of the pharmacy program is to ensure that DMAP members have access to appropriate medications while monitoring utilization and cost-effectiveness. The rapid changes in the pharmacy industry and the importance of communicating new information to the pharmacy community are critical to the quality and continuity of care for Delaware citizens. Please click t

[Highmark Health Options](#) and [AmeriHealth Caritas](#) have important information on their websites. Find information on community resources, telehealth and much more!

What's New

Provider Appeals

The Delaware Medical Assistance Program (DMAP) introduces a new electronic mailbox for Provider Enrollment Appeals. The [General Policy Manual](#) now requires all Provider Enrollment Appeals to be submitted via DMMA.ProviderAppeals@delaware.gov.

Member Eligibility

Providers may now verify a member's eligibility going back 10 years! **Note:** The *effective from* and *effective to* fields must remain within 90 days of each other per search. Read more about this additional search capability in DMAP's [How-To View a Member's Eligibility through the Provider Portal](#).

Prior Authorization (PA)

DMAP has announced a new streamlines submission process for PA requests. The PA Policy has been updated to require **all** PA requests to be submitted via the DMAP Portal. To read more, visit the [General Policy Manual](#), sections 1.21.2.1.

Payment Error Rate Measurement (PERM)

The Center for Medicare & Medicaid Services (CMS) has announced the new cycle of the PERM audit for review year (RY) 2022.

The PERM audit measures improper payments in Medicaid and Delaware Healthy Children Program (DHCP) in the State Fiscal Year (SFY) under review. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and DHCP paid claims.

All states are required to participate every three (3) years on a rotating basis. **Stay tuned for more provider information regarding the Delaware PERM audit!**

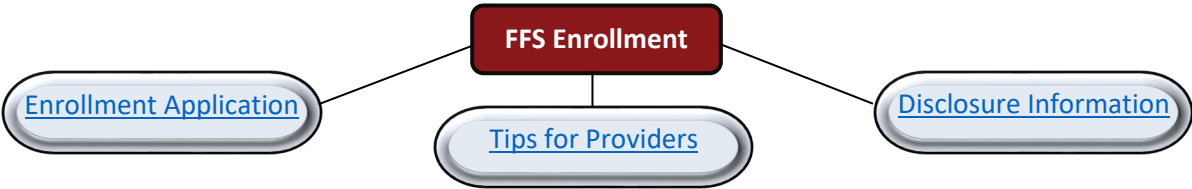


DELAWARE HEALTH AND SOCIAL SERVICES Division of Medicaid and Medical Assistance

Dental providers who **are currently enrolled** in DMAP/FFS in the following taxonomies may begin servicing eligible adult members enrolled in FFS starting 10/1/2020.

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

Dental providers who are **not currently enrolled** in DMAP/FFS with the taxonomies listed above will need to enroll in order to provide services to eligible adult members. Dental providers who have age restrictions (e.g., adults only, children only) for whom they serve should enter that information into their provider details via the Provider Portal.



Managed Care Organization (MCO) Enrollment

Dental providers who want to provide adult dental services to members in the Medicaid managed care population, **must** enroll with each MCO. For additional information, please see the MCO contact information below.

- AmeriHealth Caritas: 1-855-707-5818; delawareprovidernetwork@amerihealthcaritas.com
- Highmark Health Options: 1-844-325-6251; [Secure Email](#)

For additional information regarding the Division of Medicaid and Medical Assistance (DMMA) new Adult Dental Program, click [HERE](#).



Early Periodic Screening, Diagnosis & Treatment Corner

EPSDT Corner



Flu Season: Get Prepared

Flu season is upon us again, and it's time for vaccination. Though the influenza (flu) virus circulates year-round, activity typically picks up in October and peaks in December through February, but activity can extend as late as May during some seasons. The Center for Disease Control and Prevention (CDC) recommends that everyone ages six (6) months and older get the seasonal flu vaccine by the end of October. However, vaccination should continue throughout the season for as long as the flu virus is circulating.

Children younger than six (6) months old are too young to receive the flu vaccine. Per the CDC, children ages six (6) months old through eight (8) years old who are getting their first flu vaccine should receive two (2) vaccines this season spaced four (4) weeks apart. Children nine (9) years old and older should receive one (1) flu vaccine annually regardless of their vaccination history. The flu vaccine is available in two (2) forms—as an injection and as a nasal spray. The injection is available in the trivalent (3-strain) and quadrivalent (4-strain) form and is recommended for anyone ages six (6) months old and older. The nasal spray is a live inactivated flu vaccine and is recommended for ages two (2) years old and older; but is not recommended for those with underlying health conditions.

The flu vaccine is covered under the Vaccine for Children (VFC) Program and is free for participating providers; additionally, the administration fee is reimbursable by Medicaid. The VFC Program is managed by Delaware Health & Social Services (DHSS) Division of Public Health (DPH) and can be reached at 302-744-1060 for more information.

Additional Resources:

Because of the COVID-19 pandemic, reducing the spread of respiratory illnesses, like flu, this fall and winter is more important than ever. The CDC has worked with vaccine manufacturers to have extra flu vaccine available this flu season.

Manufacturers have already begun [distributing the flu vaccine](#) and will continue to distribute vaccine throughout the season. The CDC recommends getting a flu vaccination in September or October but getting vaccinated anytime during the flu season can help protect you. Use the [VaccineFinder](#) to find out where to get vaccinated near you.

The full plan can be viewed on DMMA's website at the following location:

http://dhss.delaware.gov/dhss/dmma/files/de_plan_cmc.pdf

Electronic Visit Verification

Coming Soon: Electronic Visit Verification to Home Health and Personal Care Services Across the Nation



Electronic Visit Verification (EVV) is mandated by Section 12006 of the 21st Century Cures Act. States must require the use of an EVV system for personal care services (PCS) and home health care services (HHCS) that require an in-home visit. Delaware is meeting the requirements of the 21st Century Cures act through an open model EVV. This allows companies to utilize the state EVV solution, AuthentiCare or operate their own solution on the condition that it complies with the requirements of the 21st Century Cures Act and allows for data sharing between AuthentiCare and the provider's EVV vendor of choice.

Delaware has partnered with Fiserv to develop, implement and operate AuthentiCare. Currently Delaware is in the development stage of the project. Anticipated 'go-live' date is 01/01/2021.

Effective 01/01/2021, all Delaware Medicaid providers that supply in home personal care services (PCS) and home health care services (HHCS) are required to have their services verified using AuthentiCare or an EVV vendor of the providers choice. Visit data will be used by Division of Medicaid and Medical Assistance (DMMA) to complete post payment reviews and federal reporting.

See the following link for additional Delaware EVV information https://dhss.delaware.gov/dhss/dmma/info_stats.html. If you have any questions, please send them to the following email address; DHSS_DMMA_EVV@delaware.gov.

Stay tuned for a provider survey that will assist the project in determining who needs devices to support their EVV efforts as well as the training calendar.

