



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF MEDICAID &
MEDICAL ASSISTANCE

Delaware Medical Assistance Program



Important Notice

Coming Soon: Electronic Visit Verification (EVV) Requirement for Home Health and Personal Care Services Providers

In compliance with [Section 1903\(l\) of the Social Security Act](#) and [Section 12006 of the 21st Century Cures Act](#), Delaware Medicaid will implement Electronic Visit Verification (EVV) for those providing in-home personal care services (PCS) and home health care services (HHCS). Delaware will use an EVV Open Model, and DMMA has partnered with Sandata to develop, implement, and operate the state EVV solution.

On December 30, 2022, all providers of in-home PCS and HHCS will be required to use EVV to verify their in-home services, using either Sandata or an EVV vendor of the provider's choice.

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

Managed Care Organizations (MCOs) for 2023:

The Delaware Department of Health and Social Services (DHSS) has selected three managed care companies to operate its Medicaid Managed Care Program. Centene's Delaware First Health will join Highmark Health Options Blue Cross Blue Shield, which began operating in Delaware in 2015, and AmeriHealth Caritas, which began in 2018.

The three managed care organizations will 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
1-855-688-6589



Highmark Health Options
1-844-325-6251

MCO Open Enrollment

Delaware Medicaid will conduct annual open enrollment during the month of October. From 10/01/2022 – 10/31/2022, members will have the opportunity to change health plans.

Members can call our Health Benefits Manager at 1-800-996-9969 to make their selections.

All open enrollment changes will be effective January 1, 2023.

Helpful Titles

- [How-To Enrollment Guide for Current In-Network MCO Providers](#)
- [How-To Enrollment Guide for New MCO Network Providers](#)
- [DMAP Provider Screening and Enrollment Frequently Asked Questions](#)

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.**

Manuals and Forms Updates

Practitioner Provider Specific: Revision Date – 9/23/2022: Sections Revised:

- Section 1.11.2.6 – Section updated in alignment with the State Plan to cover drugs indicated for the treatment of obesity to address weight loss with co-morbid conditions with prior authorization.
- Section 13.2 – Section revised in compliance with the State Plan.
- Section 32.0 – Removed Appendix Q – Chiropractic Billing Codes.

Pharmacy Provider Specific: Revision Date – 9/23/2022: Sections Revised:

- Section 3.5.6.1 – Section updated in alignment with the State Plan to cover drugs indicated for the treatment of obesity to address weight loss with co-morbid conditions with prior authorization.

General Policy Manual: Revision Date – 06/23/2022: Section Revised:

- Section 1.38.2.2.2 – Additional screening and enrollment clarification added pertaining to prospective and revalidating providers of prosthetics, orthotics, and supplies.
- Section 1.38.2.3.3 – Additional screening and enrollment clarification added pertaining to prospective and revalidating providers of prosthetics, orthotics, and supplies.

Children’s Dental Program Provider Specific: Revision Date – 05/25/2022: Sections Revised:

- Section 3.2.3 – Updated prior authorization requirements for Limited Orthodontics.
- Section 8.0 – Deleted billing codes D4320 and D4321, effective 12/31/2021. Added billing codes D4322 and D4323, effective 01/01/2022. Updated age limitation for D7961 and D7962 from 5 to 20 years of age to 0 to 20 years of age, effective 05/01/2022. Updated D8020 prior authorization requirements.

You Ask, DMAP Answers (YADA)

How do I reset my password on the DMAP Provider Portal?

Click the “**forgot password**” link on the login screen. The reply will be sent to the email on file for this account. If the email on file is not yours, you may need to complete the [Request Assistance with Resetting Password, Locating User ID and Reassigning Master User Access](#) form to request assistance.

If you are a delegate, you should check with the Portal Administrator (Master account holder) to make sure you are logging in with the right credentials.

If you are the Portal Administrator for the account and the email associated with the account is not your email, then you will not be able to utilize the “forgot password” link. You should complete and fax the form (linked above) with the request on company letterhead to 302-454-7603.

Your faxed form will be assigned to a representative who will contact you by telephone to assist you.

***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.



Electronic Visit Verification (continued)

The EVV requirement for in-home personal care services (PCS) and home health care services (HHCS) will go live **Friday, December 30, 2022**.

Per the EVV Open Model, providers may utilize one of the following:

1. Sandata's EVV system, or
2. Their own solution on the condition that it complies with the requirements of the 21st Century Cures Act, allows for no less than weekly data sharing between Sandata and the provider's EVV vendor of choice, and meets other State requirements.

For a complete list of services, see https://dhss.delaware.gov/dhss/dmma/info_stats.html.

The State of Delaware will require all providers who use their own EVV solution (alternate EVV vendors) to complete an attestation that validates their EVV solution collects, at a minimum, the following data elements:

- Type of service performed
- Name of individual receiving the service
- Date of the service
- Location of service delivery
- Time the service begins and ends
- Name of the individual providing the service



Click the following links for additional information about Delaware EVV:

- General Information: https://dhss.delaware.gov/dhss/dmma/info_stats.html
- Section 12006 of the 21st Century CURES Act – Electronic Visit Verification Systems – CMS Presentation: <https://dhs.sd.gov/docs/evv-presentation-part-1.pdf>
- Monthly Provider Forum Registration: https://mmc.zoom.us/webinar/register/WN_EdZld9jHRHK0-Kv435vNLw
- If you have not already completed our provider survey, please take a moment to do so. We are using this information to determine training and device needs. [DE DHSS Provider Electronic Visit Verification \(EVV\) Survey](#)

**If you have any questions regarding Electronic Visit Verification (EVV),
please email:**

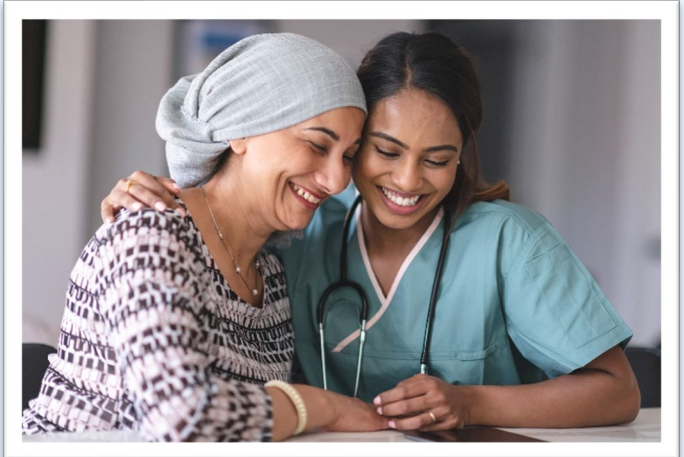
DHSS_DMMA_EVV@delaware.gov

[Public Information & Statistics – Delaware Health and Social Services – State of Delaware](#)

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), 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 of equal to 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](https://www.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.

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). 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. **Prior authorizations for DCTP are not to be submitted on the Portal.**

Please click [HERE](#) to access the form that **MUST** be utilized for all DCTP participant 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.

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 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 the DMMA

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

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

The utilization review process assists the SUR Unit 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

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 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

If you have any further questions regarding fraud, waste, or abuse, please contact the Division of Medicaid and Medical Assistance (DMMA) Surveillance Utilization Review Unit at:

Toll-Free Telephone: 1-800-372-2022

Hotline (After-Hours Voicemail Only) 1-800-372-2022, select option #1

Email: SURreferrals@state.de.us

Updated COVID-19 Vaccine Recommendations





COVID-19 Vaccines for People Who are Immunocompetent

COVID-19 Vaccine	Age Range	1st Dose (Primary Series)	2nd Dose (Primary Series)*	3rd Dose
	18 years and older	Initial dose	3–8 weeks after 1st dose	Updated Booster - At least 2 months after 2nd dose or last booster, and can be Pfizer-BioNTech or Moderna bivalent booster
	12 - 17 years old	Initial dose	3–8 weeks after 1st dose	Updated Booster - At least 2 months after 2nd dose, and can only be Pfizer-BioNTech bivalent booster
	5 - 11 years old	Initial dose	3–8 weeks after 1st dose	Booster - At least 2 months after 2nd dose, and can only be Pfizer-BioNTech monovalent booster
	6 months - 4 years old	Initial dose	3–8 weeks after 1st dose	Primary Series - At least 8 weeks after 2nd dose
	18 years and older	Initial dose	4–8 weeks after 1st dose	Updated Booster - At least 2 months after 2nd dose or last booster, and can be Pfizer-BioNTech or Moderna bivalent booster
	12 - 17 years old	Initial dose	4–8 weeks after 1st dose	Updated Booster - At least 2 months after 2nd dose, and can only be Pfizer-BioNTech bivalent booster
	6 months - 11 years old	Initial dose	4–8 weeks after 1st dose	Not recommended at this time
	50 years and older	Initial dose	Booster - At least 2 months after 1st dose, and can be Pfizer-BioNTech or Moderna monovalent booster	Updated Booster - At least 2 months after 2nd dose or last booster, and can be Pfizer-BioNTech or Moderna bivalent booster
	18 - 49 years old	Initial dose	Updated Booster - At least 2 months after 1st dose or last booster, and can be Pfizer-BioNTech or Moderna bivalent booster	Not recommended at this time
	18 years and older	Initial dose	3–8 weeks after 1st dose	Updated Booster - At least 2 months after 2nd dose, and can be Pfizer-BioNTech or Moderna bivalent booster
	12 - 17 years old	Initial dose	3–8 weeks after 1st dose	Updated Booster - At least 2 months after 2nd dose, and can only be Pfizer-BioNTech bivalent booster

*Exception – Johnson & Johnson 2nd dose is booster

Pharmacy Corner (cont.)

COVID-19 Vaccines for People Who are Moderately or Severely Immunocompromised

COVID-19 Vaccine	Age Range	1st Dose (Primary Series)	2nd Dose (Primary Series)	3rd Dose (Primary Series)*	4th Dose
	18 years and older	Initial dose	3 weeks after 1st dose	At least 4 weeks after 2nd dose	Updated Booster - At least 2 months after 3rd dose or last booster, and can only be Pfizer-BioNTech bivalent booster
	12-17 years old	Initial dose	3 weeks after 1st dose	At least 4 weeks after 2nd dose	Updated Booster - At least 2 months after 3rd dose or last booster, and can only be Pfizer-BioNTech bivalent booster
	5 - 11 years old	Initial dose	3 weeks after 1st dose	At least 8 weeks after 2nd dose	Booster - At least 3 months after 3rd dose, and can only be Pfizer-BioNTech monovalent booster
	6 months - 4 years old	Initial dose	3 weeks after 1st dose	At least 8 weeks after 2nd dose	Not recommended at this time
	18 years and older	Initial dose	4 weeks after 1st dose	At least 4 weeks after 2nd dose	Updated Booster - At least 2 months after 3rd dose or last booster, and can only be Pfizer-BioNTech or Moderna bivalent booster
	12 - 17 years old	Initial dose	4 weeks after 1st dose	At least 4 weeks after 2nd dose	Updated Booster - At least 2 months after 3rd dose or last booster, and can only be Pfizer-BioNTech bivalent booster
	6 months - 11 years old	Initial dose	4 weeks after 1st dose	At least 4 weeks after 2nd dose	Not recommended at this time
	50 years and older	Initial dose	Additional Dose - At least 4 weeks after 1st dose and should be Pfizer-BioNTech or Moderna monovalent vaccine	Updated Booster - At least 2 months after 2nd dose or last booster, and can be Pfizer-BioNTech or Moderna bivalent booster	Not recommended at this time
	18 years and older	Initial dose	Additional Dose - At least 4 weeks after 1st dose and should be Pfizer-BioNTech or Moderna monovalent vaccine	Updated Booster - At least 2 months after 2nd dose or last booster, and can be Pfizer-BioNTech or Moderna bivalent booster	Not recommended at this time
	18 years and older	Initial dose	3 weeks after 1st dose	Updated Booster - At least 2 months after 2nd dose, and can be Pfizer-BioNTech or Moderna bivalent booster	Not recommended at this time
	12 - 17 years old	Initial dose	3 weeks after 1st dose	Updated Booster - At least 2 months after 2nd dose, and can only be Pfizer-BioNTech bivalent booster	Not recommended at this time

*Exception – Johnson & Johnson and Novavax 3rd dose is booster.

[COVID-19 vaccine and booster recommendations](#) may be updated as the **Centers for Disease Control and Prevention** monitors the latest data.

Help Us Get the Word Out

The following information is being provided to members as a reminder to update their contact information to avoid any interruption of medical services. For printable versions of the flyer/poster in Spanish and English, visit the Publications > Bulletins > COVID-19 PHE Updates Folder in the [DMAP Portal Document Repository](#).

Have you heard the news?
At the end of the COVID-19 Public Health Emergency (PHE), the Division of Social Services (DSS) and the Division of Medicaid & Medical Assistance (DMMA) will restart eligibility reviews.

¿Escucho la noticia?
Al final de la Emergencia de salud pública (PHE, por sus siglas en inglés) del COVID-19, la División de Servicios Sociales (DSS, por sus siglas en inglés) y la División de Medicaid y Asistencia Médica (DMMA, por sus siglas en inglés) reiniciará las revisiones de elegibilidad.

DON'T RISK A GAP IN YOUR MEDICAID OR CHIP COVERAGE. GET READY TO RENEW NOW.
Following these steps will help determine if you still qualify:

- Make sure your contact information is up to date.
- Check your mail for a letter.
- Complete your renewal form (if you get one).

NO ARRIESGUE UNA INTERRUPCIÓN EN SU COBERTURA DE MEDICAID O CHIP. PREPÁRESE PARA RENOVAR AHORA.
Seguir estos pasos ayudará a determinar si aún califica:

- Asegúrese de que su información de contacto esté actualizada.
- Revise su buzón en busca de una carta.
- Llene su formulario de renovación (si recibe uno).

Have Questions?
Visit <https://assist.dhss.delaware.gov/> or call Change Report Center (302) 571 - 4900, Option 2 for help or to update your contact information today.

¿Tiene Preguntas?
Visite <https://assist.dhss.delaware.gov/> o llame Centro de informe de cambios (302) 571 - 4900, Opción 2 para obtener ayuda o para actualizar su información de contacto hoy.

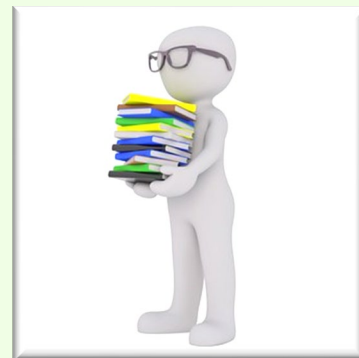
Monkeypox Resources

From the Delaware Division of Public Health (DPH):

- [Monkeypox Contacts and General Information](#)
- [Monkeypox Guide for Medical Providers in Delaware](#)
- [State Health Operations Center \(SHOC\) Resource Request Form](#)

From the Centers for Disease Control and Prevention (CDC):

- [Monkeypox Case Definition](#)
- [Interim Clinical Guidance for the Treatment of Monkeypox](#)
- [Case Reporting Recommendations for Health Departments](#)
- [Lab Advisory: Best Practices for Suspected Monkeypox Lesion Specimen Collection](#)



Children’s Dental Program

The following are **Dental Code changes for the Children’s Dental Program**. The code changes are **only** effective for the Children’s Dental Program.

The following codes **have been updated**:

- **Effective 04/01/2022:** CDT codes D7961 and D7962 age limitation updated from 5-20 years to 0-20 years.
- **Effective 05/01/2022:** CDT code D8020 no longer requires a Prior Authorization. Photographs and Panorex must be attached to claim for review. Please refer to the Children’s Dental Program Manual Section 3.2.2.3 for criteria that must be met.

Adult Dental Program

Dental providers currently enrolled in DMAP/Fee for Service (FFS) in the following taxonomies can provide services to eligible adult members enrolled in FFS. **Join us to meet the growing demands of the Adult Dental Program.** Dental providers who are not currently enrolled in DMAP/FFS with the taxonomies listed below must enroll with an MCO to provide services to eligible DMAP adult members. Dental providers who have age restrictions (e.g., adults only, children only) for whom they serve should enter that information in the provider characteristics panel on the Provider Portal.

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

Managed Care Organization (MCO) Enrollment

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

- AmeriHealth Caritas: 1-855-707-5818;
- 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](#).

DMAP Dental Manuals

The DMAP launched the new [Adult Dental Program Provider Specific Manual](#) on 10/01/2020. The Dental Provider Specific Manual is now the [Children’s Dental Program Provider Specific Manual](#), effective 10/01/2020. The former Dental Provider Specific Manual has been [archived](#) for refere

Early Periodic Screening, Diagnosis & Treatment Corner



Preventative Pediatric Health Care 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.

According to Bright Futures and the AAP, each child and family is unique; therefore, specific recommendations are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Additional visits also may become necessary if circumstances suggest concerns. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

The American Academy of Pediatrics and Bright Futures annually update their Preventative Care/Periodicity Schedule, which includes these recommendations.

Existing category updates:

- Screening for Suicide Risk ADDED to the current Depression Screening category (for ages 12-21 years). Suicide risk is now noted as an element of universal depression screening.
- Psychosocial/Behavioral Assessment category CHANGED to the Behavioral/Social/Emotional Screening (for ages newborn to 21 years).

New categories:

- Assessing risk for sudden cardiac arrest and sudden cardiac death has been ADDED to occur from 11 to 21 years of age (to account for the range in which the risk assessment can take place).
- Assessing the risk for Hepatitis B virus infection (HBV) has been ADDED to occur from newborn to 21 years (to account for the range in which the risk assessment can take place).

Updated footnotes:

- Fluoride varnish and Fluoride supplementation - Two clarifying references related to dental fluoride varnish and fluoride supplementation have been added, with no associated recommended changes to clinical practice.

The updated schedule is now published online for 2022 and can be accessed on the following website: [Preventive Care/Periodicity Schedule \(aap.org\)](https://www.aap.org/preventive-care/periodicity-schedule).

For more information, visit the [EPSDT website](https://www.aap.org/preventive-care/periodicity-schedule).

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
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (cvd) risk of 10% or greater	The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.	B	August 2022*
Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	B	October 2016*

*Previous recommendation was an "A" or "B."

Reminder: DMMA Extended Preventative Coverage to Younger Delaware Medicaid Recipients to Align with USPSTF Recommendations for Colorectal Cancer Screenings

The [United States Preventive Services Task Force](#) (USPSTF) expanded the recommended ages for colorectal cancer screening from 50 to 75 years to now include ages 45 to 75 years. The USPSTF continues to recommend selectively screening adults aged 76 to 85 years for colorectal cancer.

This expansion covers adults 45 years and older who do not have signs or symptoms of colorectal cancer and who are at average risk for colorectal cancer (i.e., no prior diagnosis of colorectal cancer, adenomatous polyps, or inflammatory bowel disease; no personal diagnosis or family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer [such as Lynch syndrome or familial adenomatous polyposis]).

Managed Care Only- Providers (MCOP) DMAP Screening and Enrollment

In compliance with [42 CFR § 438.602](#), [42 CFR Part 455](#), subparts B and E, and the [21st Century Cures Act](#), Delaware Medicaid will screen and enroll current and prospective Managed Care Organization-Only Providers (MCOPs) in 2022.

On June 6, 2022, current In-Network MCOPs began receiving registration letters for screening and enrollment from DMAP. MCOP providers with multiple National Provider Identifiers (NPIs), taxonomies, or service locations, will receive separate letters. A different letter will be sent for each combination of NPI, taxonomy, and service location.



MCOPs may receive notice from DMAP to complete a Provider Enrollment Application via the Delaware Medical Assistance Portal for Providers. Please do not discard the notice and do follow the associated instructions timely. From the date of the notice, providers will have 60 calendar days to complete the required MCOP Enrollment Application on the Provider Portal. **Failure to be screened and enrolled with DMAP will result in termination from the Delaware Medicaid Program and MCO network participation.**

The notice is specific to a unique National Provider Identifier (NPI) and taxonomy combination that must be enrolled with DMAP. If providers have additional NPI and taxonomy combinations operating in Delaware, they **will** receive a separate notice, requiring them to complete a Provider Enrollment Application for any additional NPI and taxonomy combination(s).

To ensure that you receive a notice, please update you contact information with Highmark Health Options (HHO) and AmeriHealth Caritas (AHC) via your MCO Provider Portal now! Contact information includes phone numbers, addresses (mailing, service location, billing, credentialing, and enrollment to include floor and suite numbers), point-of-contact names, and email addresses.

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.
- Contact Provider Services from 8:00 AM ET to 4:30 PM ET at 1-(800) 999-3371, select option 0, option 4.

PERM Cycle RY22 Updates

The RY22 PERM cycle review ended on April 15, 2022. As of now, the review contractors have completed all reviews for Delaware. The state is now waiting on CMS to provide their final error rate results which will be on or before the end of December 2022.

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 services provided 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, Alicia Seals at Alicia.Seals@delaware.gov, or Theodore R. Robinson, Chief of Program Integrity, DMMA, at Theodore.R.Robinson@delaware.gov.

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.

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 [Provider Portal](#). Accurate contact and demographic information is invaluable to DMAP members in need of medical service.

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. The Contact Information can be updated on the 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 invitations, and administrative updates.

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.

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.
- Complete timely DMAP Portal deactivation and removal of staff access for employees who have separated employment.
- Complete annual HIPAA training for all providers and staff.
- Report ALL suspected PHI breaches and related incidents immediately via the [Report Fraud SUR Referral Form link](#).

