DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

DELAWARE MEDICAL ASSISTANCE PROGRAM

GENERAL POLICY MANUAL

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DELAWARE HEALTH AND SOCIAL SERVICES DIVISION OF MEDICAID & MEDICAL ASSISTANCE *Delaware Medical Assistance Program*	**General Policy Manual** **Revision Table**

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
7/1/02	17.0 – 17.2	Appendix L – Recommended Childhood Vaccination Schedule form was revised to the 2002 edition.
7/1/02	1.15.1	The revision was made to correct conflicting language in the DME Provider Specific and General Policy Manuals.
7/1/02	1.20.1.2, 2.1.11, 2.2.6. Added 2.3	These changes were necessary because of the 7/1/02 implementation of Diamond State Partners. In addition to revising sections of the policy, a complete section (2.3) is added that includes required forms and procedures that are essential to DSP providers.
7/1/02	18.1, 18.2	Telephone and fax numbers were changed due to a new telephone system.
7/1/02	2.3.5.7, 12.0, 14.0, 15.0, 16.0	1) Added Behavioral Health Authorization Form to the DSP section 2) Corrected the family planning modifier in section 12.0 previously identified incorrectly. 3) Changed the order of Appendices I-K to be more systematic. Added #9 to Medicaid Credit Balance Report.
7/1/02	1.34.3.1	A previous revision of the order of Appendices I – K required changes be made when referencing these appendices.
11/15/02	1.21.2.2.3, 1.21.2.2.4	This change is being made to safeguard client confidentiality. Revised diagnosis code to V25.09.
11/15/02	1.15.1, 1.23	Adding clarification to policy.
11/15/02	1.7.2.9, 1.20.6.1.3	Per licensing requirements. Per DME policy.
10/1/02	1.28.1.1 - 1.28.2.1.3	Per Transportation Policy
1/1/03	1.34.2.2.8	To comply with SUR Unit procedures
1/1/03	2.1.9.1.1.3, 2.1.10.3, 4.1.1, 4.5.7	The name CHAMPUS (military insurance) is changed in all sections of the manual. Also, routine eye exams and eyeglasses will no longer be included in the MCO benefit package.
7/1/02	6.0 (#5 [f])	Corrected typographical error. The reference to 7(a) should

Revision Date	Sections Revised	Description
		read 6(a).
1/17/03	2.3.5.8	Adding a description of Diamond State Partners behavioral health benefit.
1/1/03	TOC, 1.21.1.1.11, 1.22.1, 1.24, 1.24.1, 1.24.2, 2.2.7.1.3	Changes in section 1 are in compliance with the 2003 Federal Poverty Level guideline. This change is effective immediately. Changes in Section 2 lifts the 31-day cap on reimbursable mental health and substance abuse treatment for those eligible to receive benefits through the Delaware Healthy Children Program (DHCP).
7/1/02	2.3.5.8	Added billing instructions for Diamond State Partners providers billing for behavioral health services
6/6/03	1.18.2	Language is being added to clarify the "Claims Submission-Timelines" policy. This update is effective immediately.
8/1/03	Added a new Section 1.17	Although the DMAP does not reimburse providers for copying or transferring client records, examples are being added to assist providers in determining when and when not to charge the client for the service. This update is being added as Section 1.17. All sections following are renumbered in the Table of Contents and in the body of the manual.
10/14/03	1.21.7	Adding prior authorization requirements for PET Scans.
7/1/02	1.21.8	Adding home health services that require prior authorization. These services are currently listed in the Home Health Manual but were not included as part of the General Policy.
1/1/02	1.21.9	Prior authorization for oral and facial prosthetics was added to the Practitioner Manual but not included in the General Policy.
12/3/03	1.21.4.1.14	Services provided by a dentist is being added to the list of services provided in Delaware, NJ, MD, PA and District of Columbia that do not require prior authorization.
1/23/04	1.19.3	Clarification of the timely filing policy.
4/1/04	2.3.5.1 and 2.3.5.7	The Prior Authorization Request Forms for medical and behavioral health services are revised. These forms must be used by providers on and after April 1, 2004.
2/27/04	1.19.1.2	Changing the POS-DUR program filing limit from 14 days to 100 days.
4/15/04	1.2.1.2, 1.2.1.2.1 and 8.0	Language is being revised with instructions to providers how they may receive a paper copy of manual updates. Since the Update Control Log is no longer used reference is deleted.
4/29/04	2.3.5.5, 2.3.5.8, 2.3.6, 2.3.6.1 and 18.5	The revisions are being made to ensure compliance with CMS regulations/requirements for MCOs. Section 18.5 is being added to give the address for DSAMH
06/23/04	1.31 to 1.36	A section is being inserted that will address the Delaware Cancer Treatment Program. This is a State funded program to provide medical coverage for cancer patients. The

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		program will be effective 7/1/04.
6/28/04	9.0, 18.2, 18.3 and 18.4	Corrected addresses and phone/fax numbers in several sections of the policy.
07/28/04	1.17	Clarifying policy regarding "physician billing Medicaid clients for copying client records and completing prior authorization forms."
8/19/04	1.16.1.4 and 1.37	CMS interprets a missed appointment as not a distinct reimbursable Medicaid service. Therefore, language is added that will prohibit providers to bill clients for missed appointments (Section 1.37). Further, the language that permits providers to bill clients for missed appointments is being removed from DMAP policy (Section 1.16.1.4).
9/23/04	1.36.1.2, 1.36.2.2.1 – 1.36.2.2.10, 1.36.5, 1.36.5.1, 1.36.5.2, 1.36.6, 14.0, 15.0 and 16.0	The Medicaid Credit Balance Report (MCBR) is being updated to facilitate recoupment of overpayments more timely.
10/14/04	1.21.4.4, 1.21.5.2, 1.21.5.3, and 1.21.5.4	The phrase, "Out-of-State Medicaid Coordinator" is changed to "Medical Review Team"
11/22/04	1.21.4.1, 1.38 (new), 18.0, and 19.0	A policy for Related Travel Expense is added. This policy addresses the: reimbursement criteria; limitations and exclusions; and how to obtain prior authorization for related travel expenses. This policy also gives notice to providers that related travel expenses must be prior authorized regardless where the medical service is provided.
02/04/05	1.6.2	Added a section to clarify general provider participation requirements and provider responsibilities for claims submitted to DMAP.
9/12/05	2.3	Revised throughout to reflect the new group managing DSP Behavioral Health Authorizations. Replaced existing Behavioral Health Prior Authorization Request Form with 4 new forms. Reorganized the section and moved all DSP forms to Appendix C, Section 8.0.
9/12/05	2.3.1	Changed to reflect the creation of the Division of Medicaid & Medical Assistance (DMMA).
9/12/05	8.0	Placed all DSP Authorization Forms in previously reserved Appendix C, Section 8.0.
9/21/05	All Sections referencing DMMA	Revised throughout to reflect the creation of the Division of Medicaid & Medical Assistance (DMMA).
9/21/05	Added new Subsection 1.16.1.10	Client pharmacy co-payment added to list of services that may be billed to DMAP clients.
1/10/06	1.27-1.27.4.2	Revised and updated the DPAP policy to include the new Medicare Part D Prescription Drug Plan

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1/18/06	1.21	Added reference to the new DMMA prior Authorization Forms.
1/18/06	1.21.1.2	Revised reference to section 2.3 for DSP required forms to reflect that the forms are now located in section 8.0.
1/18/06	18.0 Appendix M	Revised section 18.0 for all DMMA PA forms. 18.1 is now PA Request for Related Expenses and 18.2 is the DMMA PA request form.
2/14/06	1.21.10	Added policy regarding prior authorization of bariatric surgery.
7/14/06	3.2.1, 3.2.2, 3.3	Revised description of the Medical Assistance Card to include verbiage about the white version of the card.
7/26/06	8.8, 8.9	Updated the Diamond State Partners Outpatient Medication Management and Outpatient Treatment Request forms.
8/15/06	Appendix G, Sections 12.1 and 12.2	Removed procedure codes 58605 and 71020 from the Family Planning and Related Services Benefit Package based on guidance from CMS.
9/19/06	1.27.3.2	Update to Delaware Prescription Assistance Program benefit amount based on Senate Bill # 297, 143rd General Assembly (signed into State law on July 6, 2006).
10/30/06	1.29	Update and clarification made to transportation policy.
11/22/06	1.21.11 and 1.21.11.1	Adding Sleep Studies/Polysomnography section to Services Requiring Prior Authorization.
1/3/07	2.3.5	Diamond State Partner prior authorization update
4/23/07	8.1, 8.8, 8.9, 14.0, 15.0, 16.0 and 18.2	NPI wording updates
4/23/07	17.1, 17.2 new sections 17.3 and 17.4	Update to Childhood Vaccination Schedule to reflect new division by age.
7/18/07	9.0	The DMMA mission statement in Appendix D has been revised.
7/24/07	9.0	A list of the Division of Medicaid and Medical Assistance programs was added.
8/07	1.31.6	The eligibility period for the Delaware Cancer Treatment Program has been changed to 24 months.
8/6/07	4.4	Update to remove obsolete QI – 2 data
10/5/07	1.20, 1.28, 2.1 and 2.2	Update to reflect dental coverage for DHCP recipients effective 10/1/06
10/5/07	1.6, 1.10, 1.10.4 and 19.0	Added newly mandated tamper resistant prescription pad policy and new appendix.
10/22/07	1.19.2.3	Update regarding timely filing overrides.
12/1/07	1.32.5, 1.32.5.1, 1.32.5.2, 1.32.5.3 and 1.32.5.4	Added wording introducing the Acquired Brain Injury (ABI) Medicaid Waiver Program
10/29/07	1.6.3	Added directives regarding the Deficit Reduction Act initiative entitled "Employee Education About False Claims Recovery"

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7/1/07	1.21.1.2, 1.21.1.3, 2.1.10.2.25, 2.1.11.1.14 and 2.1.11.2.7	Update to reflect full coverage of PDN services under managed care effective 7/1/07.
12/14/07	1.21.1.3.1 and 2.1.9.1.1.2	Updated policy to reflect Acquired Brain Injury (ABI) Waivers relation to prior authorization and DSHP.
1/4/08	12.1	Adding new 2008 HCPCS code J7307 and previous code S0180
1/18/08	17.0, 17.1, 17.2, 17.3, 17.4, 17.5. 17.6, 17.7, 17.8	Update of the childhood and adolescent vaccination schedule for 2008 and addition of catch-up immunization schedules.
7/7/08	1.31	Added reimbursement guidance for the Delaware Cancer Treatment Program.
7/17/08	12.1	Added additional covered procedure code, J7302
7/31/08	2.3.4 and 6.0	Added Diamond State Partners Behavioral Health Benefit Prior Authorization directives and language is being added to clarify provider appeal policy.
8/29/08	8.1 PA Request Form	Updated Prior Authorization Request Form
8/29/08	2.3.5.2.2	Removed the following wording from 2.3.5.2.2 that states "Magnetic Resonance Imaging (MRI)"
8/29/08	20.2 Index	Added fax number for Robscott building
9/18/08	Overview	Removed obsolete numbering.
9/26/08	8.1 PA Request Form	Updated Prior Authorization Request Form
10/1/08	4.4	Added to covered Medicaid services
11/11/08	4.1.3	Expanded the definition of whom is expected to bill for TPL co-pays.
2/12/09	1.20.3.4	Added new procedure code wording which references the legal ADA criteria for dental coding.
4/30/09	1.23	Clarification of income limits for SLIMBs and QI1s
5/21/09	1.13.2	Reimbursement clarification
5/21/09	1.12.1	Added minimum documentation requirement specifics
5/27/09	3.4	Defines e-prescribing providers ability to access patient eligibility information
6/26/09	Section 14, Appendix I; Section 15, Appendix J; Section 16, Appendix K	Added Provider Taxonomy to Appendices
6/30/09	Section 14, Appendix I	Changes and clarification made to the various MCBR forms and instructions.
7/6/09	1.21.5.1.7	Added intestinal transplants as a covered service.
7/14/09	17.1, 17.2, 17.3, 17.4, 17.5, 17.6, 17.7 and 17.8	Update of the childhood and adolescent vaccination and catch-up immunization schedule for 2009.

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8/24/09	17.1	Updated to reflect the CDC updated recommendations for the poliovirus vaccination
12/15/09	1.12	Updates made to the General Documentation Requirements section.
12/21/09	1.11.6	Added CMS mandate that Medicaid is able to facilitate the recovery of Medicare overpayments.
1/19/10	1.21.12	New procedure codes have been added for Computed Tomographic Colonography which requires Prior Authorization.
2/8/10	7.0	Updated the Referral for Fraud and Abuse form
3/12/10	7.0	Made the Referral for Fraud and Abuse form a fill-able form.
3/31/10	6.0	Updated provider appeals procedures.
4/21/10	1.22.1.1.2	Updated Medicaid Eligibility Groups and Covered Services subsection.
5/25/10	6.0	Updated provider appeals procedures.
7/12/10	17.1, 17.2, 17.3, 17.4, 17.5, 17.6, 17.7 and 17.8	Update of the childhood and adolescent vaccination and catch-up immunization schedule for 2010
7/12/10	1.21 through 1.21.6.16.3	Updated and clarified Prior Authorization policy and the final order for this regulation appeared in the June 1, 2010 issue of the Delaware Register.
9/21/10	1.20.2.5 and 1.20.3.5	Added procedure code documentation requirements.
11/4/10	1.21.6.16.1	Added Federally Qualified Health Center to the list of providers that do not require prior authorization for services in region.
11/4/10	12.2	2011 diagnosis code changes for contraceptive management.
12/13/10	6.0	Updated provider appeals policy to include state-contracted entities.
1/14/11	12.1	Added missing family planning procedure code, 00851.
2/11/11	1.39	Added a new section for Program Integrity.
3/16/11	2.3.6, 2.3.7, 8.2	Deleted Payment Authorization reference
4/20/11	6.0	Updated provider appeals procedures.
5/3/11	1.10	Updated the section on Fraud or Abuse Reporting.
6/24/11	1.6	Added guidance on how DMAP will handle FDA issued consent decree(s) for drug or device manufacturers.
10/3/11	1.24	Effective November 1, 2011, the DMAP will allow for Labor/Delivery Services Only to be provided in a birthing center.
11/1/11	3.1.2	Guidance regarding National Council for Prescription Drug Programs (NCPDP) claims.
12/2/11	1.22	Added tobacco cessation guidance.
1/3/12	1.21, 8.1, and 18.2	Guidance on Prior Authorization processes added.
2/6/12	12.1 and 12.2	Update to procedure codes 11975 and 11977, they have been discontinued effective 1/1/2012 as part of the recent

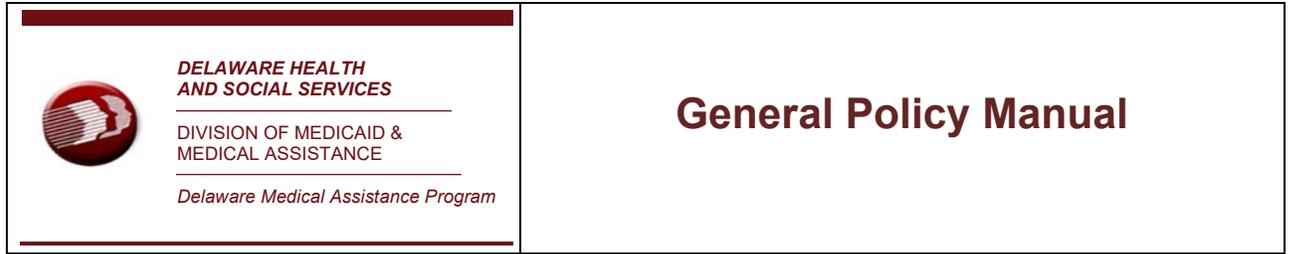| Revision Date	Sections Revised	Description
		HCPCS update.
2/21/12	1.23	Updated wording to reflect the Affordable Care Act section 1902 prohibition on Qualified Medicare Beneficiary (QMB) "balanced billing" for Medicare cost-sharing.
2/21/12	12.1	Newly added procedure code, J7300.
2/21/12	17.0	Update of the childhood and adolescent vaccination and catch-up immunization schedule for 2012.
4/11/12	1.32, 2.0, 3.0 and 10.0	Updated policy to reflect, effective 04/01/2012 additional Medicaid populations now served through a Managed Care Organization (MCO).
5/21/12	1.13	Based on section 6505 of the Affordable Care Act added wording addressing payments to providers. Medicaid will not make payments to any out of country financial institutions.
6/11/12	1.6.5	Added wording and guidance regarding the prohibition on payment for provider-preventable conditions, effective July 1, 2011.
6/21/12	8.7, 8.8, 8.9 and 8.10	Starting July 1, 2012 requests for Diamond State Partners Behavioral Health authorizations will be sent to Attention DMMA at fax number 302-255-4481.
1/15/13	12.1	Added reference "(For dates of service through 12/31/2012)" for code J1055.
1/15/13	12.2	Adding code J1050 to section 12.2.
2/8/13	2.1.9.1.1	Deleted reference to Prescribed Pediatric Care (PPEC) as categorically eligible.
5/22/13	12.2	Adding procedure code for gonorrhea testing to be consistent with Family Planning and Related Services policy in section 1.22.2.
11/22/13	1.39 – 1.39.2.5	Added provider screening and enrollment program integrity enhancements as mandated by the ACA.
11/25/13	2.3.5.1.2	Removed language in reference to the mailing and faxing of PA letters to providers as part of DMAP's Go Green initiative. Added directions to retrieve PA status via DMAP website.
5/1/14	1.39.1.1 and 1.39.1.2	Updated language from DMMA to DMAP. Clarification on enrollment and reinstatement of providers.
5/1/14	1.39.2.1	Clarification of required institutional provider enrollment fees
5/15/14	12.1	Removed S0180 as it has been obsolete since 2008.
7/15/14	14.0	Update address for the submission of MCBR Certification Form to SUR Unit location in New Castle, DE.
8/13/14	1.22 – 1.22.3.1	Deleted references to Medicare Specified Low Income Medicare Beneficiaries (SLIMBs) and Qualifying Individuals (QI-1s) and revised section numbering.
8/13/14	1.23.1 – 1.23.8	Corrected the General Policy Manual to align with the State Plan Amendment in reference to the co-ordination of Medicare Part A and B benefits.

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		Deleted references to Medicare Specified Low Income Medicare Beneficiaries (SLIMBs) and Qualifying Individuals (QI-1s) and revised section numbering.
8/13/14	1.25	Deleted Medicare Qualifying Individuals (QI-1s) reference.
8/13/14	4.4 – 4.4.2.4	Corrected the General Policy Manual to align with the State Plan Amendment in reference to the co-ordination of Medicare Part A and B benefits. Deleted references to SLIMBs and QI-1s, revised section numbering and changed sequential order for Part A and Part B services.
9/1/14	1.6.1	Added language to clarify limitations on prescriptions.
10/1/14	1.15	Added clarification for chiropractic services in reference to the specific members eligible to receive coverage.
11/1/14	2.1.10.2.17	Changed "Methadone" to "Medication Assisted Outpatient Treatment Program (MA-OTP)."
1/1/15	6.0	Updated provider appeals procedures.
4/1/15	1.11.6	Updated section to reflect correct CFR citation from 42 C.F.R. § 477.30 to C.F.R. § 447.30
5/1/15	8.1	Updated Prior Authorization Request Form to add the acceptance of ICD-10 codes and remove DSP language.
8/1/2015	2.1.9.2.1	Updated policy manual to reflect changes in initial services for the expanded population to include FFS coverage prior to enrollment in DSHP.
8/1/2015	2.1.9.2.2.1	Updated income limit for expanded population from 100% FPL to 133% FPL.
8/1/2015	2.1.9.2.2.2	Deletion to reflect change in expanded population eligibility rule.
12/01/2015	1.38.2.1	Added additional clarification in reference to DMAP provider enrollment fees.
12/01/2015	1.15	Removal of age limitations to align with current State Plan.
12/01/2015	1.23.3	Removal of age limitations to align with current State Plan. Updated section numbering.
02/01/2016	2.1.10.2.29	Updated policy manual to reflect that School Based Wellness Center services have be added to the MCO benefit Package effective 1/1/2015
02/01/2016	2.1.11	Removal of DSP language, as the program ended 12/31/2014.
02/01/2016	2.1	Update to section 2.1 to reflect universal language change from client to member.
02/01/2016	2.1.11.1.1	Removal of pharmacy language as it is a covered service under the MCO benefit package effective 1/1/2015.
02/01/2016	2.1.11.2.1	Removal of pharmacy language as it now covered for expanded adult members under the MCO benefit package effective 1/1/2015.
02/01/2016	1.21.6.17	Added language in reference to Prior Authorization requirements for Behavioral Health Services.

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02/01/2016	1.22.1.2.23	Removal of age limitations to align with current State Plan.
04/01/2016	8.0	Revised Forms
04/01/2016	Universal	Updated policy manual to reflect the removal of Diamond State Partners (DSP) language, program ended 12/31/2014.
04/01/2016	1.0 – 1.14	Updated policy manual to reflect language updates to change "client" to "member" as appropriate.
06/15/2016	1.38.1.1	Updated section to add the definition of an encumbered license for clarification.
11/1/2016	1.21.6	Adding additional Prior Authorization for Breast Cancer Assay of Genetic Expression.
12/1/2016	1.22.1.2	Added Preventive Services and Telemedicine Services under Covered Services.
12/1/2016	1.13.5	Updated policy in compliance with Affordable Care Act and State Plan.
04/01/2017	1.13.6	Updated policy to align with State Plan revision of Pharmaceutical Services; effective 1/1/2016
7/1/2017	1.15	Removed Chiropractic Services in compliance with the Delaware State Plan.
7/1/2017	1.22	Added Chiropractic Services in compliance with the Delaware State Plan.
9/1/2017	1.15	Added Dental clarification in reference to services for children up to age twenty.
9/1/2017	1.22.1.2.23	Updated Preventive Services link for USPSTF website containing lactation services.
9/1/2017	1.26	Removal of Delaware Prescription Assistance Program (DPAP) policy. Program ended 8/31/2017.
9/1/2017	1.37.1.4	Removal of DPAP language, program ended 8/31/2017.
9/1/2017	9.0	Updated Appendix D, removal of DPAP from list of programs.
9/1/2017	1.22.1.5	Updated Third Party Liability billing instructions and policy in compliance with the Delaware Medicaid Enterprise System (DMES).
9/1/2017	4.0	Updated Third Party Liability billing instructions and policy in compliance with the Delaware Medicaid Enterprise System (DMES).
9/1/2017	10.0	Added resource code clarification
9/1/2017	11.0	Added coverage code effective and end date updates.
11/1/2017	13.0 Appendix H	Medical Necessity definition updated to align MCO contract language and DMAP policies.
3/15/2018	1.22.1.2.27 and 1.22.1.2.28	Lactation Counseling and Gender Dysphoria Disorder have been added to the list of covered services.
4/01/2018	1.13.6	Added Pharmacy Reimbursement policy and updated 340B Public Health Service Program policy to align with State Plan.
5/1/2018	1.13.6	Updated section numbering for 340B Public Health Service Program policy.

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01/01/2019	1.26	Added Delaware Prescription Assistance Program (DPAP) policy. Effective date 01/01/2019.
01/01/2019	1.37.1.4	Added DPAP language, effective 01/01/2019.
01/01/2019	9.0	Updated Appendix D, added DPAP to the list of programs.
01/01/2019	1.38.2.1	Updated Provider Enrollment Fee requirement in compliance with CMS guidelines.
01/01/2019	1.38.2.3	Updated High Risk Level Provider Enrollment requirements to include Medicare certification for DME providers and Medicare and/or accreditation for HHA providers.
01/01/2019	1.7.2.5.1	Updated Licensure/Certification requirement for HHA providers to include accreditation.
01/01/2019	All	Complete manual revision to align with the Delaware Medicaid Enterprise System (DMES) and the Delaware Medical Assistance Portal.
05/15/2019	20.1	Updated the Fiscal Agent street address.
08/01/2019	1.6.5	Added controlled substance prescribing and dispensing requirements in accordance with the Delaware Prescription Monitoring Act.
08/01/2019	6.0	Updated section 6.0 (4)(f) to align with DMES and the Delaware Medical Assistance Portal for Provider, Secure Correspondence.
08/01/2019	13.0	Updated definition for medical necessity in compliance with the State Plan.
11/15/2019	1.31	Section updated to align with the Lifespan Waiver Amendment.
12/1/2019	1.31	Clarifications added to align with the Lifespan Waiver Amendment effective July 1, 2017 and the renewal effective July 1, 2019.
12/1/2019	20.4	Updated contact information for the Division of Developmental Disabilities.
02/10/2020	All	In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.
02/10/2020	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.
09/01/2020	6.0	Section updated to announce new mailbox for the submission of Provider Enrollment Appeals.
09/01/2020	1.22.1.2.28	Added Lung Cancer Screening as a covered Medicaid Service.
09/15/2020	1.21.2.1	Prior Authorization Policy updated to require all prior authorization requests to be submitted via the DMAP Portal.
09/15/2020	8.0	Manual updated to remove Prior Authorization Forms to align with update to require portal submission.
11/01/2020	1.15.1	Section updated to remove the exclusion of dental services for members over twenty years of age to align with Adult Dental Program effective 10/01/2020.

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11/01/2020	7.0	Updated email address for SUR Unit Referrals.
11/01/2020	All	Updated the Fiscal Agent name from DXC Technology to Gainwell Technologies.
04/01/2021	1.35	Medicaid Credit Balance Report (MCBR) complete section revision in compliance with DMES updates to require all MCBRs to be submitted via the DMAP Provider Portal.
04/01/2021	14.0	Section 14.0 Appendix I removed in compliance with DMES Medicaid Credit Balance Report updates.
04/01/2021	15.0	Section 15.0 Appendix J removed in compliance with DMES Medicaid Credit Balance Report updates.
04/01/2021	16.0	Section 16.0 Appendix K removed in compliance with DMES Medicaid Credit Balance Report updates.
05/20/2021	1.22	Added new section regarding nutritional assessment, counseling, education, and intensive behavioral therapy to align with the State Plan and the United States Preventive Services Task Force (USPSTF) recommendations for Obesity Treatment and Intervention. Updated section numbering.
05/20/2021	2.1.10.2	Added new section regarding nutritional assessment, counseling, education, and intensive behavioral therapy to align with the State Plan and the United States Preventive Services Task Force (USPSTF) recommendations for Obesity Treatment and Intervention. Updated section numbering.
11/19/2021	2.1	Section updated to reflect coverage under the Adult Dental Program.
01/31/2022	1.38.2	Section updated in compliance with §42 CFR 438.602, §42 CFR Part 455, subparts B and E, and the 21st Century Cures Act to require enhanced screening and enrollment processes for all Managed Care Organizations and network providers.
05/25/2022	1.7.1.1	Updated with supervision requirements for dental services provided at teaching institutions, FQHCs, or other State-funded clinics.
06/24/2022	1.38.2.2.2	Additional screening and enrollment clarification added pertaining to prospective and revalidating providers of prosthetics, orthotics, and supplies.
06/24/2022	1.38.2.3.3	Additional screening and enrollment clarification added pertaining to prospective and revalidating providers of prosthetics, orthotics, and supplies.
10/14/2022	1.15.1	Section updated in alignment with the State Plan to cover drugs indicated for the treatment of obesity.
11/22/2022	1.38.2.2.1	Updated section to include the disclosure of changes related to permits, certifications, and accreditations.
11/22/2022	1.38.2.2.2	Additional screening and enrollment clarification for high-risk provider types that are not recognized by Medicare for enrollment.

Revision Date	Sections Revised	Description
11/22/2022	1.38.2.3.2	Updated section to include the disclosure of changes related to permits, certifications, and accreditations.
11/22/2022	1.38.2.3.3	Additional screening and enrollment clarification for high-risk provider types that are not recognized by Medicare for enrollment.
06/16/2023	1.7.1.1	Section updated in compliance with the Delaware State Plan.
07/01/2023	1.19, 1.19.1.2, 1.19.1.3, 1.19.2.1, 1.19.3, 6.0 Appendix A	Updated section to reflect the removal of paper claims information in compliance with DMES and electronic claims filing requirements.
07/01/2023	1.19.2.2, 1.19.4, 1.19.5, 1.19.6	Removed sections to reflect the removal of paper claims information in compliance with DMES and electronic claims filing requirements.
10/16/2023	1.21	Revised section numbering.
10/16/2023	1.21.7	Added prior authorization for a new Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial in compliance with CMS regulation.
10/16/2023	14.0	Added new Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial in compliance with CMS regulation.
12/12/2023	1.38.2.1	Section updated to provide additional policy clarification for institutional providers regarding provider enrollment application fee hardship exception requests.
12/20/2024	TOC section 1.34	Extended services for pregnant women (Smart Start) language removed in compliance with the Delaware State Plan.
12/20/2024	1.21.6.14	Extended services for pregnant women (Smart Start) language removed in compliance with the Delaware State Plan.
12/20/2024	1.34	Extended services for pregnant women (Smart Start) language removed in compliance with the Delaware State Plan.
12/20/2024	2.2	Section updated to remove premium language for the Delaware Healthy Children Program in compliance with the Delaware State Plan.
12/20/2024	2.2.1.7	Section updated to remove premium language for the Delaware Healthy Children Program in compliance with the Delaware State Plan.
12/20/2024	2.2.4.4	Section updated to remove premium language for the Delaware Healthy Children Program in compliance with the Delaware State Plan.
12/20/2024	2.1.10.2.19	Extended services for pregnant women (Smart Start) language removed in compliance with the Delaware State Plan.

DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

General Policy Manual

Table of Contents

1.0   General Information

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General Policy Manual

1.0   General Information

1.1   Introduction

1.1.1   Delaware Health and Social Services (DHSS) is designated as the single agency in Delaware responsible for the overall administration of Medicaid (Title XIX) and other medical assistance programs. This administrative responsibility is discharged at the operational level through the Delaware Medical Assistance Program (DMAP) of the Division of Medicaid & Medical Assistance (DMMA).

1.1.2   The Medicaid program was created by Title XIX of the Social Security Act "for the purpose of enabling each State...to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services."

1.1.3   The DMAP is funded by both State and Federal dollars. To receive funding, the DMAP must comply with rules that are issued by the Federal Government as Title 42 of the Code of Federal Regulations (42 CFR), Chapter IV, Subchapter C.

1.2   Provider Manual Updates

1.2.1   Provider Manual updates can be obtained through the [Delaware Medical Assistance Portal for Providers](), here after referred to as the [Provider Portal]().

1.2.1.1   The Delaware Medical Assistance Provider Portal contains the most current version of all Provider Manuals. The address for the Web site is https://medicaid.dhss.delaware.gov/. The Portal is available to any provider having access to the public Internet.

1.3   Medicaid Newsletter

1.3.1   Gainwell Technologies, in cooperation with the DMAP, produces and distributes a quarterly Medicaid Newsletter.

1.3.2   This newsletter is produced for providers of medical care enrolled in the DMAP. This forum is used to clarify present DMAP policy and to alert providers to any new policies.

1.3.3   Providers are urged to read this newsletter carefully. Providers may review DMAP newsletters via the Provider Portal.

1.3.3.1   To view the newsletter via the Provider Portal, providers can access the Provider Portal at https://medicaid.dhss.delaware.gov/.

1.3.4   Notification of policies and procedures through the newsletter is considered formal notification and the provider can be held accountable for information contained therein. Knowledge of DMAP policy by the provider is assumed once the newsletter has been posted to the Provider Portal.

1.4   State Agency

1.4.1   **The DMAP has two functional groups of employees.**

1.4.1.1   One group is the regional workers who determine eligibility for nursing home members, foster children, etc., through personal contact and interviews in local Division offices, nursing homes, applicants' homes and hospitals throughout the state.

1.4.1.2   The second group is the State Office Medicaid administrative staff. The administrative staff is responsible for on-going programs and policy issues to assure that the Medicaid programs meet required federal and/or state rules and regulations. These responsibilities include:

1.4.1.2.1   Development and maintenance of policy and procedures manuals.

1.4.1.2.2   Contractual agreements for enrollment of providers.

1.4.1.2.3   Determination of covered services.

1.4.1.2.4   Setting of fees for payment.

1.4.1.2.5   Monitoring the fiscal agent.

1.4.1.2.6   Auditing and performing utilization reviews of providers.

1.4.1.2.7   Imposition of provider sanctions.

1.4.1.2.8   Researching and evaluating new program alternatives.

1.4.1.2.9   Implementing new programs.

1.5   Fiscal Agent

    1.5.1   Gainwell Technologies is the fiscal agent for the DMAP. Gainwell Technologies is a claims processing company. General responsibilities of the fiscal agent are:

1.5.1.1   Receiving, processing, and paying claims submitted by enrolled providers of health care for services rendered to eligible members.

1.5.1.2   Maintaining the Point of Sale (POS) system, including adjudicating on-line claims and implementing the criteria established by the Drug Utilization Review (DUR) Board for prospective DUR.

1.5.1.3   Providing on-going provider relations such as receiving and responding to provider inquiries and for on-going communication and assistance to all providers.

1.5.1.4   Aiding providers in interpreting DMAP policies, procedures, and requirements.

1.5.1.5   Aiding providers in accessing current member eligibility, restrictions, and managed care enrollment through the Electronic Verification System and through Health Care Portal-based inquiry.

1.5.1.6   Providing accounting, statistical, and costing information to the DMAP.

1.5.1.7   Advising and assisting the DMAP in carrying out the provisions of the Program.

1.5.1.8   Supplying providers with Billing Manuals and receiving and reviewing DMAP enrollment applications from applicant providers.

1.5.1.9   Reserved

1.6   Provider Contractual/Programmatic Responsibilities

    1.6.1   A provider who signs a contract with the DMAP is responsible to meet certain conditions in order to remain an eligible provider and receive payment for services rendered. The provider must abide by the DMAP's policies and procedures, for example, including but not limited to:

- Directing members to the most appropriate, medically necessary, and cost-efficient care possible.

- Acceptance of final DMAP payment disposition as payment in full for Medicaid covered services; [therefore, providers cannot charge the member for any services reimbursable by the DMAP (refer to Billing DMAP Members section in this General Policy for exceptions)].

- Billing all other insurance resources or legally liable third parties prior to billing DMAP (unless under special arrangement as a managed care provider in which third party liability is accounted for in the capitated rate).

- Keeping records necessary to verify the services provided and permitting federal/state representatives access to the records.

- Determining that the member has valid Medical Assistance eligibility before rendering service and, if the member is enrolled in managed care, assuring that all necessary authorizations from the managed care organization are obtained prior to the delivery of services.

- Informing the member of any service that will not be covered by the DMAP prior to the delivery of the service.

- Making restitution for any overpayment promptly.

- Notifying the DMAP of any suspensions or exclusions from any program.

- Sending copies of professional license or certifications to Gainwell Technologies, the fiscal agent, whenever renewed or altered.

- Notifying Gainwell Technologies, in writing of any changes related to their Medicaid participation including but not limited to, changes in address or changes in group affiliation.

- Providers are responsible for using DMAP approved tamper resistant prescription pads (guidelines located

in Appendix N) or electronic prescription methods for all outpatient drugs unless you are prescribing for an institutional or group setting that does validate all medication and dispensed quantities.

- Generating only one prescription for medications that are covered by the DMMA.

1.6.2   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. State employees are prohibited from submitting claims on behalf of non-government providers.

Providers acknowledge that by submitting a claim to DMAP they certify the services were rendered prior to the submission of the claim.

1.6.3   Providers are required to abide by the following directive located in section 6032 of the Deficit Reduction Act of 2005 titled "Employee Education About False Claims Recovery". The provider is responsible for establishing written policies for all employees (including management), and any contractor or agent of the entity, that includes detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse if they receive or make payments under a state plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

Any entity is defined as a governmental agency, organization, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for–profit or not-for-profit, which receives or makes payments, under a State plan approved under title XIX or under any waiver of such plan.

Annually is defined as the Federal fiscal year (October 1 to September 30).

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the above directive applies if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims using one or more provider identification or tax identification numbers.

1.6.4   If the FDA has issued a consent decree to a drug or device manufacturer, Medicaid reserves the right to deny or recoup payment when the FDA subsequently determines that the drug or device manufacturer is in violation of the settlement agreement. Providers who use a drug or device covered under an FDA consent decree must maintain a copy of the appropriate Certificate of Medical Necessity (CMN) on file to justify the medical necessity of the product. CMNs must be made immediately available to the DMAP upon request. The DMAP accepts no liability for a provider's misuse of a drug or device covered under an FDA consent decree.

1.6.5   In accordance with the Delaware Prescription Monitoring Act, all DMAP providers must comply with the [Delaware Prescription Monitoring Program](#) (PMP) when generating a prescription for a controlled substance for a DMAP member. Providers are required to review the member's patient utilization report. The query should include Delaware and all of the surrounding states; New Jersey, Pennsylvania and Maryland. For medications that are Drug Enforcement Agency (DEA) Schedule III-V, the PMP website should be queried at least every six months. For Schedule II medications that are prescribed for chronic conditions, the PMP website should be queried every three months. DMAP requires providers to document in the patient record all controlled substances that have been prescribed and filled inside and outside of the provider's practice. Providers must document all actions taken to collaborate with other clinicians prescribing controlled substances in the patient record in regards to mutual patients.

1.6.6   Effective July 1, 2011 section 2702 of the Affordable Care Act prohibits states from paying for any medical care directly related to provider –preventable conditions (PPC). Provider-preventable conditions are defined as medical conditions, occurring in any healthcare setting, which could have reasonably been prevented through the application of evidence-based guidelines. PPCs apply to both inpatient hospital-acquired conditions (HAC) and other provider-preventable conditions (OPPC). Provider-preventable conditions are not covered services, and the DMAP cannot

make payments or will recover payment for services related to provider-preventable conditions. Delaware considers the following conditions to be Hospital Acquired Conditions when occurring in an inpatient or outpatient setting:

1. Foreign Object Retained After Surgery

2. Air Embolism

3. Blood Incompatibility

4. Stage III and IV Pressure Ulcers

5. Falls and Trauma

    - Fractures

    - Dislocations

    - Intracranial Injuries

    - Crushing Injuries

    - Burns

    - Electric Shock

6. Manifestations of Poor Glycemic Control

    - Diabetic Ketoacidosis

    - Nonketotic Hyperosmolar Coma

    - Hypoglycemic Coma

    - Secondary Diabetes with Ketoacidosis

    - Secondary Diabetes with Hyperosmolarity

7. Catheter-Associated Urinary Tract Infection (UTI)

8. Vascular Catheter-Associated Infection

9. Surgical Site Infection Following:

    - Coronary Artery Bypass Graft (CABG) – Mediastinitis

    - Bariatric Surgery

    - Laparoscopic Gastric Bypass

    - Gastroenterostomy

    - Laparoscopic Gastric Restrictive Surgery

- Orthopedic Procedures

- Spine

- Neck

- Shoulder

- Elbow

Other Provider-Preventable Conditions include:

1. Wrong surgical or other invasive procedure performed on a patient;

2. Surgical or other invasive surgery performed on the wrong body part;

3. Surgical or other invasive procedure performed on the wrong patient.

NOTE: No reduction in payment for a provider-preventable condition will be imposed where it has been determined that the condition for a particular patient existed prior to the initiation of treatment by that provider. Providers are required to identify and report provider-preventable conditions through the claims process (whether fee-for-service or managed care), even where the billed or paid amount may be zero.

1.7   Licensure/Certification

1.7.1   All providers who are enrolled with the DMAP must be professionally and properly licensed and/or certified, in accordance with the federal and state laws in the state in which they are located. The provider type must match the State licensing category.

1.7.1.1   Dental services provided at teaching institutions, FQHCs, or other State-funded clinics, including the Department of Public Health, must be furnished by or under the supervision of a DMAP-enrolled dentist and comply with the rules and regulations of the Board of Dentistry and Dental Hygiene, and state and federal laws.

1.7.2   In addition, the following providers must meet the requirements for participation in Medicare (Title XVIII) as evidenced by certification from the Division of Public Health Office of Health Facilities Licensure and Certification:

1.7.2.1   Inpatient and Outpatient Hospitals

1.7.2.2   Rehabilitation Agencies

1.7.2.3   Independent Laboratories

1.7.2.4   Hospice Organizations

1.7.2.5   Home Health Agencies must possess current Medicare certification and / or accreditation from one of the accreditation agencies as provided by the National Association for Home Care & Hospice.

1.7.2.6   Certified Physical Rehabilitation Units of an Acute Care Hospital

1.7.2.7   Ambulatory Surgical Centers/Free Standing Surgical Centers

1.7.2.8   Renal Care Centers

1.7.2.9   Prescribed Pediatric Extended Care (PPEC)

1.7.3   Long term care facilities are certified by the Division of Health Care Quality. The Division of Health Care Quality uses Medicare/Medicaid/State criteria to determine if facilities are eligible to participate in the DMAP. The DMAP does not require a long term care facility to be enrolled with Medicare as a condition for Medicaid enrollment.

1.7.4   With the exception of behavioral health services provided through a Managed Care Organization (MCO), mental health clinic services shall be rendered only by providers who have been certified by the Division of Substance Abuse and Mental Health (DSAMH) of DHSS.

1.7.5   Ambulance companies located in Delaware must be certified in accordance with the State Fire Prevention Commission (Title 16, Del. Code, Chapter 67). Ambulance companies located outside of Delaware must be properly licensed and certified by the State in which they are located.

1.7.6   Failure to be certified and properly licensed at the time service was provided may result in penalties and denial of payment by the DMAP.

1.7.7   Each provider is responsible for sending a copy of its license/certification renewal to Gainwell Technologies. If the

new license/recertification has not been received on or prior to the expiration date of the prior license/certification, all payments will be held until the current copy is received and the provider file is updated.

1.8   Freedom of Choice

1.8.1   "Fee for service" providers have the freedom of choice to serve, or not serve, any DMAP individual they wish, as long as their refusal to provide a service is not on the basis of discrimination or a violation of the Delaware Patient Bill of Rights or any other DMAP policy. "Fee for service" reimbursement is the traditional health care payment system, under which physicians and other providers charge for each unit of service they provide. By signing the contract, the provider has agreed to comply with all the terms, requirements and provisions of the Civil Rights Act of 1964, the Rehabilitation Act of 1973 and any other Federal, state, local or any other anti-discriminatory act, law, in the policy along with all amendments and revision of these laws, and will not discriminate against any applicant, employee, or service member because of race, creed, religion, age, sex, color, national or ethnic origin, handicap, or any other discriminatory basis or criteria.

1.8.2   Members who are neither restricted nor enrolled in the Diamond State Health Plan (DSHP) also have this same privilege regarding the provider of their medical services. They may choose whomever they wish to provide the medical care they need as long as the provider they choose is enrolled with the DMAP.

1.8.3   Members who have private accessible managed care/HMO must comply with the rules of their private insurance. The DMAP will not pay for services that are denied by the private managed care/HMO for reasons related to the insured's failure to comply with the policy's procedures.

1.8.4   Members who are enrolled in the DSHP and Delaware Healthy Children Program (DHCP) may disenroll during the yearly open enrollment/unenrollment period and choose another managed care organization (MCO) to provide their medical care. Once enrolled in an MCO, the member and provider must also abide by the rules of that program as well as DMAP rules.

1.9   Authorized Access to Information

1.9.1   Information concerning any DMAP member must be kept
               strictly confidential from non-DMAP authorities. At a
               minimum, the following information must be safeguarded:

1.9.1.1   Names and addresses

1.9.1.2   Medical services provided

1.9.1.3   Social and economic conditions or circumstances

1.9.1.4   Agency evaluation of personal information

1.9.1.5   Medical data, including diagnosis and past history of disease or disability

1.9.2   The DMAP and its authorized representatives have the right
               to access any information directly related to the administration
               of the Delaware Medical Assistance Program. This is a
               contractual obligation of the provider. Also, at the time of
               application, members sign the following statement:

1.9.2.1   "I agree to allow Delaware Health and Social Services, directly or through
            its agents, or the Diamond State Health Plan, or the Delaware Healthy
            Children program, to have access to all medical and school-based health
            and related services records of every member of my household who is
            eligible for medical assistance in order to administer the Medical
            Assistance Program, coordinate care, determine medical necessity, and
            evaluate or pay for pending or incurred medical services."

1.9.3   When additional information is required in order to make a
               payment decision it is the responsibility of the provider of the
               service to forward the requested documents at no cost to the
               DMAP or its designated representatives.

1.10   Fraud or Abuse Reporting

1.10.1   Information about any member or provider suspected of
               possible DMAP abuse or fraud should be directed to the
               Surveillance and Utilization Review (SUR) Unit. In addition to
               the link providers may also refer to the Index in the back of
               this manual for the address, telephone and fax number to the
               DMAP State office. All information will be considered
               confidential. Anonymous referrals are also accepted.
               Providers may copy and use the Referral Form found in
               Appendix B.

1.10.2   A copy of Delaware Social Services' Reporting DMAP
                Member Fraud and Abuse pamphlet is found in Appendix D of
                this manual.

1.10.3   **Definition and Examples of Fraud and Abuse**

1.10.3.1   Fraud is the intentional attempt to obtain or provide services for which the
            member is not entitled.

1.10.3.2   Abuse is an attempt to obtain or provide services that are not medically
            necessary. Abuse may also include issues regarding quality of service.

Examples of:	Fraud	Abuse
For Members	1) Lending a medical assistance card 2) Altering a medical assistance card 3) Altering a prescription 4) Sharing medication	1) Consistent use of emergency room for non-emergency services 2) Excessive use of controlled substances 3) Seeing multiple doctors without medical need
For Providers	1) Billing the DMAP for services not provided, redefining/misusing procedure codes; dispensing units not medically necessary; etc. 2) Billing for "MAC" (or "FUL") overrides when not properly documented. 3) Generating prescriptions in a quantity intended to permit the sharing of medication. The amount prescribed should be appropriate for a single DMMA member's use only.	1) Directing members to the emergency room or other services when not medically necessary 2) Complaints regarding quality of service

1.10.4   DMMA requires that providers take due caution to protect
                prescription blanks from being misused. Providers who have
                prescription blanks missing should follow the reporting
                guidelines of both the Medical Board and the Board of
                Pharmacy. As of October 1, 2007, all written prescriptions
                need to be on tamper resistant paper. Refer to Appendix N.

1.11   Provider Review/Audits

1.11.1   All DMAP providers are subject to routine review and/or audit by authorized representatives of the DMAP such as, but not limited to, the DMAP Surveillance and Utilization Review (SUR) staff, the Medicaid or Independent Professional Review Team, Utilization Review Team, DMAP Fraud Control Unit, or independent audit firms.

1.11.2   Such reviews and audits are conducted to determine the accuracy and propriety of provider billings, compliance with Program policy and procedures, quality of care, and utilization of services. By contract, providers agree to allow the authorized representatives access to all requested financial and medical records as appropriate including private pay records. The representatives are also permitted to reproduce records as they deem appropriate.

1.11.3   The DMAP may seek to exclude from the Program any provider whom it determines has abused the Program or suspend it for fraudulent activities. The DMAP must also suspend from the Program any party who has been convicted of a Program-related crime whenever the federal authority directs such action. Medicaid fraud legislation exists which allows for various penalties due to infractions committed by providers.

1.11.4   The Program can impose other restrictions on providers found responsible for less severe infractions against the Program. Such restrictions include, but are not limited to:

- The requirement of approval prior to the submission of claims.

- The withholding of reimbursements.

- The recoupment of overpayment.

1.11.5   The Program affords all providers certain appeal rights for adverse actions taken by the Program. The process is described in Appendix A.

1.11.6   The program is mandated to withhold the Federal share of Medicaid payments to a provider if the provider has been determined by CMS to have a Medicare overpayment that has not yet been settled or has failed to provide information necessary to determine the amount of the overpayments. The intent of the regulation at 42 C.F.R. § 447.30 is to facilitate the recovery of Medicare overpayments.

1.12   General Documentation Requirements

1.12.1   In addition to the documentation requirements addressed in the Provider Specific Policy Manuals, it is the responsibility of all providers to maintain documentation for each Medicaid member that substantiates the medical necessity of all services provided. At a minimum, providers must maintain the following documentation for all claims billed to the DMAP as mandated by CMS in section 2500.2 of the State Medicaid Manual:

- A diagnosis that is consistent with the service billed

- Date of service

- Name of member

- Medicaid identification number

- Name of providing agency

- Name of person providing the service

- Nature, extent, units and place of service

It is also the responsibility of providers to maintain documentation for each Medicaid member that substantiates the medical necessity of each service billed. In addition to the minimum documentation requirements addressed above, there may be other documentation requirements specific to certain services. These requirements are described in the Provider Specific Policy Manuals.

1.13   Reimbursement and Provider Charges

1.13.1   All providers, unless otherwise noted in this manual, must bill the DMAP using their usual and customary (U&C) charges or, when specified in the Provider Specific Policy Manual, prospective rates established on a contractual basis with the DMAP.

1.13.2   The DMAP will reimburse the lower of the provider's U&C or the prospectively determined rate, unless federal policy proscribes that a particular rate or payment amount be used, in which case the federal policy will govern the payment. Specific methods of charging the DMAP are addressed in the subsequent sections of this manual. The provider must inform the DMAP of payments from any other source for the same services for which the provider is billing the DMAP.

1.13.3   The DMAP reimburses non-institutional out-of-state services for those individuals not covered under a managed care plan as follows: Services provided out-of-state, for which Delaware has established a universal rate or cap, will be reimbursed at

the provider's usual and customary charge or Delaware's rate/cap, whichever is lower. Where there is no established rate or cap (i.e., providers are paid a provider-specific rate/cap), the DMAP will establish a rate or cap that is consistent with its reimbursement methodology for the specific service.

1.13.4   All DMAP managed care organizations will receive a monthly capitated rate for each enrolled member. A rate will be prospectively determined by DMAP for each eligibility category. The managed care organization is responsible for reimbursing the provider for services given to an enrolled member. All services covered by the DMAP, but not included in the managed care basic benefit package, will be reimbursed directly to the provider by the DMAP according to the policy for that service.

1.13.5   As required by Section 6505 of the Affordable Care Act, DMAP will not make any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

1.13.6   **Pharmaceutical Reimbursement**

1.13.6.1   DMAP will reimburse pharmaceuticals using the lower of the following:

- The usual and customary (U&C) charge to the general public for the product,

- Actual Acquisition Cost (ACA),

- National Average Drug Acquisition Cost (NADAC),

- Wholesale Acquisition Cost (WAC),

    o   WAC for legend

    o   WAC minus 2% for non-legend, or

- Delaware Maximum Allowable Cost.

1.13.6.2   DMAP will meet the reimbursement of the Federal Upper Limit (FUL) defined drugs in the aggregate by reviewing that the NADAC does not exceed the FUL levels.

1.13.6.3   The Drug Reimbursement Methodology for establishing the lower of the Usual and Customary (U&C) or Actual Acquisition Cost (AAC) is provided in the table below:

Category	Ingredient Cost	Professional Dispensing Fee
Brand Drug	NADAC	$10
Generic Drug	NADAC	$10
Drugs without NADAC	WAC for legend and WAC -2% for non-legend; or a Delaware Maximum Allowable Cost, whichever is lower	$10
340B Purchased Drug	AAC for dispensed drugs	$10
	AAC for physician administered drugs	$0
Contract 340B Pharmacy	Drugs acquired through the Federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered.	N/A
Drugs purchased by 340B entities enrolled with DMMA as utilizing public health service products, which based on specific conditions, must purchase drugs outside of the 340B inventory when that drug is not available or eligible for 340B purchase.	NADAC	$10
Federal Supply Schedule	AAC	$10
Drugs Acquired at Nominal Price	AAC	$10
Specialty Drugs-Mailed	AAC (Invoice price)	$27
Drug Not Dispensed by Retail Pharmacy	NADAC or WAC, whichever is lower	$10
Physician Administered Drugs	AAC based on invoice price if maximum unit cost is greater than or equal to $50. For drugs where the maximum cost is less than $50, the cost will be based on direct price or Average Selling Price plus 6%.	N/A
Clotting Factor	AAC (Invoice Price)	$27
Investigational Drugs (when prior authorized; as a general rule not covered product)	AAC	$10

1.13.6.4   Public Health Service 340B Drug Discount Program

Section 340B of the Public Health Services (PHS) Act Program was established under Section 602 of the Veteran Health Care Act of 1992. The Affordable Care Act of 2010 provides greater access to services under the 340B Program while containing health cost.

1.13.6.4.1   Entities that purchase Section 340B of the Public Health Service Act Program products must request to use these drugs for all DMAP patients

including Medicaid fee-for-service patients and for patients whose care is covered by Medicaid Managed Care Organizations.

1.13.6.4.2   Providers must adhere to DMAP's registration process in order to dispense 340B Public Health Service Act Program products. To obtain approval to use 340B PHS products, providers must satisfy the following requirements.

- Attest to using 340B PHS products for all DMAP members regardless of the payer.

- Attest to submitting 340B PHS related claims with an amount due that does not exceed your organization's Usual and Customary Cost (U&C) or that which is billed to a cash paying customer.

- Submit letters of petition indicating intent and attestations to use 340B PHS products to:

        Division of Medicaid and Medical Assistance
        Attention: Pharmacy Director
        Herman Holloway Campus, Lewis Building
        1901 N. DuPont Highway
        New Castle, DE 19720

- Submit invoices on a bi-annual basis. Invoices that reflect purchases from January through June should indicate the purchase price of the top 25 most expensive medications. The definition of 'most' in this situation will be based on an individual dose. Invoices for July through December should reflect the purchase price for the top 25 medication as defined by the frequency of use.

- Invoices must be sent within 30 days of the end of the biannual period to the Surveillance Utilization and Review Unit.

- Claims submitted to the Managed Care Organization will need to reflect the discount at which your organization purchases the product. DMAP will ensure against collecting duplicate rebates such that the loss of any potential manufacturer rebates is addressed by a reduction in costs to the agency.

- Provide the NPI of the entity that will be the performing provider.

1.13.6.4.3   All requests for inclusion of the use of 340B products will be reviewed and a response in writing will be provided within 30 days of the receipt of the request. Approvals will be based on the effective date which reflects the start of the next federally defined rebate quarter.

1.13.6.4.4   Providers approved by the DMMA Pharmacy Director to participate in the 340B PHS Program may dispense related products.

1.13.6.4.5   Claims that were not submitted with an average cost, based acquisition cost, or lower, on the invoice review will be adjusted.

1.13.6.4.6   Reimbursement for DMAP claims, for both clinically administered outpatient medications and dispensed prescriptions will be based on the actual acquisition cost.

1.13.6.4.7   There is a one-time professional dispensing fee per thirty (30) day period unless the class of drugs is routinely prescribed for a limited number of days.

1.13.6.4.8   Definitions
Delaware Maximum Allowable Cost (DMAC): the maximum price set for reimbursement.

- When a single source product has Average Sales Prices provided by the manufacturer that indicates the WAC is exaggerated,

- When the NADAC does not reflect the most current cost of a multiple source drug, or

- If a single provider agrees to a special price.

1.13.7   Entities that purchase Section 340B of the Public Health Service Act products must request to use these drugs for DMAP patients directly for Fee-for-Service and through coverage of the Managed Care Organizations. DMAP reserves the right to disseminate the guidelines to address issues related to reimbursement and rebates on a case by case basis.

1.14   Services-Medical Necessity

1.14.1   DMAP payments are predicated on the understanding that all services provided are medically necessary.

1.14.2   All providers have the ethical and programmatic responsibility to direct members to the most appropriate, medically necessary and cost-efficient care possible. Where it has been

determined that any service provided to a DMAP member was deemed not to be medically necessary, suspended claims will be denied and paid claims will be voided.

1.14.2.1   This policy applies to all providers and services, and supersedes whether Medicare or another primary carrier has paid benefits for the service. Although Medicaid normally pays an amount equal to part or all of the Part B deductible and/or coinsurance amounts remaining after Medicare has paid, these amounts are not reimbursable by Medicaid when the services are medically unjustified.

1.14.3   Providers may not bill DMAP members for the denied or voided services. Because the DMAP would have made payment if the services had been necessary, members are not liable for these non-covered and non-reimbursable services. An exception to this prohibition on billing members is made in one specific instance as it relates to restricted members. When a restricted member chooses to see an unauthorized provider for non-emergency services for which the DMAP refused payment, the member is liable for payment even if the service is determined to be medically necessary.

1.14.4   The DMAP definition of medical necessity is found in Appendix H of this manual.

1.15   Non-Covered Services

1.15.1   Some services are generally not covered by the DMAP except if covered by Medicare or are in a managed care organization's benefit package. These services include, but are not limited to:

- Services which are not medically justified.

- Vaccines required for travel outside the United States.

- Cosmetic surgical procedures and treatment. The DMAP does not reimburse any provider for any services related to cosmetic treatment/procedures or plastic surgery services. Cosmetic services are defined as beautification or aesthetic procedures, surgery, drugs, etc. designed to improve the appearance of an individual's physical characteristic that are within the broad range of normal, by surgical alteration or other means.

- Procedures (other than those transplants covered by

transplant criteria) designated as experimental by the Medicare program.

- Services denied by Medicare as not medically necessary.

- Drugs dispensed by the practitioner. However, oral abortive agents that meet the federal abortion criteria are covered when administered by a practitioner.

- Autopsies.

- Routine eye care and/or corrective lenses (except aphakic or bandage lenses necessary after cataract surgery) for persons twenty-one years of age and over.

- Hearing aids for individuals twenty-one years of age and over.

- Social services.

- Pharmaceuticals not covered include: DESI drugs, drugs used for cosmetic purposes, fertility drugs, drugs used in the treatment of sexual dysfunction, investigational drugs and compound prescriptions (without at least one entity).

- Infertility related services. The DMAP does not cover any services related solely to the treatment of infertility. Examples of these non-covered services include drug therapy, surgical procedures, laboratory testing, radiology services, hospital services and physician services.

- Podiatric services. The DMAP will pay for routine foot care ONLY for members who are diagnosed as having diabetes or circulatory/vascular disorders.

- Respite care (except when provided as a service through a HCBS waiver program).

- Prescriptions not generated by a DMAP provider may not be honored except in cases of emergency where the member is out of the region. DMAP will only cover the cost of medical care that is either provided by or initiated by a practitioner enrolled in the program.

1.16   Billing DMAP Members

1.16.1   The DMAP and federal regulations generally do not permit providers to bill Medicaid members for medical services. However, the provider may bill the patient if one of the following instances occur:

1.16.1.1   If the person was not eligible for DMAP coverage on the date of service.

1.16.1.2   If the service is "not covered" by the DMAP OR if the service is not medically necessary, AND if it is documented that the member is informed prior to the delivery of the service that DMAP will not make payment AND the member still elects to receive the service. A "not covered" service is a service not provided for as a benefit of the DMAP.

1.16.1.3   If the service is considered "medically unnecessary" by the DMAP AND if it is documented that the member is informed prior to the delivery of the service that the DMAP will not make payment AND the member still elects to receive the service.

1.16.1.4   Reserved

1.16.1.5   If the provider does not accept DMAP as a general practice or only accepts it in specific instances AND if it is documented that the DMAP member is informed prior to the delivery of the service.

1.16.1.6   If a medical service provided to a restricted member is denied because proper notification was not given to and approved by the Medicaid Office (refer to Restricted Member section of this General Policy) OR a verifiable emergency did not exist as determined by the DMAP.

1.16.1.7   If a managed care member went to a non-managed care DMAP provider for service included in the managed care service package AND it is documented that the member was informed prior to the delivery of service that the DMAP would not make payment AND the member still elected to receive the service.

1.16.1.8   If a member is "non-cooperative" in providing a valid Medical Assistance card, other insurance information, and signed insurance forms (where the member is the policy-holder), or other information vital, necessary, and related to payment of the provided service.

                IMPORTANT "Non-cooperative" is defined as the member's willful disregard and intentional refusal to cooperate in providing necessary

billing related information to the provider. This policy does not permit providers to bill members indiscriminately, rather only in cases of documented non-cooperation, and the burden of proof lies with the provider. A provider's administrative error, careless bookkeeping practices, or inability to reach a member by phone, etc. does not constitute non-cooperation by the member.

1.16.1.9   Some nursing home and waiver members may be required to contribute toward their cost of care. The Medicaid agency will establish any liability and notify the provider as to the amount it may bill the member. The nursing home or waiver provider should never bill a member without Medicaid authorization.

1.16.1.10   If the member receives a prescription drug or prescribed over-the-counter product from a pharmacy provider and is not excluded from responsibility for co-payment. Refer to the Pharmacy Provider Specific Policy Manual for additional information.

1.16.2   Whenever possible, documentation should be retained in the patient's file which substantiates the fact that the provider informed the member of his/her responsibility for payment.

1.17   Fee for Copying Member Records/Administrative Cost (including Prior Authorization Forms)

The DMAP considers general administrative activities related to a DMAP covered service or to the on-going health care maintenance of the member to be a routine part of a provider's business. Examples of such activities include copying or transferring member records or completing prior authorization forms. Reimbursement for these types of activities is included in the rates paid to providers by DMAP.

Therefore, the provider is prohibited from billing any such activity separately to a DMAP member when the activity is done to support either 1) the on-going health care maintenance of the DMAP member, or 2) a DMAP covered service. However, if the purpose is not directly related to the member's on-going health care maintenance or to a DMAP covered service and it conforms with the provider's policy to charge all customers for this activity, then the provider is permitted to bill the member. The provider shall advise the member in advance of this separate charge.

Under no circumstance is the provider allowed to bill such activity as a separate charge to the DMAP.

Note: The guide below is intended to assist providers in determining if the member can be billed for administrative activities such as copying or transferring records or for the completion of prior authorization forms. The examples are not limited to those listed:

Example	Is the provider permitted to bill DMAP members for administrative activities?	
	Yes	**No**
Copying or transferring records if the member changes their PCP within the Medicaid or MCO network		The activity supports the on-going health care of the member
Copying records for the member's personal use (e.g., recreational participation, educational purposes, etc.)	The activity does not support the maintenance of the member's health care; charge must conform with the provider's policy regarding charging all patients	
Copying records if the member relocates and is no longer using providers in the Medicaid or MCO network		The activity supports the on-going health care of the member
Copying records if the member has been referred by the practitioner to a specialist		The activity supports the on-going health care of the member
Copying medical records requested for the member's personal legal proceedings	The activity does not support the maintenance of the member's health care; charge must conform with the provider's policy regarding charging all patients	
If the medical service requires the completion of a prior authorization form		The activity supports the on-going health care of the member

1.18   Newborn ID Number

1.18.1   Each Medicaid member is assigned a unique Medical Assistance ID number when determined eligible for Medicaid.

1.18.2   In cases of newborns, the DMAP cannot assign a number until the mother completes an application for Medicaid on behalf of the child. Providers cannot submit claims for newborns until the ID number has been assigned. *Do not submit claims for newborns using the mother's Medical Assistance ID number.*

1.19   Claims Submission-Timeliness

1.19.1   It is a federal requirement that claims to DMAP be submitted no later than twelve months from the date of service. If the claim has not been submitted within twelve months from the date of service, the claim will be denied unless one of the following circumstances is met:

1.19.1.1   A Medicaid/Medicare claim, or a claim for a member covered by other insurance which has been submitted to Medicare or the primary carrier in a timely manner, will be considered for DMAP payment up to six months after the provider receives notice of the disposition of the claim, even if it is received by DMAP more than twelve months after the date of service.

1.19.1.2   The POS-DUR pharmacy claim must be submitted within one hundred days of the date of service.

1.19.1.3   Claims for services to persons who are eligible for retroactive Medicaid may not be able to be submitted within twelve months of the date of service. If a member is determined to be eligible for retroactive Medicaid, one of the following must be uploaded to all claim submissions to document retroactive eligibility:

1.19.1.3.1   Nursing home providers must attach a copy of the patient's budget sheet indicating a retroactive effective date.

1.19.1.3.2   All other providers must attach a copy of the Retroactive Notification.

1.19.1.4   Claims voided as a result of a fraud or abuse investigation may be resubmitted within six months of the date the claim was voided by DMMA. A letter from the Division of Medicaid & Medical Assistance DMAP S/UR Unit must be attached to document the waiving of timely filing requirement.

1.19.1.5   Claims submitted in accordance with a court order, a hearing decision, or an agency corrective action may not be able to be submitted within twelve months of the date of service. A letter from the appropriate authority must be attached to document the waiving of timely filing requirements.

          1.19.2   Claims that do not meet one of the above five criteria that have been submitted to the DMAP for payment within twelve months from the date of service but have not been paid within twelve months of the date of service will be considered for payment if the initial submission can be documented and the submission date is within 24 months of the date of service. Acceptable documentation includes:

1.19.2.1   The claim number in the note section of the claim or uploaded to the Remittance Advice (RA) that documents that the claim was submitted within one year from the date of service.

1.19.2.2   A letter from the Out-of-State Medical Assistance Coordinator which documents the date of receipt of the claim by the Division of Medicaid & Medical Assistance.

          1.19.3   A claim that has been paid may be adjusted up to two years from the date of service.

1.20   Procedure Codes

          1.20.1   **CPT$^®$/HCPCS Codes**

1.20.1.1   The DMAP uses CPT$^®$/HCPCS procedure codes as its listing of descriptive terms and identifying codes for reporting medical services and procedures performed by practitioners. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical, and diagnostic services.

1.20.1.2   The two levels of HCPCS are:

1.20.1.2.1   Level I is made up of those codes listed in the CPT$^®$ book which is published by the American Medical Association. These procedure codes are revised and updated on an annual basis. Providers are urged to purchase the CPT$^®$ book and to replace their book each year. Books may be purchased from https://commerce.ama-assn.org/store/ or by mail from:

> American Medical Association
> PO Box 74008935
> Chicago, IL 60674-8935

1.20.1.2.2   Level II is made up of nationally assigned procedure codes listed in the HCPCS book that begin with a letter from A – V followed by four numbers. Providers are urged to purchase the HCPCS book and to replace their book each year. Books may be purchased from https://commerce.ama-assn.org/store/ or by mail from:

> American Medical Association
>
> Order Department
>
> P.O. Box 930876
>
> Atlanta, GA 31193-0876

1.20.1.3   Providers are never to redefine CPT®/HCPCS procedure codes to meet their needs.

1.20.1.4   Providers are reminded to choose their CPT®/HCPCS procedure codes carefully with the following cautions in mind:

1.20.1.4.1   Do not use multiple procedure codes when a single procedure code accurately describes the services rendered.

1.20.1.4.2   Some codes specify bilateral or unilateral. Be sure to utilize a code that correctly indicates this factor.

1.20.1.5   The practice of creating a one-page "summary" of Medicaid procedure codes which is passed from billing clerk to billing clerk is strongly discouraged. This practice often leads to improper billing, delayed payments, confusing correspondence and improper payments.

1.20.1.6   The level of service billed must correspond to the definition of that particular code rather than the expected reimbursement amount. The provider must also maintain the documentation required supporting the level of service billed.

1.20.1.7   Even though the DMAP uses CPT®/HCPCS procedure codes as its instrument in facilitating payment to providers, this does not mean that Medicaid covers all CPT®/HCPCS procedure codes.

1.20.2   ICD-10 CM

1.20.2.1   The DMAP uses ICD-10 CM procedure codes as its listing of descriptive terms and identifying codes for reporting medical services and

procedures in an inpatient hospital setting. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical and diagnostic services.

1.20.2.2   Hospital providers are urged to purchase the ICD-10 CM book and to replace their book each year. Books may be purchased from https://commerce.ama-assn.org/store/ or by mail from:

> MEDICODE
>
> 5225 Wiley Post Way, Suite 500
>
> Salt Lake City, UT 84116
>
> Telephone #: (801) 536-1000
>
> Fax #: (801) 536-1011

1.20.2.3   Providers are never to redefine ICD-10 CM procedure codes to meet their needs.

1.20.2.4   Even though the DMAP uses ICD-10 CM procedure codes as its instrument in facilitating payment to inpatient hospital providers this does not mean that the DMAP covers all ICD-10 CM procedure codes.

1.20.2.5   Providers must maintain documentation supporting the code billed.

1.20.3   CDT Procedure Codes

1.20.3.1   The DMAP uses CDT procedure codes as its listing of descriptive terms and identifying codes for reporting dental services and procedures.

1.20.3.2   Dental providers are urged to purchase the most recent version of the CDT procedure code book and to replace their book whenever it is updated by the American Dental Association. Books may be purchased from the American Dental Association website.

> American Dental Association
>
> 211 East Chicago Avenue
>
> Chicago, IL 60611
>
> 312.440.2500

1.20.3.3   Providers are never to redefine CDT procedure codes to meet their needs.

1.20.3.4   Current Dental Terminology, (CDT) (including procedure codes,
                  definitions (descriptors), and other data) is copyrighted by the American
                  Dental Association. All rights reserved. Applicable FARS/DFARS apply.

1.20.3.5   Providers must maintain documentation supporting the code billed.

1.21   Prior Authorization

    1.21.1   The Social Security Act at Section 1902(a)(30)(A) permits the
                  DMAP to require prior authorization.

    1.21.2   Providers must obtain prior authorization from the DMAP
                  before initiating the service. The DMAP will deny payment for
                  services that require prior authorization yet are initiated
                  before DMAP approval except as specified in section 1.21.3.

1.21.2.1   To start the Prior Authorization process, a DMAP Prior Authorization
                  request must be submitted via the [DMAP Portal](#).

    1.21.3   Authorization may be granted after the service has been
                  provided in the following circumstances. All other
                  requirements for prior authorization of the service apply.

1.21.3.1   The service has been denied by Medicare or other insurance and the
                  reason for the denial is documented on the EOB.

1.21.3.1.1   The DMAP does not cover services denied by Medicare as not medically
                  necessary and will not authorize these services.

1.21.3.2   The provider was recently enrolled as an out-of-state or out-of-region
                  provider and was required to provide a service to a Medicaid member
                  prior to enrollment.

1.21.3.3   The member has been determined to be eligible for retroactive Medicaid.

1.21.3.4   The member has an urgent medical need for the service defined as:

1.21.3.4.1   A delay in service provision of three business days from the date the
                  rendering provider initiates or receives the order for the service would
                  place the health of the member in serious jeopardy OR

1.21.3.4.2   A delay in service provision of three business days from the date the
              rendering provider initiates or receives the order for the service would
              result in institutionalization of the member or prevent discharge of the
              member from an institution.

        1.21.4   The DMAP must approve the treatment plan and services
                      before the provider receives payment for urgent medical
                      services provided prior to obtaining authorization.

        1.21.5   Within one business day of the provision of the service,
                      providers requesting authorization for urgent medical services
                      provided prior to obtaining authorization must submit:

1.21.5.1   All documentation normally required for the service being authorized and

1.21.5.2   Patient history/treatment notes that document the urgent nature of the
            patient's condition or the necessity of the service to prevent
            institutionalization or to prevent a delay in discharge of the member from
            an institution. If the urgent medical need for the service is not
            substantiated, authorization of the service will be denied and no payment
            will be made.

1.21.5.3   Providers should designate the request as Urgent.

        1.21.6   The following services require prior authorization. The list
                      reflects the major categories of services that require prior
                      authorization but is not all-inclusive. Refer to your provider
                      specific policy manual for complete information on services
                      requiring prior authorization. Refer to the designated provider-
                      specific policy manuals for specific information required to
                      support the prior authorization request for the services listed
                      below. Prior authorization is not required if Medicare has paid
                      for the service.

1.21.6.1   Private Duty Nursing Services– Refer to the Private Duty Nursing
            Provider Specific Policy Manual.

1.21.6.2   Pharmaceuticals – Certain pharmaceuticals require prior authorization.
            Refer to the Pharmacy Provider Specific Policy Manual.

1.21.6.3   Prescribed Pediatric Extended Care (PPEC) – Refer to the Prescribed
            Pediatric Extended Care Program Provider Specific Policy Manual.

1.21.6.4   Transplants – Refer to the Inpatient Hospital or Practitioner Provider
            Specific Policy Manual.

1.21.6.5   Durable Medical Equipment and Supplies – Certain equipment and
                supplies require prior authorization. Refer to the Durable Medical
                Equipment Provider Specific Policy Manual.

1.21.6.6   Positron Emission Tomography (PET) Scans – Refer to the Outpatient
                Hospital or Practitioner Provider Specific Policy Manual.

1.21.6.7   Home Health Services – Certain home health services require prior
                authorization. Refer to the Home Health Provider Specific Policy Manual.

1.21.6.8   Oral and Facial Prosthetics – Refer to the Specific Criteria for
                Prosthodontists section of the Practitioner Provider Specific Policy
                Manual.

1.21.6.9   Bariatric Surgery - Refer to the Inpatient Hospital or Practitioner Provider
                Specific Policy Manual.

1.21.6.10   Sleep Studies/Polysomnography - Refer to the Outpatient Hospital or
                Practitioner Provider Specific Policy Manual.

1.21.6.11   Dental and Orthodontic Services – Certain dental and orthodontic
                services require prior authorization. Refer to the Dental Provider Specific
                Policy Manual

1.21.6.12   Elderly and Disabled Waiver Services – Refer to the Elderly and Disabled
                Waiver Provider Specific Policy Manual.

1.21.6.13   Acquired Brain Injury Waiver Services – Refer to the Acquired Brain Injury
                Waiver Provider Specific Policy Manual.

1.21.6.14   Computed Tomographic (CT) Colonography - Refer to the Outpatient
                Hospital or Practitioner Provider Specific Policy Manual.

1.21.6.15   Breast Cancer Assay of Genetic Expression – Refer to the Independent
                Laboratory Provider Specific Policy.

1.21.6.16   Behavioral Health Services – Refer to the Practitioner Provider Specific
                Manual, Specific Criteria for Psychiatrists.

1.21.6.17   Out-of-State Services

1.21.6.17.1   All services provided outside of Delaware require prior authorization for
                payment, except for services from the following providers in New Jersey,
                Pennsylvania, Maryland, or the District of Columbia.

NOTE: DMAP members are required to receive prior authorization for related travel expenses regardless of where the medical service is provided. Refer to the Related Travel Expenses (Meals/Lodging/Other) section of this manual for details.

1.21.6.17.1.1   Acute Care Hospital (inpatient and outpatient)

1.21.6.17.1.2   DME/Oxygen Supplier

1.21.6.17.1.3   Ground Ambulance

1.21.6.17.1.4   Independent Laboratory

1.21.6.17.1.5   Nurse Midwife

1.21.6.17.1.6   Optician

1.21.6.17.1.7   Optometrist

1.21.6.17.1.8   Podiatrist

1.21.6.17.1.9   Pharmacy

1.21.6.17.1.10   Physician

1.21.6.17.1.11   Ambulatory Surgical Center

1.21.6.17.1.12   Dialysis Center

1.21.6.17.1.13   Certified Nurse Practitioner

1.21.6.17.1.14   Dentist

1.21.6.17.1.15   Federally Qualified Health Center

1.21.6.17.2   All out-of-state services not noted above require prior authorization to ensure compliance with DMAP rules and regulations.

1.21.6.17.3   The prior authorization request must include a detailed medical history that documents the need for out-of-state care.

1.21.7   **Coverage of a Beneficiary Participating in a Qualifying Clinical Trial**

Payment for services provided under a clinical trial requires an attestation of trial appropriateness by the health care provider and the principal investigator of the trial. The form "Medicaid Attestation Form on the Appropriateness of the

Qualified Clinical Trial" (Section 14, Appendix I) must be completed and submitted via the DMAP Provider Portal.

1.22   Medicaid Eligibility Groups and Covered Services

There are three Medicaid eligibility groups:

- Categorically Eligible

- Women eligible for family planning and related services

- Expanded population

1.22.1   Categorically Eligible

1.22.1.1   Who is Eligible

The following individuals/families *may* be eligible for Medicaid in Delaware as categorically eligible if they meet certain low income and resource requirements:

1.22.1.1.1   Anyone who gets a benefit from Supplemental Security Income (SSI) or State Supplemental Payments (SSP).

1.22.1.1.2   People needing nursing facility care whether living in a medical facility or at home and receiving waiver services for persons with developmental disabilities, the elderly/disabled, persons with HIV/AIDS, persons with acquired brain injuries, or persons eligible for the Assisted Living Medicaid Waiver Program.

1.22.1.1.3   Foster children or special needs children who need medical services to support and encourage their adoption.

1.22.1.1.4   Low income families with dependent children and certain families that lose Medicaid benefits when their income from employment or child/spousal support payments is counted.

1.22.1.1.5   Individuals who lose their SSI eligibility when they receive, or get increases in certain Social Security benefits or return to work but remain disabled. Also, children who lost SSI because of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) change in the disability determination.

1.22.1.1.6   Pregnant women and infants up to age one who have family incomes at or below 200% of the federal poverty level.

1.22.1.1.7   Children age one through age five in families with income at or below 133% of the federal poverty level.

1.22.1.1.8   Children age six through age eighteen in families with income up to 100% of the federal poverty level.

1.22.1.1.9   Severely disabled children being cared for in their own homes.

1.22.1.1.10   Qualified Medicare Beneficiaries (QMBs). These are individuals with income at or below 100% of the poverty level. These individuals are not eligible for the full range of Medicaid services. Refer to the Qualified Medicare Beneficiaries section of this Policy Manual. (See Section 1.23 for information on coordination of benefits.)

1.22.1.2   What Services are Covered

The DMAP pays for the following services for categorically eligible Medicaid members. Some of these services have limitations. Both the General Policy and the Provider Specific section(s) should be referenced for information on these limitations.

1.22.1.2.1   Inpatient hospital services

1.22.1.2.2   Outpatient hospital and clinic services

1.22.1.2.3   Federal health center services, including community, rural and migrant health centers.

1.22.1.2.4   Laboratory and X-ray services

1.22.1.2.5   Home Health services

1.22.1.2.6   Long-term care facility services

1.22.1.2.7   Periodic preventive health screens and other necessary diagnostic and treatment services for children under age twenty-one (Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program).

1.22.1.2.8   Family planning services (including voluntary sterilization if consent form is signed after patient turns age twenty-one).

1.22.1.2.9   Physician, nurse-midwife, and certified nurse practitioner services.

1.22.1.2.10   Pharmaceutical services

1.22.1.2.11   Podiatry services

1.22.1.2.12   Optometry/optician services

1.22.1.2.13   Transportation services

1.22.1.2.14   Private duty nursing

1.22.1.2.15   Hospice services

1.22.1.2.16   Extended services for pregnant women to assure that they receive the necessary medical and social support that will positively impact on the outcome of their pregnancies.

1.22.1.2.17   Community support services for aged, disabled, intellectual developmental disabled and HIV/AIDS individuals focused on providing alternatives to institutionalization.

1.22.1.2.18   Durable medical equipment and supplies

1.22.1.2.19   Rehabilitation Agency services

1.22.1.2.20   Ambulatory Surgical Center services

1.22.1.2.21   Dialysis Center services

1.22.1.2.22   Prescribed Pediatric Extended Care services

1.22.1.2.23   Preventive Services - The DMAP will cover U.S. Preventive Services Task Force (USPSTF) recommendations for preventive services that have been assigned a grade of A or B.

1.22.1.2.24   Telemedicine Services – Refer to the Practitioner Provider Specific Manual

1.22.1.2.25   This section regarding tobacco cessation reflects the policies as they relate to Medicaid members who are exempt from managed care coverage and includes pregnant women, as mandated by section 1905(bb)(2) of the Act. Comprehensive tobacco cessation services are based on the current PHS Guidelines and include both counseling and pharmacotherapy, without cost sharing. The DMAP will provide reimbursement for rebated tobacco cessation products, Nicotine Replacement Therapy products, and counseling through the Delaware Tobacco Quitline. Tobacco cessation services will be provided by licensed providers practicing within the scope of practice under Delaware Law. Pharmacies will bill for tobacco cessation services according to the normal procedures as outlined in the Pharmacy Provider Specific Policy Manual.

1.22.1.2.26   Chiropractic services. Refer to Section 13 and 32 (Appendix Q) of the Practitioner Provider Specific Policy Manual.

1.22.1.2.27   Lactation Counseling Services

1.22.1.2.28   Lung Cancer Screening

1.22.1.2.29   Gender Dysphoria Disorder, refer to Practitioner Provider Policy Manual.

1.22.1.2.30   Nutrition assessment, counseling, education and intensive behavioral
therapy for obesity treatment:
Adults
- Intensive behavioral therapy recommendations for adult members
with a qualifying diagnosis and a BMI greater than (>) 30, no less
than 12 visits.
- Intensive behavioral therapy recommendations for adults with one
or more risk factors for cardiovascular disease and a BMI of
greater than (>) 25, no less than 6 contact hours.

Children
- Intensive behavioral therapy recommendations for children 3
years or older with a BMI greater than (>) 95th percentile, no less
than 12 visits.
- Intensive behavioral therapy recommendations for children 3
years or older with a BMI > 85th percentile, no less than 8 visits.

1.22.1.2.31   Other services as defined by the Delaware Medicaid State Plan as
medically necessary.

1.22.1.3   Other programs in the DMAP, such as the Chronic Renal Disease (CRD)
and the Qualified Medicare Beneficiary (QMB) programs have more
limitations on the services provided than does Medicaid. The services
covered under the QMB program are listed in QMB section of this
General Policy Manual.

1.22.1.4   Certain individuals who have applied for AFDC, SSI, SSP, or a Medicaid
only program and who are excluded from managed care may be eligible
to have Medicaid cover unpaid bills that were incurred within three
months prior to the month that they apply for Medicaid. The only
individuals who may be found eligible for retroactive Medicaid are those
who receive Medicare or long term care services.

1.22.1.5   Medicaid eligibility is re-evaluated periodically. Providers are required to
verify member eligibility and other important member information prior to
rendering services by accessing one of the Electronic Verification System
(EVS) options. Instructions for accessing EVS are described in the EVS
manual.

1.22.2   Family Planning and Related Services

1.22.2.1   Who is Eligible

Females of childbearing years whose Medicaid (categorically or expanded population) is terminated for a non-fraudulent reason are eligible for family planning and related services for 24 months. Family planning services are defined as those services provided to females of childbearing age to temporarily or permanently prevent or delay pregnancy.

1.22.2.2   What Services Are Covered

1.22.2.2.1   The Family Planning and Related Services Benefit Package includes:

1.22.2.2.1.1   Contraceptive management, including non-systemic drugs and devices (excluding condoms), systemic drugs, and related surgical procedures (for example, ligation of fallopian tubes).

1.22.2.2.1.2   Diagnosis and treatment of sexually transmitted diseases (STDs) when provided or prescribed during the family planning visit.

1.22.2.2.1.3   HIV screening, diagnosis, and counseling ONLY when provided during a family planning visit.

1.22.2.2.2   Coverage of pharmaceuticals prescribed during the family planning visit to eradicate the causative organism of a covered STD will be added to the Family Planning and Related Services Benefit Package. Those pharmaceuticals covered for a diagnosis of STD will be limited to the following four therapeutic classes: antibiotic, anti-viral, anti-fungal, anti-protozoan. Pharmaceuticals prescribed to treat an STD *outside* of a family planning visit are not covered.

1.22.2.2.3   When a medication is being used to treat a covered STD and the medication is prescribed during a family planning visit, the prescriber, in his own handwriting, is required to indicate on the prescription the ICD-9 code V25.09 (family planning advice) and the appropriate ICD-9 code that will identify the covered STD. Without this information the pharmacy should not submit the claim to the DMAP. Members will be responsible for the cost of these medications if all conditions are not met.

1.22.2.2.4   When the prescription is covered, the pharmacist must enter a diagnosis code of V25.09. If filing a claim, the National Council for Prescription Drug Programs (NCPDP) Form, diagnosis code V25.09 must be placed in the appropriate field. This indicates that the pharmacist has verified that the required documentation is on the prescription. MICROMEDEX supplies the indications for medications covered by the DMAP. Only those drugs that have approved indications for the covered diseases will be reimbursable.

1.22.2.2.5   Treatment of and pharmaceuticals related to HIV are not covered under this benefit.

1.22.2.2.6   The following STDs are covered (as noted above) for treatment and
                related pharmaceuticals:

1.22.2.2.6.1   Candidiasis

1.22.2.2.6.2   Chancroid

1.22.2.2.6.3   Chlamydial Infections

1.22.2.2.6.4   Genital Herpes

1.22.2.2.6.5   Genital Viral Warts

1.22.2.2.6.6   Gonorrhea

1.22.2.2.6.7   Granuloma Inguinale

1.22.2.2.6.8   Lymphogranuloma Venereum

1.22.2.2.6.9   Syphilis

1.22.2.2.6.10   Trichomoniasis

1.22.2.2.7   Covered services must be delivered by the following providers under the
                normal limitations of the Delaware Medicaid program:

1.22.2.2.7.1   Certified nurse practitioner

1.22.2.2.7.2   Family planning clinic

1.22.2.2.7.3   Federally qualified health center (FQHC)

1.22.2.2.7.4   Independent laboratory

1.22.2.2.7.5   Inpatient or outpatient hospital

1.22.2.2.7.6   Nurse midwife

1.22.2.2.7.7   Pharmacy

1.22.2.2.7.8   Physician

1.22.2.2.7.9   Ambulatory surgical center (ASC)

1.22.2.3   Non-Covered Services

Services not covered in the Family Planning and Related Services Benefit Package include but are not limited to:

- Abortions

- Condoms

- Pharmaceuticals other than non-systemic and oral contraceptives, antibiotics, anti virals, anti fungals, and anti protozoans. For example, medications used to treat the pain associated with the STD will not be covered.

- Pharmaceuticals prescribed to treat an STD *outside* of a family planning visit

- Follow up treatment for an STD that was diagnosed and treated during a family planning visit

- Gynecological procedures unrelated to family planning

- Hysterectomy

- Procreative management

- Reversal of sterilization

- Treatment of and pharmaceuticals related to HIV

- Treatment of infertility by any modality

1.22.2.4   Refer to Appendix G for services and procedures covered for Family Planning and Related Services Benefit Package.

1.22.2.5   Refer To Appendix G for services and procedures covered when paired with a diagnosis of contraceptive management for Family Planning and Related Services benefit package.

1.22.3   Expanded Population

1.22.3.1   Additional individuals are eligible as a result of the Diamond State Health Plan (DSHP). Refer to DSHP (Medicaid Managed Care) section of this General Policy.

1.23   Qualified Medicare Beneficiaries (QMBs)

1.23.1   Individuals who are over-income for SSI-related Medicaid may be eligible as Qualified Medicare Beneficiaries (QMBs) if they have income at or below 100% of the Federal Poverty Limit (FPL). These individuals must be determined eligible for Medicare before their eligibility for the QMB Program can be determined.

1.23.2   QMB recipients are not eligible for the full range of DMAP services, but are eligible for the full range of Medicare services. DMAP will coordinate benefits for Medicare Part A and B and will only pay up to the amount of the current Medicaid fee-for-service rate at the time of services rendered. (See 1.23.6)

1.23.3   If a QMB also carries other health insurance coverage in addition to Medicare and Medicaid, that resource must be billed before Medicaid.

1.23.4   DMAP will deny any claims submitted for any services and charges other than the Medicare coinsurance and/or deductible. (See 1.23.2)

1.23.5   Participating providers agree to accept the final DMAP payment disposition as payment in full. Therefore, QMB recipients should not be billed for any non-covered charges or remaining portions of the Medicare deductible, copayments and coinsurance. Exceptions to the DMAP policy prohibiting the billing of members are available in the Billing DMAP Members section 1.16 of the General Policy Manual.

1.23.6   Providers are required to verify member eligibility and other important member information prior to rendering services by accessing one of the Electronic Verification System (EVS) options. Instructions on accessing EVS are available in the EVS section of this manual.

1.24   Emergency and Labor/Delivery Services Only

NOTE: Providers are required to verify member eligibility and other important information prior to rendering services by accessing one of the Electronic Verification System (EVS) options. Instructions to accessing EVS are described in the EVS section of this manual.

1.24.1   Emergency Only services must be rendered in an acute care hospital emergency room or in an acute care inpatient hospital. Labor/Delivery Services Only may be delivered in either an acute care hospital emergency room, an acute care inpatient hospital or birthing center.

1.24.2   **The DMAP defines an emergency as:**

1.24.2.1   A sudden serious medical situation that is life threatening; OR

1.24.2.2   A severe acute illness or accidental injury that demands immediate medical attention or surgical attention; AND

1.24.2.3   Without the treatment a person's life could be threatened or he/she could suffer serious long lasting disability.

1.24.3   Medically necessary physician (surgeon, pathologist, anesthesiologist, emergency room physician, internist, etc.) or midwife services rendered during an emergency service that meets the above criteria are covered.

1.24.4   Ancillary services (lab, x-ray, pharmacy, etc.) rendered during an emergency service that meets the above criteria are covered.

1.24.5   Emergency ambulance services to transport these individuals to and from the services defined above are also covered.

1.24.6   Services not covered include, but are not limited to:

- ANY service delivered in a setting other than an acute care hospital emergency room or an acute care inpatient hospital except Labor/Delivery Services delivered in a birthing center.

- ANY service (pharmacy, transportation, office visit, lab, x-ray, or home health, etc.) that *precedes* **or** *is* subsequent to a covered emergency service (except

that emergency ambulance transportation directly
related to the emergency service IS covered).

- Organ transplants.

- Long term care or rehabilitation care.

- Routine prenatal care and post-partum care.

1.25   Immunization Vaccines

1.25.1   For Children Ages 0 Through 18 Years

1.25.1.1   The state of Delaware participates in the Vaccines for Children (VFC)
Program which supplies free vaccines to providers for VFC eligible
children under age 19. Children eligible to receive VFC-provided vaccines
include the following:

1.25.1.1.1   Children who receive Medicaid.

1.25.1.1.2   Uninsured children.

1.25.1.1.3   Children who are American Indian or Alaskan Native.

1.25.1.2   In addition, children who have health insurance that does not cover
vaccines can receive VFC-provided vaccines at federally qualified health
centers and rural health clinics.

1.25.1.3   The VFC program is operationally administered by the Division of Public
Health. Providers must enroll in the VFC Program to receive free
vaccines and to receive an administration fee. For further information and
enrollment materials please call DPH at 1-800-282-8672.

1.25.1.4   Medicaid does not pay providers for the cost of vaccines available
through the VFC Program, but will pay an administration fee for each
immunization given to a Medicaid eligible child not enrolled in the
Diamond State Health Plan, the State's Medicaid managed care program.

1.25.1.5   Under the DSHP, the participating Managed Care Organizations (MCOs)
are responsible for all primary care services including immunizations. The
administration fees for DSHP enrolled children are accounted for in the
capitated rate paid to the MCOs, therefore the Medicaid Program does
not pay providers for immunizations administered to DSHP enrolled
children. MCOs determine their own policies on reimbursement of
administration fees.

1.25.1.6   Providers will be paid the administration fee for children who have not yet been enrolled in a MCO and for those Medicaid eligible children who are ineligible for participation in the DSHP. The state of Delaware will also pay VFC-enrolled providers the administration fee for immunizations given to non-Medicaid VFC eligible children. Enrolled providers must submit an Immunization Registry (IR) form to the Division of Public Health where the immunization data is recorded and passed electronically to Gainwell Technologies for adjudication and payment.

1.25.1.7   The immunization vaccines covered under the VFC Program are identified in the Childhood Immunization Schedule found in Appendix L. VFC participating providers will receive an administration fee (as specified above) for these vaccines when administered according to the schedule recommended by the Advisory Committee on Immunization Practices (ACIP):

1.25.1.8   Generally, only combined antigen vaccines will be provided through the VFC Program. Single antigen vaccines will be available and related administration fees reimbursable only when a normally appropriate combined antigen is contraindicated.

1.25.2   For Adults Ages 19 Years and Older

1.25.2.1   Providers may continue to be reimbursed for the actual cost of medically necessary vaccines provided to adults age 19 or older. NOTE: Vaccines required for travel outside the United States are not covered.

1.25.2.2   Claims for adult immunizations should be sent directly to Gainwell Technologies for processing and payment. They should not be sent to the Division of Public Health's Immunization Registry. Administration fees will not be reimbursed separately for adult immunizations. The administration fee will continue to be considered part of the office visit fee paid in addition to the payment made for the vaccine.

1.26   Delaware Prescription Assistance Program (DPAP)

1.26.1   The Delaware Prescription Assistance Program (DPAP) provides payment assistance for prescription drugs and certain Medicare Part D costs to Delaware's low-income senior and disabled citizens who are ineligible for, or do not have, prescription drug benefits through state or private sources (excluding Medicare Part D). DMAP's fiscal agent under contract with the State administers the program.

1.26.2   To be eligible for this program a person must:

1.26.2.1   Be a US citizen or a lawfully admitted alien.

1.26.2.2   Have income that is less than 200% of the Federal Poverty Level (FPL) or have prescription drug expenses that exceed 40% of his or her annual income.

1.26.2.3   Be a resident of the State of Delaware.

1.26.2.4   Be ineligible for Medicaid prescription benefits.

1.26.2.5   Be enrolled in Medicare Part D and the Medicare Part D Low Income Subsidy if eligible.

1.26.2.6   Be ineligible for and/or not receiving a prescription drug benefit through a Medicare supplemental policy or any other credible third party payer prescription benefit (excluding Medicare Part D coverage);

1.26.2.7   Be an individual aged 65 or over or be an individual between the ages 19 and 64 who is receiving disability (Social Security Disability Insurance) benefits under Title II of the Social Security Act.

        1.26.3   The DPAP is administered by the Department of Health and Social Services and will follow these rules and regulations.

1.26.3.1   Prescription drugs covered under the program are restricted to medically necessary products manufactured by pharmaceutical companies that agree to provide manufacturer rebates. Policy and guidelines will follow the existing DMAP limitations. Services covered included generic and brand name Food & Drug Administration approved prescription drugs, as well as cost effective over-the-counter drugs prescribed by a practitioner. Medicare Part D participants may receive payment assistance for medications not covered under Part D. Necessary diabetic supplies not covered by Medicare B or D will also be covered.

1.26.3.2   Payment assistance shall not exceed $3,000 in a benefit year to assist each eligible person in the purchase of prescription drugs and payment of certain Medicare Part D costs. There will be a co-payment of $5 or 25% of the cost of the prescription whichever is greater. The same co-payment amounts shall apply to prescription drugs excluded under Medicare Part D but covered under DPAP. The pharmacy will collect the co-payment before the prescription is dispensed. Co-payments may be waived in cases of good cause. Members may request that their co-payments be waived if they have experienced a catastrophic situation resulting in unexpected, extraordinary expenses related to loss or significant damage to shelter or the well being of themselves or their immediate family. The request must be in writing and explain the circumstances that led to the request. Verification will be required in the form of collateral contacts such

as repair bills, police or insurance reports, etc. The DPAP team will notify the member if good cause is granted. Co-payments will be waived for the remainder of the fiscal year.

1.26.4   Part D as Primary Coverage:

1.26.4.1   Medicare Part D coverage will be primary to payment assistance under the DPAP.

1.26.4.2   Medicare Part D costs covered by DPAP are the monthly basic premiums, deductibles and drug costs falling into the Part D coverage gap up to the DPAP benefit limits. Medicare Part D costs covered by DPAP do not include Medicare Part D co-payments.

1.27   Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

1.27.1   "Early and Periodic Screening, Diagnosis and Treatment" means:

1.27.1.1   Screening and diagnostic services provided to determine physical or mental defects in Medicaid eligible individuals under age twenty-one (through age twenty); and,

1.27.1.2   Health care, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered during the screening process.

1.27.2   EPSDT services are mandated by Federal regulation to provide preventive health care to children and young adults at periodic intervals determined by the Medicaid program and appropriate medical officials. At a minimum, the screening of these individuals must include:

1.27.2.1   Comprehensive health and developmental history

1.27.2.2   Comprehensive unclothed physical examination

1.27.2.3   Appropriate vision testing

1.27.2.4   Appropriate hearing testing

1.27.2.5   Appropriate laboratory tests

1.27.2.6   Health education and anticipatory guidance

1.27.2.7   Dental screening services beginning at age 1

1.27.2.8   Immunizations needed at the time of the screen.

        1.27.3   The diagnosis and treatment component must include:

1.27.3.1   Diagnosis and treatment of medical conditions including defects in vision
        and hearing and the provision of eyeglasses and hearing aids.

1.27.3.2   Dental care, as early as needed, for relief of pain and infections,
        restoration of teeth and maintenance of dental health.

1.27.3.3   Immunizations as needed if not included as part of the screening.

1.27.3.4   Prenatal care services

1.27.3.5   Any other medically necessary services identified during the screening
        process whether normally provided under the State's Medicaid program
        or not

        1.27.4   EPSDT Services and Guidelines

1.27.4.1   Refer to the Practitioner Specific Policy Manual for information regarding
        EPSDT Services and Guidelines.

1.28   Transportation

        1.28.1   Emergency Ambulance

1.28.1.1   The DMAP only reimburses enrolled ambulance companies for
        emergency transportation services when transportation is to or from a
        Medicaid covered service.

1.28.1.2   Emergency transports are payable if the patient's condition meets the
        "federal prudent layperson" standard of the 1997 Balanced Budget Act
        (BBA).

1.28.1.2.1   The BBA defines an "emergency medical condition" as a medical
        condition manifesting itself by acute symptoms of sufficient severity
        (including severe pain) such that a prudent layperson, who possesses an
        average knowledge of health and medicine, could reasonably expect the
        absence of immediate medical attention to result in placing the health of

the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

1.28.2   **Non-Emergency Ambulance and Other Modes**

1.28.2.1   DMAP utilizes a transportation management system to facilitate all non-emergency transportation (NET) services. The transportation management company is responsible for verifying member eligibility and scheduling the most appropriate transportation to meet the member's needs.

1.29   Estate Recovery Program

1.29.1   The Estate Recovery Program applies to members, age fifty-five or over, who have received Long Term Care (LTC) services. LTC includes nursing home and home and community based services waiver programs. Recovery will not be initiated until after the death of the member. Providers need to be aware of this program and are requested to submit bills for Medicaid services for deceased members as soon as possible. The DMAP will need to request a claims history and submit a claim to the estate within eight months of the member's death.

Note: This is not a change in the procedure regarding the billing deadline of one year from the date of service. Providers can bill up to one year after the date of service but the DMAP would appreciate earlier billing for deceased patients.

1.30   Delaware Cancer Treatment Program

1.30.1   The Delaware Cancer Treatment Program provides medical insurance coverage to Delawareans for the treatment of cancer. The program serves Delawareans who have no health insurance.

1.30.2   DMAP's fiscal agent under contract with the State administers the program.

1.30.3   To be eligible for this program a person must:

1.30.3.1   Have an income that is less than 650% of the Federal Poverty Level (FPL).

1.30.3.2   Be a resident of the state of Delaware.

1.30.3.3   Be diagnosed with any cancer on or after July 1, 2004 or be receiving benefits for the treatment of colorectal cancer through the Division of Public Health's Screening for Life Program on June 30, 2004.

1.30.3.4   Need treatment for cancer in the opinion of the enrollees treating licensed physician.

1.30.3.5   Be ineligible for Medicaid, Medicare, Breast and Cervical Cancer Program.

1.30.3.6   Have no health insurance coverage.

1.30.3.7   Be an individual over the age of 18 years.

　　　　　　　1.30.4   Coverage for the Delaware Cancer Treatment Program is limited to the treatment of cancer.

　　　　　　　1.30.5   The Delaware Cancer Treatment Program does not include nursing home or long-term institutionalization.

　　　　　　　1.30.6   An individual is eligible for the Delaware Cancer Treatment Program for 24 months after the date cancer treatment is initiated.

　　　　　　　1.30.7   Reimbursement guidance;

1.30.7.1   If the medical treatment/service is for a health condition directly related to or a result of the cancer, the claim is considered for payment if there is a valid cancer diagnosis code on the claim, with or without documentation. If the diagnosis is not on the approved cancer diagnosis list, the claim is auto-denied.

1.30.7.2   If the claim is submitted with a cancer disease classification as the primary diagnostic ICD 10 - CM code, and all other DCTP criteria are met the procedure is considered for payment.

1.31   Medicaid Home & Community Based Services (HCBS)

All waiver and state plan HCBS members are also eligible for all services normally covered by the DMAP.

1.31.1   Division of Developmental Disabilities (DDDS) Lifespan Waiver

1.31.1.1   DDDS Lifespan Waiver services provided through the Division of
            Developmental Disabilities (DDDS) are targeted to individuals with
            intellectual disabilities (IDD) (including brain injury), Autism Spectrum
            Disorder and Prader Willi Syndrome.

1.31.1.2   The waiver provides services and supports as an alternative to
            institutional services and is designed to enable the individual to live safely
            in the community and to respect and support their desire to work or
            engage in other productive activities.

1.31.1.3   Lifespan Waiver enrollees are concurrently enrolled with an MCO under
            the Diamond State Health Plan to receive their acute medical care
            benefits, such as primary care, pharmacy, and hospitalization.

1.31.1.4   The Lifespan waiver will offer the following services:

            • Residential Habilitation (in either a group home or apartment or with a
              shared living provider)
            • Supported Living – Must be in the individual's own home or apartment
            • Day habilitation
            • Prevocational Service
            • Supported Employment (Individual and Group)
            • Behavior Consultation
            • Nurse Consultation
            • Community Participation
            • Respite
            • Personal Care
            • Community Transition
            • Specialized medical equipment and supplies (not otherwise covered
              under Medicaid)
            • Home or vehicle modifications
            • Assistive technology
            • Medical Residential Habilitation

1.31.1.5   More detailed information can be found in the Home and Community
            Based Services Provided Under the DDDS Lifespan Waiver for Persons
            with Intellectual Developmental Disabilities Provider Manual.

            1.31.2   **Pathways to Employment State Plan HCBS**

1.31.2.1   Pathways to Employment services, provided through the Division of
            Developmental Disabilities (DDDS), is a program designed to support
            low-income teens and young adults aged 14 to 25 with intellectual
            developmental disabilities/autism, physical disabilities or visual
            impairment in Delaware who want to work. The program helps
            participants get prepared for work, find jobs, and succeed in the
            workplace.

1.31.2.2   Pathways to Employment participants receive employment-related
              services to meet their individual needs. Services available through
              Pathways to Employment include:

- Employment Navigator
- Career Exploration and Assessment
- Supported Employment – Individual
- Supported Employment – Small Group
- Benefits Counseling
- Financial Coaching
- Non-Medical Transportation
- Personal Care (including a self-directed option)
- Orientation, Mobility, Assistive Technology

1.31.2.3   More detailed information can be found in the Pathways to Employment
              Provider Policy Manual.

1.32   Restricted "Lock-In" Members (Fee for Service/Non-Managed Care)

1.32.1   The DMAP "restricts" or "locks-in" certain members who are
              exempt from the Diamond State Health Plan (refer to the
              Diamond State Health Plan-Who Must Enroll section of this
              General Policy for a list of those exemptions) when it has
              been determined that they are engaged in abusive or
              fraudulent practices such as over-utilization of emergency
              room services or prescription drugs, lending a Medical
              Assistance card to an unauthorized person, etc. This
              restriction status is different from managed care programs in
              which members choose and are enrolled with a primary care
              physician or medical care plan.

1.32.2   In general, "restriction" means that DMAP will limit "fee for
              service" payments to one primary physician and one primary
              pharmacy. Women who are exempt from the Diamond State
              Health Plan (DSHP) are also permitted one
              obstetrician/gynecologist. Upon referral from the primary
              physician, any member with a special medical condition is
              permitted to have a specialist as an additional caretaker.
              Exceptions will only be made in cases of verifiable emergency
              or when a primary provider requests consultation or special
              services. If the restricted member visits other doctors or has
              prescriptions filled at other pharmacies (except in those
              situations cited above), DMAP will not pay for these
              unauthorized claims and the member can be held responsible
              for such claims. However, providers can avoid difficulty in
              obtaining payment if they are consistent in accessing one of

the EVS options (see EVS section of this manual) for member eligibility and other important member information prior to rendering services. Pharmacy providers should check for pharmacy restriction through the DMAP Point of Sale (POS) Computerized system.

1.32.3   Once an abuse/fraud has been identified, the member is notified by mail explaining the purpose of his/her restricted/"lock-in" status. In addition, all practitioners known to have seen this individual within the last twelve months are sent a notice of the restriction and imposition date. A restricted member's case is reviewed within one year to decide if his/her restriction should be continued or lifted. After one year, the member's restricted status may be lifted or continued for an additional twenty-four months.

1.32.4   After selection by the member of one primary physician and pharmacy, the DMAP Office determines by contact and written confirmation that a provider agrees to act in this capacity. No provider should accept the Medical Assistance card of a restricted member for payment unless this agreement has been reached, or confirmation for consultation/special services has been given by the DMAP office or if a true emergency exists.

1.33   Hospice Members

1.33.1   Hospice care is an optional benefit covered by the DMAP for terminally ill individuals whose medical prognosis for life expectancy is six months or less.

1.33.2   According to hospice procedures, each hospice participant has an attending physician who serves as a primary caretaker for treatment of the terminal illness. In most cases, for services performed by the attending physician, payment is obtained by billing DMAP directly. DMAP is also directly responsible under the normal limitations of the Program for payment to providers who deliver medical care that is *not* related to the patient's terminal illness.

1.33.3   However, for all services other than those performed by the attending physician which are related to the terminal illness, DMAP pays the hospice organization. Therefore, for these services, the provider must obtain authorization and payment from the hospice organization.

1.33.4   Documentation in the form of notes and a written statement which describe the relationship between the services and the

terminal illness may be required to determine the appropriate payment source. If the provider is uncertain about whether or not the service is related to the terminal illness, the provider should contact the hospice organization for assistance in making this determination. Generally, the hospice organization will be the most knowledgeable source regarding the terminal illness and the medically necessary services for their patients. If it is determined that the DMAP is the appropriate payment source, attaching documentation to establish that the services are unrelated to the terminal illness will expedite the payment process.

1.33.5   To determine which members are hospice participants and thus, from whom they should seek payment, the hospice provider is required to access one of the EVS options to verify the member's involvement in hospice. Instructions to accessing EVS is described in the EVS section of the billing manual.

1.34   Medicaid Credit Balance Report (MCBR)

1.34.1   General Information

1.34.1.1   Title XIX of the Social Security Act established the Medicaid Program under which federal grants are provided to states for medical assistance to low income persons. The Program is jointly financed by the Federal and State governments and administered by the states. Within broad Federal rules, each state decides eligibility groups, types and ranges of services, payment levels for services, and administrative and operating procedures. The state's description of its Medicaid Program is called its State Plan.

1.34.1.2   Payments for services included within the State Plan are made directly by the state to the individuals or entities that provide the services. Each state designates a single State Agency which administers the operation of its Medicaid Program. On the Federal level, the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services oversees the Title XIX Program, monitors compliance with Federal requirements, provides Federal matching funds for qualified Medicaid expenditures incurred by the states, and reviews Medicaid expenditures for appropriateness and accuracy. States report their Medicaid expenditures and claim Federal-matching moneys on a quarterly basis. Federal Medicaid regulations under 42 CFR 433.300 subpart F, mandates that States adjust any outstanding Medicaid credit balances within sixty (60) days after notification by a provider.

1.34.1.3   Federal Medicaid regulations require that the state Medicaid agency take reasonable measures to determine the legal liability of third parties to pay

for services under the State Medicaid Plan. In summary, these regulations require that all benefits available through other party payers be exhausted, since the Medicaid Program is the payer of last resort. Federal Financial Participation (FFP) is not available if the State Medicaid Agency fails to fulfill the Federal requirements with regard to established liability and seeking reimbursements.

1.34.1.3.1   CMS has completed reviews in several states to determine if the Federal requirements were being met. CMS discovered instances where Medicaid funds were being retained by providers, even though other third party payments sources had made payments for the same service. CMS's review revealed that a large number of patient records indicated credit balances in cases where the Medicaid Program was the secondary payer. In many cases, the provider billed the Medicaid Program and a third party payer. Payments made by a third party payer were credited to patient accounts, along with payments received from the Medicaid Program. However, the appropriate refunds were not made to the Medicaid Program. Credit balances were also caused by duplicate Medicaid payments.

1.34.1.3.2   When such circumstances occur, the provider is obligated to immediately refund the appropriate credit balances to appropriate Medicaid authorities.

1.34.2   Purpose

1.34.2.1   To ensure that Medicaid properly recovers improper or excess program payments resulting from patient billing or claims processing errors, the DMAP has established a Provider Credit Balance reporting requirement. CMS has similarly mandated credit balance reporting requirements under the Medicare Program.

1.34.2.2   In accordance with 42 CFR 433.300 subpart F, the DMAP requires identified in-state and out-of-state provider types to submit a quarterly MCBR. The quarterly MCBR submission is a requirement for all in-state and out-of-state providers who were paid greater than $10,000.00 in each calendar quarter (for either in-patient and/or outpatient services, in the case of hospital providers), by DMAP. Providers are required to monitor their claims submissions to track their $10,000.00 payment threshold for each quarter. The MCBR must be submitted even in the event when there are not credit balances on Medicaid accounts at the close of business in the reporting period. The following types are required to submit a quarterly MCBR:

Taxonomy	Provider Type
282N00000X	Acute Care Hospitals
283X00000X	Rehabilitation Hospitals
283Q00000X	Psychiatric Hospitals
284X00000X	Specialty Hospitals

314000000X	Skilled Nursing Homes (SNF)
251E00000X	Home Health Agencies
261QE0700X	Renal Dialysis Facilities
313M00000X	Intermediate Care Facilities
261QR0400X	Rehabilitation Agency
103TR0400X	Day Health and Rehabilitation Services

1.34.2.3   The MCBR will be specifically used to monitor the identification and recovery of "credit balances" due to the DMAP. Generally, when a provider receives improper or excessive payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit". For example, if payments are made by the DMAP and another insurer/payer, DMAP must be reimbursed. DMAP is always considered as the payer of last resort when a patient has another insurer. However, DMAP credit balances include money due the DMAP regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period (e.g., 90 days), and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the DMAP. In these instances, the provider is responsible for identifying and repaying all of the moneys due to the DMAP.

1.34.3   Completing the Medicaid Credit Balance Report Certification

1.34.3.1   Required timeframes for the completion of the MCBR

A completed MCBR Certification must be submitted at the end of each quarter to the Medicaid Surveillance and Utilization Review Unit (SUR) via the Provider Portal within 30 days after the close of each calendar quarter.

Providers are required to complete the MCBR Certification even when Medicaid credit balances are not reflected in the provider's records for the reporting quarter.

1.34.4   Submitting the MCBR Certification

The report must include all Medicaid credit balances reflected in the provider's accounting records including transfers, holdings or other general accounts used to accumulate credit balance funds as of the close of business each calendar quarter. **Providers must report all suspected Medicaid credit balances reflected in the provider's records regardless of when they occurred.** Providers are required to report and repay all improper or excess payments that have been received from the time the provider enrolled in the DMAP. Penalties for non-timely submission or failure to submit the MCBR, could result in (but are not

limited to) the suspension of the provider's Medicaid payments and/or impact the provider's continued eligibility to participate in the DMAP.

For Medicaid Credit Balances Identified on Claims:
When the MCBR Certification is submitted, providers must pay all amounts owed to DMAP and upload a copy of the remittance advice that indicates that an adjustment has been made via the Provider Portal. DMAP does not accept checks and checks are not permitted to be uploaded to the Provider Portal. Providers that do not have access to the secure Provider Portal should contact Provider Services at **1-800-999-3371** to remedy their outstanding Medicaid credit balances

1.34.4.1   The following guidelines must be applied when completing the MCBR Certification:

1.34.4.1.1   Attestation

Attestation is required when a Medicaid credit balance is not reflected in the provider's records for the reporting quarter. The attestation is completed on the MCBR Certification Panel.

1.34.4.1.2   Outstanding Medicaid Credit Balance Report

Providers must submit a MCBR form when a Medicaid credit balance is reflected in the provider's records for the reporting quarter. The outstanding balance is reflected in the following MCBR form panel.

1.34.4.1.3   Refer to DMAP's How-To Corner document section for additional instruction for the completion of the MCBR Certification Panel on the Provider Portal.

1.34.5   **Validation**

1.34.5.1   By contract, providers agree to permit DMAP, and/or its authorized representatives, access to all requested financial and medical records, as appropriate, including private pay records. The DMAP retains the right to access records and reports to validate the MCBR. The DMAP will determine the necessity to access records and reports. The DMAP and/or its authorized representatives are also permitted to reproduce records, as they deem appropriate.

1.34.5.2   In the event a provider submits inaccurate MCBR reports for two quarters, DMMA may suspend the provider's Medicaid payments until the provider completes in-service and/or training regarding the proper completion of the MCBR. The details of the in-service and/or training will be provided on a case by case basis.

Note: Providers that submit their MCBR Certification during the last 10 days of the reporting may experience a delay in processing and subsequent adverse action.

1.35   Charging Medicaid Members for Missed Scheduled Appointments

Centers for Medicare and Medicaid Services (CMS) prohibits providers from billing Medicaid members who miss scheduled appointments. This policy is premised on the fact that a missed appointment is not a distinct reimbursable Medicaid service, but a part of the provider's overall costs of doing business. The Medicaid rate covers the cost of doing business, and providers may not impose separate charges on Medicaid members.

1.36   Related Travel Expenses (Meals/Lodging/Other)

1.36.1   Overview

1.36.1.1   Reimbursement of related travel expenses may be provided to eligible DMAP members to ensure reasonable access to and from medical services for the purpose of receiving treatment and/or medical evaluation. Reimbursements are intended as a supplement and may not cover all related travel expenses. Related travel expenses are provided as necessary services supports for any eligible DMAP member and escort, if required, who have no other resources available for the provision of related travel expenses. Related travel expenses appropriate to the medical and or functional needs of the member may include: meals, lodging, parking fees and tolls. In hardship cases cash advances for food can be made for up to one week.

1.36.1.2   All related travel expenses must be prior authorized. Refer to 'How to Obtain Prior Authorization' found in this section of the manual.

1.36.1.3   DMAP may reimburse for related travel expenses for an eligible Medicaid member and ONE authorized escort when:

- It is medically necessary for the member to travel to receive treatment and/or medical evaluation and the member is required to remain on the premises of the medical service provider; and/or

- The location of the medical service provided results in displacement of a DMAP member for a consecutive 24-hour period.

1.36.1.4   Related travel expenses are reimbursed ONLY if transportation is included in the member's benefit package. DMAP coverage groups and/or Aid Categories that exclude transportation services as part of the benefit package include, but are not limited to, the following: Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLIMBs), Delaware Healthy Children Program (DHCP), Illegal Aliens (except in emergencies), Family Planning and Related services, Delaware Prescription Assistance Program (DPAP).

1.36.1.5   An escort is defined as an individual who must accompany a member due to member's physical/mental/developmental capacity. Examples of an escort include, but are not limited to, a parent, guardian, or an individual who assumes parental like responsibility, or an adult child of a geriatric parent. The escort's presence is required to ensure that the member receives proper medical service/treatment. Members are responsible for

providing their own escorts. DMAP is not responsible for arranging for or compensating an escort for services rendered.

1.36.2 Reimbursement Criteria

1.36.2.1   It is the responsibility of the member, a member's relative or a representative acting on behalf of the member to submit the prior authorization request for travel expenses and to make the necessary arrangements (i.e., meals, escort, lodging, etc.)

1.36.2.2   Related travel expenses for an escort may be reimbursed if the eligible member is under the age of 21 years and if the treatment and/or medical evaluation to be received is medically necessary.

1.36.2.3   Members age 21 and over requesting related travel expenses for an escort must submit a medical certification statement. The certification must document that the member has a physical/mental/developmental disability that requires assistance of an escort.

1.36.2.4   DMAP will reimburse a parent who is between the ages of 18 and 21 for related travel expenses when accompanying his or her minor child.

1.36.2.5   DMAP reimburses for related travel expenses (including tips/gratuity) as follows:

- $30.00 maximum allowed per day per person for meals (receipts not required)

- $40.00 maximum allowed per day for lodging (with receipts or invoices)

- Incidental related travel expenses not covered by the DMAP broker require receipts if the expense exceeds $10.00 per occurrence.

1.36.2.6   DMAP will prior authorize related travel expenses based on medical necessity. A re-determination is required for travel expenses that exceed 31 days.

1.36.3 Limitation and/or exclusions

1.36.3.1   DMAP limits reimbursement of related travel expenses to ONE authorized escort per eligible member per medical service treatment and/or evaluation. DMAP eligible members who are receiving inpatient hospital services will not be entitled to meals/lodging reimbursement.

1.36.3.2   The following are not related travel expenses and DMAP reimbursement will not be authorized:

- An escort for companionship or social reasons

- An escort under age 21 accompanying an adult

- Personal care items for an escort or member

- Earned or unearned income, wages, fees or similar compensation lost or forfeited by the member and/or escort

- Related travel expenses for volunteer drivers

- Related travel expenses for day trips

- Related travel expenses for medical service treatment and/or evaluations provided in the state of Delaware

- Alcoholic beverages

- Movie rental, pay television (including cable and/or direct TV service)

- Internet service

- Room service

- Regional and long distance phone charges and fees assessed for local calls

- Laundry and/or dry cleaning

- Other items as determined by DMAP

1.36.3.3   Lodging must be obtained at the most economical facility available. Local resources such as Ronald McDonald House must be used whenever possible.

1.36.4   How To Obtain Prior Authorization

1.36.4.1   All travel expenses must be prior authorized. Prior authorization requests for travel expenses must be submitted in writing using the Prior Authorization Request for Related Travel Expenses form. Refer to appendix M of this manual for a copy of the required form.

1.36.4.2   The request for prior authorization must include the following information.

1.36.4.2.1   Name, address and phone number of Medicaid member

1.36.4.2.2   Member's Medicaid ID number

1.36.4.2.3   Member's date of birth

1.36.4.2.4   Dates and number of days related travel expenses are needed

1.36.4.2.5   Lodging arrangements (name, address and phone number)

1.36.4.2.6   Name, address, phone number and Social Security number of escort (if applicable)

1.36.4.2.7   Detailed medical history from attending practitioner documenting the medical necessity of the services to be received.

1.36.4.2.8   Letter from the attending practitioner that documents that the treatment and/or medical evaluation to be received is not available in Delaware

1.36.4.2.9   Name, address and phone number of facility in which treatment and/or medial evaluation will be received

1.36.4.3   Completed Prior Authorization Request for Related Travel Expenses Form (refer to Appendix M) and all required information must be mailed or faxed to:

> Medical Review Team
> P.O. Box 906
> Lewis Building
> New Castle, DE 19720
> OR
> Faxed to: (302) 255-4425

1.37   Program Integrity

1.37.1   Provider Suspension

1.37.1.1   Suspension of Provider Agreement – In the event DMAP identifies a suspected case of fraud or abuse based on reliable evidence, it may summarily suspend the provider agreement when such action is necessary to prevent or avoid immediate danger to the public health and safety of it citizens or the financial security of the Agency and the State of Delaware. DMAP will notify the provider of the suspension which will be effective immediately upon written, electronic, or oral notification. This provider agreement suspension temporarily bars the provider from participation in the medical assistance program, pending investigation and DMAP action. When a provider agreement is suspended under this section, DMAP will provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal. DMAP will not reinstate or enroll providers that present encumbrances, including licenses, suspensions, terminations, or exclusions from Medicare or other State Medicaid or

CHIP programs. An encumbered license means a license that is revoked, suspended, or made probationary or conditional by the state licensing or registering authority as the result of disciplinary action. Non-encumbered providers must submit an enrollment application and will be considered for enrollment at the discretion of DMAP.

1.37.1.2   Suspension of Payments – DMAP may suspend payments in whole or in part when the agency receives reliable evidence of fraud or willful misrepresentation under the DMAP Program. DMAP may also suspend payments where a provider suspected of fraud or abuse fails to provide immediate access to medical or billing records. Further, DMAP may withhold payments without first notifying the provider of its intention to withhold such payments. DMAP will send written notice according to 42 CFR 455- 233(b) within five (5) days of taking such action. The notice will state: a) that the payments are being withheld under the terms of the Provider Manual and Federal regulations at 42 CFR 455.23, b) that the withholding is temporary and will identify the circumstances when the withholding will be terminated, c) that the withholding applies to certain types of Medicaid claims, and d) that the provider has the right to submit written evidence for consideration by DMAP. When a provider requests an administrative review, DMAP will provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal. Suspensions of payment will be temporary and will not continue after DMAP or the prosecuting authorities determine there is insufficient evidence of fraud or willful misrepresentation by the provider, or legal proceedings related to the provider's alleged fraud or abuse are completed.

1.37.2   **Provider Screening and Enrollment**

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 (CHIP) to prevent fraud, waste, and abuse. In compliance with 42 CFR 455, Subpart E, the enhanced provisions include enrollment fees, additional provider screening requirements, temporary provider enrollment moratoria, and provider termination.

1.37.2.1   Provider Enrollment Fee

Effective, March 30, 2010, Section 6401(a) of the Affordable Care Act (ACA) requires states to impose a fee on institutional providers for program integrity efforts. The fee is required at initial enrollment, revalidation, reactivation, and re-enrollment. The enrollment fee amount is established by the Centers for Medicare and Medicaid Services (CMS) and updated annually. The Delaware Medical Assistance Program (DMAP) will begin collection of fees in August of 2013. Institutional providers who are enrolled in or have paid the application fee to Medicare or another State's Medicaid or CHIP Program are exempt from paying the fee to DMAP. Individual providers and professional provider groups are not required to pay the fee. The enrollment fee may also be waived for providers who present proof of hardship. DMAP will review all hardship

exception requests on a case-by-case basis and has the authority to deny hardship exception requests. Hardship exception requests that meet DMAP criteria will be advanced to the Centers for Medicare and Medicaid Services (CMS) as the only authority for approval.

1.37.2.2   Provider Screening and Enrollment Requirements for the Fee-For-Service (FFS) Program

The Affordable Care Act (ACA) requires states to perform enhanced screening of providers at initial enrollment, re-enrollment, establishment of a new location, change of location, disclosure and revalidation. Ordering, referring and prescribing providers are required to enroll with DMAP in a limited capacity and are subject to the new provider screening initiatives. The ACA requires DMAP to deny or terminate the enrollment of any providers, disclosed entities, or individuals who do not meet ACA screening guidelines.

1.37.2.2.1   Disclosure

In compliance with [42 CFR 455, Subpart B](), providers and fiscal agents must complete an online disclosure statement at enrollment, revalidation, re-enrollment and reactivation, identifying persons with 5% or more ownership, controlling interest, and all managing employees.

Providers must also disclose any change contained in the enrollment application within thirty (30) calendar days of the event. Reportable changes include but are not limited to the following changes in:
- Ownership, controlling interest or managing employees;
- Conviction of criminal offense in any program under Medicare, Medicaid or Title XX;
- Licensure, permit, certification, accreditation;
- Federal tax identification number;
- Bankruptcy;
- Additions, deletions, or replacements in group membership; and
- Any change in address, telephone number, or email.

1.37.2.2.2   Provider Risk Categories

Based on the potential for fraud, waste, and abuse, CMS has assessed the various Medicare provider types and assigned risk categories. DMAP will assign a risk category in accordance with CMS guidelines for non-Medicare providers. Provider screening requirements vary depending on ACA-defined risk categories. The risk categories are "limited", "moderate", and "high." Providers falling within two risk levels will be assigned the higher risk level category. DMAP reserves the right to modify provider risk levels as it pertains to encumbrances, adverse actions, sanctions, terminations, and suspensions.

- Limited Risk Level – All providers and disclosure-identified individuals must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various databases will be reviewed routinely throughout the phases of enrollment for sanctions, exclusions, terminations, and

encumbrances. Limited risk level providers include but are not limited to the following as identified by CMS:

- o Physicians
- o Non physician practitioners
- o Medical groups or clinics
- o Hospitals
- o Ambulatory Surgical Centers (ASCs)
- o Early Stage Renal Disease (ESRD) facilities
- o Federally Qualified Health Centers (FQHCs)
- o Skilled Nursing Facilities (SNFs)

- Moderate Risk Level – Moderate risk providers are subject to unannounced pre-enrollment and post-enrollment site visits. Moderate risk providers and disclosure-identified individuals must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various databases will be reviewed routinely throughout the phases of enrollment for sanctions, exclusions, terminations, and encumbrances. Moderate risk level providers include but are not limited to the following as identified by CMS:
  - o Ambulance providers
  - o Community Mental Health Centers
  - o CORF – Comprehensive Outpatient Rehabilitation Facilities
  - o Revalidating providers of Durable Medical Equipment (DME), Prosthetics, Orthotics, and Suppliers
  - o Revalidating Home Health Agencies (HHA)
  - o Hospice organizations
  - o Laboratories – independently owned

- High Risk Level – High risk providers and disclosure-identified persons with 5% or more ownership are required to comply with a fingerprint-based criminal background check (FCBC) and unannounced pre-enrollment and post-enrollment site visits. High risk providers and disclosure-identified persons must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various databases will be reviewed routinely throughout the phases of enrollment for sanctions, exclusions, terminations, and encumbrances.

  High risk level providers include but are not limited to the following as identified by CMS:
  - o Providers of Durable Medical Equipment (DME), Prosthetics, Orthotics and Suppliers (newly enrolling)
  - o Home Health Agencies (newly enrolling)

  Providers of Durable Medical Equipment (DME), Prosthetics, Orthotics and Suppliers must successfully enroll with Medicare prior to enrolling with DMAP. Home Health Agencies (HHA) must successfully enroll with Medicare and / or possess current accreditation from at least one of the national accreditation

organizations prior to enrolling with DMAP. A current list of approved accreditation organizations can be found at the [National Association for Home Care & Hospice](#) website. High-risk provider types that are not recognized by Medicare for enrollment will be reviewed for DMAP enrollment on a case-by-case basis.

1.37.2.2.3   Ordering, Referring and Prescribing Providers (ORPs)

Physicians and non-physician practitioners whose sole interaction with members is limited to ordering, referring, or prescribing items and/or services, are required to enroll with DMAP in a limited capacity for purposes of identifying the providers who write the orders, referrals, and prescriptions. Failure to enroll with DMAP will result in the denial of claims for items ordered, referred, or prescribed for Medicaid beneficiaries by an ORP.

1.37.2.2.4   Temporary Provider Enrollment Moratoria

The ACA requires states to comply with a temporary provider enrollment moratorium when directed by the federal Secretary of Health and Human Services to combat fraud, waste, and abuse. States may also implement restrictions on new enrollment for provider types that are identified as high risk for fraud, waste, and abuse.

1.37.2.2.5   Provider Termination

Section 6501 of the ACA mandates that States terminate the enrollment of providers who have been terminated from Medicare or another State's Medicaid or CHIP program. On a monthly basis, DMAP will screen all enrolled providers through various federal databases for sanctions, exclusions, and terminations. All individuals and entities identified through disclosure statements are also subject to these screenings. DMAP will terminate providers and disclosed entities or individuals who do not meet ACA screening guidelines unless DMAP, in its sole discretion, opts to request a waiver from CMS.

1.37.2.2.6   Provider Appeal Rights

Denial and termination decisions following provider screening and enrollment procedures are appealable; however, the scope of the appeal is limited to whether the provider was terminated by Medicare or the initiating state Medicaid or CHIP program. The appeal does not provide an opportunity for the provider to contest the basis of the termination by Medicare or other state's Medicaid or CHIP program. Refer to Section 6.0 Appendix A in the General Policy Provider Manual for information regarding provider appeals.

1.37.2.3   Enhanced Program Integrity Requirements for Delaware Managed Care Organizations (MCO) and Managed Care Organization Only Providers (MCOP)

In compliance with [42 CFR 438.602](#), [42 CFR Part 455](#), subparts B and E, and the [21st Century Cures Act](#), DMAP will conduct enhanced screening and enrollment processes for all Managed Care Organizations and network providers. *For the purpose of DMAP policies and communications MCO network providers may also be referred to as Managed Care Organization Only Providers (MCOPs) and Managed Care Organizations may also be referred to as Managed Care Organization Plans*. Additional screening requirements include the following:

1.37.2.3.1   Provider Screening and Enrollment Requirements

- The DMAP will perform enhanced screening of all MCOPs at initial enrollment, re-enrollment, establishment of a new location, change of location, disclosure, and revalidation. MCOPs are required to enroll with DMAP in a limited capacity for the required screening; however, they are not required to service fee-for-service (FFS) members. Failure to enroll with DMAP will prevent MCOP participation in the Medicaid program.

- In accordance with federal requirements, DMAP will deny or terminate enrollment for MCOPs that do not meet the required screening guidelines. *Refer to section 1.38 of the General Policy Manual for the complete list of screening and enrollment guidelines*.

    o   Ordering, Referring and Prescribing Providers (ORPs)

    Physicians and non-physician practitioners whose sole interaction with members is limited to ordering, referring, or prescribing items and/or services are required to enroll with DMAP in a limited capacity for purposes of identifying the providers who write the orders, referrals, and prescriptions. Network providers enrolled as ORP providers will not be able to bill or submit claims. Failure to enroll with DMAP will result in the denial of claims for items ordered, referred, or prescribed for MCO members.

1.37.2.3.2   Disclosure

In compliance with [42 CFR 455, Subpart B](#), MCO Plans and MCOPs must complete an online disclosure statement at enrollment, revalidation, re-enrollment and reactivation, identifying persons with 5% or more ownership, controlling interest, and all managing employees. Providers must also disclose any change contained in the enrollment application within thirty (30) calendar days of the event. Reportable changes include but are not limited to the following changes in:

- Ownership, controlling interest or managing employees;
- Conviction of criminal offense in any program under Medicare, Medicaid, or Title XX;
- Licensure, permit, certification, accreditation;
- Federal tax identification number;

- Bankruptcy;
- Additions, deletions, or replacements in group membership; and
- Any change in address, telephone number, or email.

1.37.2.3.3   Provider Risk Categories and Federal Database Checks

Based on the potential for fraud, waste, and abuse, CMS has assessed the various Medicare provider types and assigned risk categories. DMAP will assign a risk category in accordance with CMS guidelines for non-Medicare providers. Provider screening requirements vary depending on ACA-defined risk categories. The risk categories are "limited", "moderate", and "high." Providers falling within two risk levels will be assigned the higher risk category. DMAP reserves the right to modify provider risk levels as it pertains to encumbrances, adverse actions, sanctions, terminations, and suspensions. In compliance with § 438.610(c), MCO Plans must take appropriate action for any network provider that does not meet screening guidelines upon notification from DMAP.

- Limited Risk Level – All providers and disclosure-identified individuals must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various federal databases will be reviewed routinely throughout the phases of enrollment for sanctions, exclusions, terminations, and encumbrances. Limited risk level providers include but are not limited to the following as identified by CMS:

  o Physicians
  o Non physician practitioners
  o Medical groups or clinics
  o Hospitals
  o Ambulatory Surgical Centers (ASCs)
  o Early-Stage Renal Disease (ESRD) facilities
  o Federally Qualified Health Centers (FQHCs)
  o Skilled Nursing Facilities (SNFs)

- Moderate Risk Level – Moderate risk providers are subject to unannounced pre-enrollment and post-enrollment site visits. Moderate risk providers and disclosure-identified individuals must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various databases will be reviewed routinely throughout the phases of enrollment for sanctions, exclusions, terminations, and encumbrances. Moderate risk level providers include but are not limited to the following as identified by CMS:

  o Ambulance providers
  o Community Mental Health Centers
  o CORF – Comprehensive Outpatient Rehabilitation Facilities
  o Revalidating providers of Durable Medical Equipment (DME), Prosthetics, Orthotics, and Suppliers
  o Revalidating Home Health Agencies (HHA)
  o Hospice organizations

      o   Laboratories – independently owned

- High Risk Level – High risk providers and disclosure-identified persons with 5% or more ownership are required to comply with a fingerprint-based criminal background check (FCBC) and unannounced pre-enrollment and post-enrollment site visits. High risk providers and disclosure-identified persons must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various databases will be reviewed routinely throughout the phases of enrollment for sanctions, exclusions, terminations, and encumbrances.

  High risk level providers include but are not limited to the following as identified by CMS:

  - Providers of Durable Medical Equipment (DME), Prosthetics, Orthotics, and Suppliers (newly enrolling)
  - Home Health Agencies (newly enrolling)

  Providers of Durable Medical Equipment (DME), Prosthetics, Orthotics, and Suppliers must successfully enroll with Medicare prior to enrolling with DMAP. Home Health Agencies (HHA) must successfully enroll with Medicare and / or possess current accreditation from at least one of the national accreditation organizations prior to enrolling with DMAP. A current list of approved accreditation organizations can be found at the National Association for Home Care & Hospice website. High-risk provider types that are not recognized by Medicare for enrollment will be reviewed for DMAP enrollment on a case-by-case basis.

1.37.2.3.4   Periodic Audits

The DMAP and/or its contractors will conduct periodic audits regarding the accuracy, truthfulness, and completeness of the MCO Plan's encounter and financial data.

1.37.2.3.5   Whistleblowers

The DMAP will initiate processes to receive and investigate referrals and allegations as they relate to fraud, waste, and abuse in the Delaware Medicaid Program and the Delaware Healthy Children Program.

2.0   Managed Care Options

2.1   Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP+)

2.1.1   The Diamond State Health Plan (DSHP) is a health insurance program that provides a comprehensive package of health benefits for low income Delawareans.

2.1.1.1   The Diamond State Health Plan Plus (DSHP+) is a health insurance program that provides a comprehensive package of health and home based benefits for the elderly and Delawareans with physical disabilities.

2.1.2   The DSHP and DSHP+ are not a provider of health care services; they are managed care programs administered by the Delaware Medical Assistance Program (DMAP) and funded by both federal and state dollars.

2.1.3   Under DSHP and DSHP+ eligible beneficiaries have a choice of managed care organizations (MCO). Eligible persons will select a plan and a primary care provider (their family doctor) who will assume responsibility for preventive and primary care and for necessary referrals. Beneficiaries will have a medical home, just as most insured people do.

2.1.4   The DMAP will interact with the health plans and monitor them for access to and quality of health care provided.

2.1.5   DSHP and DSHP+ will help improve the health status of most low-income people by emphasizing prevention, early intervention, community based services, and continuity of care.

2.1.6   **Health Benefits Manager**

2.1.6.1   DHSS contracts with a provider of health benefits management services. The Health Benefits Manager (HBM) will:

2.1.6.1.1   Provide outreach and education relative to enrollment.

2.1.6.1.2   Explain plans and enroll beneficiaries in them.

2.1.6.1.3   Help teach beneficiaries how to use managed care.

2.1.6.1.4   Act as beneficiary services representative.

2.1.6.1.5   Monitor beneficiary satisfaction or problems with plans.

2.1.6.1.6   Establish linkages with the community and the health plans.

2.1.6.2   DHSS oversees the HBM and will be actively involved in monitoring its
                 performance, as well as the performance of the managed care organizations
                 (MCOs).

      2.1.7   **Who Will Provide Services**

2.1.7.1   Selected MCOs will provide health services to DSHP beneficiaries.

2.1.7.2   MCO's provide services through a network of providers to cover DMAP's DSHP
                 and DSHP+ populations.

2.1.7.3   The MCOs are encouraged to work with community providers of mental health,
                 substance abuse, home health care and other services that enrolled beneficiaries
                 will need.

2.1.7.4   The Nemours Pediatric Centers and the Federally Qualified Health Centers
                 (FQHC) will contract with MCOs to continue to provide health services to low
                 income children.

      2.1.8   **Beneficiary Rights and Responsibilities**

2.1.8.1   When members enter a plan, they are required to choose a primary care
                 physician who will act as a medical home for them unless the member is a full
                 dual eligible OR resides in a nursing home (NH).

2.1.8.2   It is the plan's responsibility to see that members get appropriate, timely care and
                 that they are treated courteously.

2.1.8.3   DHSS will be monitoring the performance of the plan. If the MCO or HBM cannot
                 resolve a problem, the State's formal fair hearing procedure can be invoked.

2.1.8.4   Beneficiaries have the responsibility to utilize preventive services such as
                 receiving regular check-ups, available health screenings and appropriate
                 immunizations. They should keep appointments and follow doctors' instructions.

2.1.8.5   Plans also have the right to request a transfer for members for good cause. The
                 member must then select another plan. They may not opt out of the MCO
                 program.

      2.1.9   **Who Must Enroll In the DSHP?**

2.1.9.1   Categorically Eligible

2.1.9.1.1   All categorically eligible beneficiaries MUST enroll in the DSHP or DSHP+ except
                 the following exempt groups:

- Developmental Disabled Waiver

- Partial duals (QMB's, SLMB's, and Q1's)

- PACE

- ICF/MR

- Emergency Services Medicaid

- Presumptive Pregnancy

- Breast and cervical cancer

- 30 Day Acute Care

- Transient farm workers who reside in the State for less than three months
  a year

2.1.9.1.2   Covered services (refer to Medicaid Eligibility Groups and Covered Services,
                 Categorically Eligible section of this General Policy) provided to these exempt
                 individuals will be reimbursed on a "fee for service" basis.

2.1.9.2   Expanded Population

2.1.9.2.1   All expanded population beneficiaries must enroll in the DSHP. This population is
                 eligible for all services included in the MCO benefit package to include non-
                 emergency transportation, dental services, behavioral health services, and
                 EPSDT/CSCRP services for members under age twenty-one provided by
                 enrolled school districts.

2.1.9.2.2   The following individuals/families may be eligible for Medicaid in Delaware as
                 part of the expanded population if they meet certain requirements:

2.1.9.2.2.1   Any uninsured adult age 19 or over who has family income at or below 133% of
                 the federal poverty level.

2.1.10   Coverage Under the MCO Benefits Package

2.1.10.1   Eligible MCO beneficiaries will receive two insurance cards. One card will be
                 issued by the MCO and valid for the services included in the MCO benefit
                 package chosen by the beneficiary.

2.1.10.2   The services listed below are included when medically necessary in the MCO Benefit Package.

2.1.10.2.1   Physician

2.1.10.2.2   Inpatient hospital and outpatient hospital – includes all pharmaceuticals and blood products

2.1.10.2.3   Independent laboratory

2.1.10.2.4   Home health

2.1.10.2.5   Emergency transportation

2.1.10.2.6   Medically necessary durable medical equipment/supplies

2.1.10.2.7   Podiatry

2.1.10.2.8   Optometry/optician

2.1.10.2.9   Rehabilitation agency

2.1.10.2.10   Ambulatory surgical center

2.1.10.2.11   Dialysis center

2.1.10.2.12   Family planning

2.1.10.2.13   Nurse/midwife

2.1.10.2.14   Certified registered nurse practitioner;

2.1.10.2.15   General medical clinic services except environmental investigation for source for lead and Preschool Developmental Diagnostic Nursery (PDDN)

2.1.10.2.16   EPSDT screening clinic except Part C Multidisciplinary Assessment

2.1.10.2.17   Medication Assisted Outpatient Treatment Program (MA-OTP) clinic

2.1.10.2.18   Hospice

2.1.10.2.19   EPSDT group and individual services

2.1.10.2.20   EPSDT nutrition services, occupational, speech and physical therapies

2.1.10.2.21   Nutrition assessment, counseling, education and intensive behavioral therapy for obesity treatment:

Adults
- Intensive behavioral therapy recommendations for adult members with a qualifying diagnosis and a BMI greater than (>) 30, no less than 12 visits.
- Intensive behavioral therapy recommendations for adults with one or more risk factors for cardiovascular disease and a BMI of greater than (>) 25, no less than 6 contact hours.

Children
- Intensive behavioral therapy recommendations for children 3 years or older with a BMI greater than (>) 95th percentile, no less than 12 visits.
- Intensive behavioral therapy recommendations for children 3 years or older with a BMI > 85th percentile, no less than 8 visits.

2.1.10.2.22   Behavioral Health, Substance Use Disorder (SUD), and Crisis Intervention (CI) Services: Adult member services are provided by the MCO with the exception of PROMISE Program participants. Behavioral health benefits for members under age 18 are limited to 30 units provided by the MCO; additional units are provided by the Department of Services for Children, Youth and Their Families (DSCYF). Inpatient behavioral health services are provided by DSCYF for members under age 18.

2.1.10.2.23   Federally Qualified Health Center (FQHC)

2.1.10.2.24   Skilled nursing services in a nursing facility up to 30-day annual limit

2.1.10.2.25   Private duty nursing services (PDN)

2.1.10.2.26   Removal of bony-impacted wisdom teeth

2.1.10.2.27   Nursing homes

2.1.10.2.28   Waivers excluding the DD waiver

2.1.10.2.29   School Based Wellness Centers

2.1.10.2.30   Pharmacy

2.1.10.3   Reserve

2.1.11   Additional Services are Covered Under the Medical Assistance Program

The second insurance card will be a Medical Assistance card that will be used for services not covered by the MCO benefits package but reimbursed by the Medical Assistance program. These services are often referred to as "wrap around services". The categorically eligible and the expanded population receive a different package of "wrap around services".

2.1.11.1   Wrap Around Services that are Covered for the Categorically Eligible Medicaid Member

The services listed below are not included in the MCO Benefit Package but are covered for the categorically eligible Medicaid member using their Medical Assistance Card:

2.1.11.1.1   Extended behavioral health services authorized by the Division of Substance Abuse, and Mental Health (DSAMH) for adults deemed severely and persistently ill (SPI).

2.1.11.1.2   Non-emergency transportation

2.1.11.1.3   Environmental investigation for source of lead provided by DPH for members under age 21.

2.1.11.1.4   Preschool Developmental Diagnostic Nursery (PDDN)

2.1.11.1.5   Part C Multidisciplinary Assessment

2.1.11.1.6   Prescribed Pediatric Extended Care (PPEC) services for members under the age of 21 that are authorized by Medicaid staff.

2.1.11.1.7   EPSDT/CSCRP services provided by enrolled school districts.

2.1.11.1.8   Chronic renal disease program transportation services authorized by Medicaid staff.

2.1.11.1.9   Part C developmental therapy and social work

2.1.11.1.10   Behavioral health services for children authorized by the Department of Services for Children, Youth, and Their Families (DSCYF).

2.1.11.2   Wrap Around Services that are Covered for the Expanded Population

The services listed below are not included in the MCO Benefit Package but are covered for the expanded population Medicaid member using their Medical Assistance Card.

2.1.11.2.1   Extended behavioral health services authorized by the Division of Substance Abuse, and Mental Health (DSAMH) for members deemed seriously and persistently ill.

2.1.11.2.2   Non-emergency transportation

2.1.11.2.3   Chronic renal disease program transportation services authorized by Medicaid staff.

2.1.11.2.4   Dental services for members under age 21.

2.1.11.2.5   EPSDT/CSCRP services provided by enrolled school districts

2.1.12   **Reserved**

2.1.13   **Restricted "Lock-In members with MCO Coverage**

2.1.13.1   The DMAP "restricts" or "locks-in" certain members when it has been determined that they are engaged in abusive or fraudulent practices such as overutilization of prescription drugs. This restriction status is different from managed care programs in which members choose and are enrolled with a medical care plan.

2.1.13.2   In general, restriction means that the DMAP will limit payments to one primary pharmacy. If the restricted member has prescriptions filled at other pharmacies, the DMAP will not pay for these unauthorized claims and the member can be held responsible for such claims.

2.1.13.3   Once an abuse/fraud has been identified, the member is notified by mail explaining the purpose of his/her restricted/lock-in status. A restricted member's case is reviewed within one year to decide if his/her restriction should be continued or lifted. After one year, the member's restricted status may be lifted, or continued for an additional twenty-four months.

2.1.13.4   After selection, by the member, of one pharmacy, the DMAP Office determines by contact and written confirmation that a provider agrees to act in this capacity. No pharmacy should accept the Medical Assistance card of a restricted member for payment unless this agreement has been reached, or confirmation for consultation/special services has been given by the DMAP office.

2.1.13.5   To avoid difficulty in obtaining payment, providers shall always access one of the EVS options for restricting status. Instructions to accessing EVS are described in the EVS section of the billing manual.

2.1.14   **Accessible Managed Care Insurance Carriers**

2.1.14.1   Members are required to comply with the rules and procedures of their private accessible managed care insurance. The DMAP will no longer pay for medical services that have been denied by private accessible managed care insurance carriers for reasons related to the insured's failure to comply with the policy's procedures. Examples are claims denied by the private managed care insurance because:

2.1.14.1.1   There was no referral from the primary care physician.

2.1.14.1.2   The medical provider was out of the network.

2.1.14.1.3   There was no pre-certification or authorization.

2.1.14.1.4   Emergency room service without referral for a non-emergency service.

2.1.14.2   Services that are not included in the accessible managed care insurer's plan but are covered by the DMAP will be paid by the DSHP MCO that the member has selected.

2.2   Delaware Healthy Children Program (DHCP)

Section 4901 of the Balanced Budget Act of 1997 (P.L. 105-33) establishes Title XXI of the Social Security Act that defines a new State Child Health Insurance Program (SCHIP). This enables States to initiate and expand the provision of health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverages for children.

Enabling legislation in Delaware named this program the Delaware Healthy Children Program (DHCP) and established rules within the requirements of Title XXI.

2.2.1   Health Benefits Manager

DHSS contracts with a provider of health benefits management services. The Health Benefits Manager (HBM) will:

2.2.1.1   Provide outreach and education relative to enrollment.

2.2.1.2   Explain plan and enroll beneficiaries.

2.2.1.3   Help teach beneficiaries how to use managed care.

2.2.1.4   Act as beneficiary services representative.

2.2.1.5   Monitor beneficiary satisfaction or problems with plan.

2.2.1.6   Establish linkages with the community and the health plan.

2.2.2   Who will provide the service?

2.2.2.1   Selected MCOs will provide health services to DHCP beneficiaries.

2.2.2.2   The MCOs are encouraged to work with community providers of mental health, substance abuse, home health care and other services that enrolled beneficiaries will need.

2.2.3   Beneficiary Rights and Responsibilities

2.2.3.1   When members enter the DHCP they select or are assigned primary care physicians who will provide medical homes for them.

2.2.3.2   It is the plan's responsibility to see that members get appropriate, timely care and that they are treated courteously.

2.2.3.3   DHSS will be monitoring the performance of the plan.

2.2.3.4   If the MCO or HBM cannot resolve a problem, the State's formal grievance procedure can be invoked.

2.2.3.5   Beneficiaries have the responsibility to utilize preventive services, such as receiving regular check-ups, available health screenings, and appropriate immunizations. They should keep appointments and follow doctors' instructions.

2.2.3.6   Plans also have the right to disenroll members for good cause, such as consistently using the emergency room inappropriately. The member must then select another plan.

2.2.3.7   The member may not opt out of the MCO program.

2.2.4   Who is eligible for the DHCP?

To be eligible for the DHCP the child must:

2.2.4.1   Be under the age of 19 years (through 18).

2.2.4.2   Have a family income less than or equal to 200% of the Federal Poverty Level (FPL).

2.2.4.3   Be a current Delaware resident with intent to remain.

2.2.4.4   Be uninsured for at least six previous months (exceptions to this would be made if coverage is lost due to: death of parent, disability of parent, termination of employment, change to a new employer who does not cover dependents, change of address so that no employer-sponsored coverage is available, expiration of the coverage periods established by COBRA, employer terminating health coverage as a benefit for all employees).

Note: Applicants who have been uninsured less than six months will be given a time when their pending application for the program can be approved.

2.2.5   Other Standards

2.2.5.1   A child must:

2.2.5.1.1   Be a citizen of the United States or must have legally resided in the U.S. for at least five years if their date of entrance into the U.S. is 8/22/96; **OR**

2.2.5.1.2   Meet the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) definition of qualified alien who is not subject to the five-year bar; AND

2.2.5.1.3   Be ineligible for enrollment in any public health plan.

2.2.5.2   All DHCP beneficiaries MUST enroll with an MCO. This population is not eligible for any services until the effective date of their MCO enrollment.

2.2.5.3   Families may not choose the DHCP coverage as an alternative to Medicaid. Federal law requires that any child eligible under Medicaid must accept Medicaid coverage if they wish to participate in either program.

2.2.6   Coverage under the DHCP MCO Benefits Package

2.2.6.1   Those eligible for the DHCP will receive two insurance cards. One card will be issued by the MCO and is valid for services included in the DHCP basic benefits package.

2.2.6.2   The following services are included in the DHCP and are covered as part of a basic MCO benefit package when medically necessary:

2.2.6.2.1   Inpatient hospital services

2.2.6.2.2   Outpatient hospital services

2.2.6.2.3   Physician services

2.2.6.2.4   Surgical services

2.2.6.2.5   Clinic Services (including health center services) and other ambulatory health care services

2.2.6.2.6   Laboratory and radiological services

2.2.6.2.7   Prenatal care and pre-pregnancy family planning services and supplies

2.2.6.2.8   Outpatient mental health services, other than outpatient substance abuse treatment services, but including services furnished in a State-operated mental hospital and including community-based services - thirty days of outpatient care included in the basic MCO benefit

2.2.6.2.9   Durable medical equipment and other medically-related or remedial devices such as prosthetic devices, implants, eyeglasses, hearing aids, and adaptive devices)

2.2.6.2.10   Disposable medical supplies

2.2.6.2.11   Home and community-based health care services **-** limited to medically necessary home health services provided by the MCOs as part of the basic benefit. Does NOT include personal care, chore services, day care, respite care, or home modifications. Home health aide services are covered as medically necessary according to the State's published definition.

2.2.6.2.12   Nursing care services **-** there is a limit of twenty-eight hours of Private Duty Nursing (PDN) services per week in the basic benefit, no additional hours available

2.2.6.2.13   Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest – subject to the rules for Federal funding

2.2.6.2.14   Outpatient substance abuse treatment services – limited to thirty days inclusive of outpatient mental health services

2.2.6.2.15   Case management services

2.2.6.2.16   Care coordination services

2.2.6.2.17   Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders

2.2.6.2.18   Hospice care

2.2.6.2.19   Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services

2.2.6.2.20   Medical transportation - emergency transportation only as provided in the basic benefit package

2.2.6.2.21   Removal of bony-impacted wisdom teeth

2.2.6.3   NOT included in this program are dental services (other than the removal of bony-impacted wisdom teeth), non-emergency transportation and any other service not specified above.

2.2.7   Additional Services Are Covered Under The Medical Assistance Program

The second insurance card will be a DHCP card that will be used for services not covered by the MCO but reimbursed by Medicaid. These services are often referred to as "wrap around services."

2.2.7.1   Wrap Around Services that are Covered by Medicaid for DHCP Eligible Members

2.2.7.1.1   Prescription drugs **-** with the same limitations as the Title XIX program.

2.2.7.1.2   Over-the-counter medications - limited to drug categories where the over-the-counter product may be less toxic, have fewer side effects, and be less costly than an equivalent legend product.

2.2.7.1.3   Inpatient and outpatient mental health and substance abuse services as authorized by the Department of Services to Children, Youth and Their Families (DSCYF) or the Division of Substance Abuse and Mental Health (DSAMH).

2.2.7.1.4   Dental services

2.2.8   Emergency Room Co-Pay

2.2.8.1   The family must pay $10.00 co-pay (coinsurance) per emergency room visit. This co-pay will be waived if the emergency room visit results in immediate inpatient hospitalization or if a prudent layperson would interpret the need for the visit to the ER to be an emergency.

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3.0   Medical Assistance Card

3.1   Overview

3.1.1   The Medical Assistance Card is used to verify an individual's eligibility for medical assistance benefits.

3.1.2   Providers are required to verify member eligibility, managed care enrollment, and other important member information prior to rendering services by accessing one of the EVS options. Instructions for accessing EVS are described in the EVS section of the billing manual. Providers submitting National Council for Prescription Drug Programs (NCPDP) claims that are interactive may treat the claim response as verification of eligibility, coverage and patient responsibility.

3.1.2.1   The provider will receive a confirmation number at the time of each member inquiry. This confirmation number only verifies member eligibility and is not a guarantee of payment. It is the provider's responsibility to review the services covered by the plan the member is eligible for to determine whether the service will be covered.

3.1.3   The medical assistance card(s) are mailed to the "head of household" or "payee" and issued to each individual family member.

3.1.4   The medical assistance card is a permanent card. New cards will be issued only if the original card is lost or stolen.

3.2   General Information

3.2.1   There are two valid medical assistance cards. Both cards are plastic and are permanent cards.

3.2.2   The card may either be gray or white in color and is affixed with the burgundy logo of Delaware Health and Social Services.

3.2.3   The front of the medical assistance card identifies the member's name, Medicaid ID#, date of birth and card issue number.

3.2.4   The following information is found on the back of the medical assistance card:

3.2.4.1   A magnetic strip that is coded with the member's ID number.
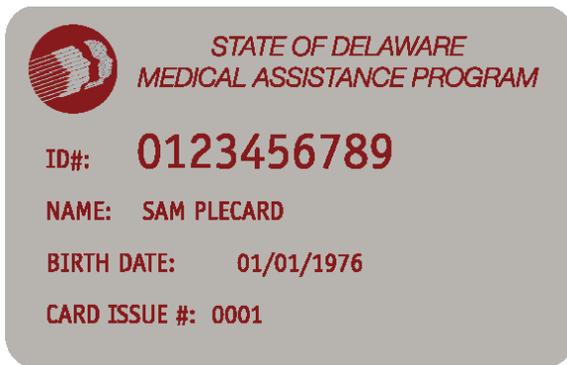
3.2.4.2   The telephone numbers to VRS and Provider Relations. These numbers may be used by the provider to verify member eligibility and member information.

3.2.4.3   The telephone number and TTY number of Customer Relations. Card holders may use these numbers to answer questions regarding the card and/or their medical coverage.
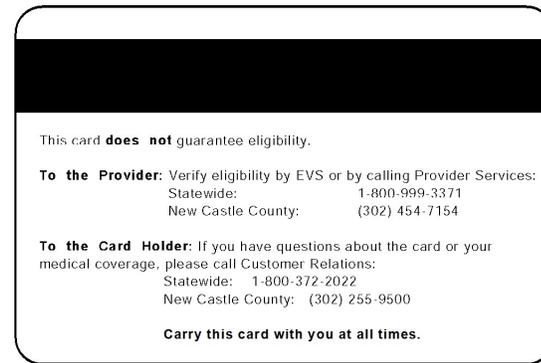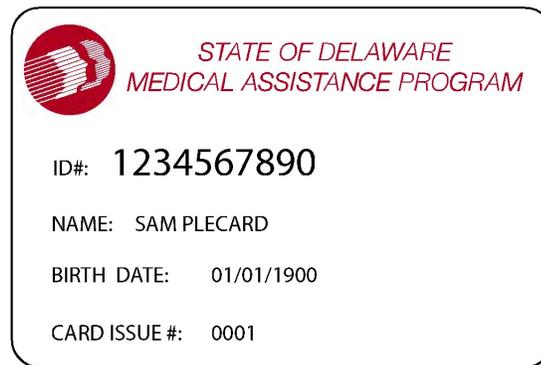
3.2.5   An individual may lose their eligibility at any time. Therefore, it is extremely important that each individual be required to present their Medical Assistance card at the time of each medical service so the provider may check the member information at the time of each visit.

3.3   Copy of the Medical Assistance Card

Effective July 2002-Present

STATE OF DELAWARE
MEDICAL ASSISTANCE PROGRAM

ID#: 0123456789

NAME: SAM PLECARD

BIRTH DATE: 01/01/1976

CARD ISSUE #: 0001

This card **does not** guarantee eligibility.
To the Provider: Verify eligibility by EVS or by calling Provider Services:
          Statewide: 1-800-999-3371
          New Castle County: (302) 454-7154
To the Card Holder: If you have questions about the card or your medical coverage, please call Customer Relations:
          Statewide: 1-800-372-2022
          New Castle County: (302) 577-4900
          Carry this card with you at all times.

Effective August 2006-Present

STATE OF DELAWARE
MEDICAL ASSISTANCE PROGRAM

ID#: 1234567890

NAME: SAM PLECARD

BIRTH DATE: 01/01/1900

CARD ISSUE #:   0001

This card **does not** guarantee eligibility.

To the Provider: Verify eligibility by EVS or by calling Provider Services:
          Statewide: 1-800-999-3371
          New Castle County: (302) 454-7154

To the Card Holder: If you have questions about the card or your medical coverage, please call Customer Relations:
          Statewide: 1-800-372-2022
          New Castle County: (302) 255-9500

          Carry this card with you at all times.

3.4   Eligibility Confirmation

3.4.1   It is the provider's responsibility to verify a member's current eligibility and managed care enrollment each time a service is provided. The provider should request that the member show a current Medical Assistance card and Managed Care Organization (MCO) card, to establish eligibility.

3.4.2   Pharmacy providers should refer to the Billing Instructions/POS Transactions section of the Pharmacy Manual, which outlines member eligibility confirmation via the authorization number for POS/DUR.

3.4.3   The provider may obtain assistance regarding eligibility information, restricted/hospice/managed care/Qualified Medicare Beneficiary coverage and third party liability information by accessing the VRS and/or the EVS/(POS) for restriction status.

3.4.4   E-Prescribing providers, through their POC system, will have the ability to receive eligibility information for their patients one day in advance. This verification does not guarantee payment.

4.0   Coordination of Benefits/Third Party Liability

4.1   Other Coverage

4.1.1   DMAP members are often covered by other medical insurance plans. Prominent examples in the State of Delaware are Medicare, Blue Cross/Blue Shield, Military Health Insurance for Active Duty, Retired Military, and Their Dependents, Aetna, Principal Health Care, and Health and Welfare Funds through union membership. Other coverage is usually employment related and many times are carried on children by an absent parent.

4.1.2   Other coverage may also include charitable funds, other governmental programs, court settlements, workmen's compensation coverage, no-fault insurance, or payment by a proprietary source through a contractual arrangement.

4.1.3   In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by combining the member's co-payments, co-insurance and deductibles. Claims that do not contain a patient responsibility will deny.

4.1.4   When calculating payment methodology for claims with TPL primary, DMAP will pay the lesser of patient responsibility or DMAP allowed amount minus TPL paid amount.

4.2   Last Payer

4.2.1   Because other insurance coverage is commonly available, the Federal Government, as a way of saving taxpayers' moneys, has required by law that DMAP be a payer of last resort. This means that Medicaid can only pay after all other available insurance coverage has been billed first. If a provider receives payment from a third party after the DMAP has paid a claim, the provider must report the payment to the DMAP. Refer to the Billing Instructions, Refund Adjustments section of your provider manual.

4.3   Eligibility Condition

4.3.1   It is important for members to inform medical providers of other health coverage. As a condition of eligibility, the member must sign a statement on the Medicaid application agreeing to inform the Program of other coverage and to allow the DMAP to recover moneys paid out where a liable third party, such as an insurance company, is responsible.

4.4　　　　　　Medicaid/Medicare Members

Medicaid "Buys-In" Part A and/or Part B Medicare for certain eligible members. Some of these members are eligible for the whole range of Medicaid services. QMBs are not eligible for the full range of Medicaid services; however, they are eligible for the full range of Medicare services. When coordinating benefits for dual eligible members, Medicaid will not pay any charges denied by Medicare with the exception of:

- Those services not covered by Medicare but covered by Medicaid, or
- Services covered by both Medicare and Medicaid but with different limits or criteria. In these instances Medicaid will determine coverage on the basis of its own policy.

4.4.1　　　　　　Part A & Part B Medicare Services.

4.4.1.1　　　In order for claims for dual eligible members to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by combining the member's co-payments, coinsurance and deductibles. Claims that do not contain patient responsibility will deny.

4.4.1.2　　　When calculating payment methodology for claims for dual eligibles, DMAP will pay the lesser of patient responsibility for DMAP allowed amount minus Medicare paid amount.

4.4.1.3　　　Zero payment will be made when the Medicare payment is equal to or higher than the Medicaid rate.

4.4.1.4　　　For the QMB members, the services must be covered by Medicare to be considered for payment by the DMAP.

4.4.1.5　　　For services that are not covered by Medicaid, DMAP will pay the full Medicare coinsurance and deductible.

4.4.1.6　　　Participating providers agree to accept the final DMAP payment disposition as payment in full. Therefore, members eligible for both Medicaid and Medicare should not be billed for any non-covered charges or remaining portions of the Medicare deductible and coinsurance. Exceptions to the DMAP policy prohibiting the billing of members are available in the Billing DMAP Members section of this General Policy Manual.

4.5   Third Party Liability Guide

4.5.1   The Third Party Liability Guide found at the end of this section may be of assistance when inquiring about other health insurance on your patients.

4.5.2   The usual elements necessary for billing a medical plan are:

4.5.2.1   Name, address, and policy number of the insurance company

4.5.2.2   Policyholder's Identification number (ID)

4.5.2.3   Policy Group number

4.5.2.4   Coverage Description

4.5.2.5   Effective dates of coverage

4.5.3   Effective 01/01/2017 providers may obtain insurance information known to the DMAP by accessing the Delaware Medical Assistance Provider Portal. Providers may also use one of the EVS options as described in the EVS section of this manual. Providers must report any additional third party coverage or changes in coverage to the DMAP.

4.5.4   Effective 01/01/2017, providers may access the Provider Portal for Third Party Carrier Code information. Refer to Appendix F for Third Party Coverage Code information.

4.5.5   Because DMAP is a payer of last resort, it is especially important to screen patients for the existence of other health insurance coverage. Keep in mind that other insurance will usually pay more for the incurred charges than DMAP, hence it is beneficial to always inquire thoroughly.

4.5.6   To aid in turning up other possible sources of coverage, the following guide has been prepared. Although the DMAP program attempts to collect this information when a member becomes eligible, additional efforts in this area should not only increase provider's payments, but decreases the expenditures of taxpayers' moneys.

4.5.7   Third Party Liability Guide For Medical Providers

If You Find:	Then A Case Member May Be Eligible:
Any case member is over 65 or blind or disabled	Medicare and Medicare Supplemental Policies
A member, absent parent, step-parent, dependent child, new spouse of an absent parent, or anyone else who is legally or voluntarily responsible for a case member is EMPLOYED or a UNION MEMBER	Employment related health insurance
A case member, spouse of a case member, absent parent, or step-parent is ACTIVE DUTY MILITARY or A VETERAN	Military Health Insurance for Active Duty, Retired Military, and Their Dependents Coverage
Any case member has been in an accident or otherwise accidentally injured: INJURY/TRAUMA/ACCIDENT	*Workman's Compensation *Homeowner's Insurance *Automobile Insurance *Liability Insurance

5.0   Medicaid Newsletters

5.1   Information Updates

Providers may receive DMAP Newsletters via email notification by registering for 'Notify Me' on the [Provider Portal](). Providers may review previous editions as well as other informative documents via the [Provider Portal]().

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	Appeal Procedures for Adverse Actions for Providers Under the State of Delaware Medical Assistance Program

6.0　　　　　Appendix A – Appeal Procedures

1. PURPOSE

Delaware Health and Social Services is designated as the single state agency in Delaware responsible for the overall administration of Medicaid (Title XIX) and other medical assistance programs. This administrative responsibility is discharged at the operational level through the Delaware Medical Assistance Program (DMAP). The appeal procedures outline DMAP requirements and responsibilities in maintaining program integrity. The appeal procedures also assure compliance with federal regulatory requirements. The federal regulatory authority is the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

2. AUTHORITY

The regulations outlined in the appeal procedures are promulgated pursuant to the authority granted to the Secretary of the Department of Health and Social Services by 31 Delaware Code Chapter 1 §107.

3. DEFINITIONS

(a) Adverse Action – an official denial of services and/or denial of payment for those services, termination or non-renewal of a provider contract, limitation(s) on participation, denial of provider enrollment, or any action having an adverse monetary result. There is no right of appeal for denied Prior Authorization requests since the provider incurs no monetary loss for a service denied to a member.
(b) Deputy Director – the Deputy Director of DMMA or his/her designee.
(c) Director – the Director of DMMA or his/her designee.
(d) Hearing Officer – The Director or a person appointed by the Director to preside over a Director's level hearing
(e) Provider – any person or entity furnishing goods and/or services to DMAP-eligible members pursuant to a provider agreement with the DMAP or any person or entity offering to enter into a provider agreement with the DMAP.

4. GENERAL PROVISIONS

(a) A provider appeal filed in accordance with the DMAP appeal procedures does not stop the adverse action. However, upon application by the provider, the Director may, in its sole discretion and as permitted by federal law, grant a stay of the adverse action pending the outcome of the hearing.
(b) If the adverse action includes both monetary and contract/participation penalties, the provider shall appeal both actions simultaneously.
(c) The DMAP appeal process is not a formal legal proceeding; therefore, technical rules of evidence do not apply.
(d) Providers may be held responsible for costs incurred by the State related to processing appeals.
(e) Prior to submitting an appeal to the State, providers must exhaust all avenues of appeal and/or resolution through the entity that imposed the adverse action.

(1) For adverse actions imposed by a State-contracted entity, including the Recovery Audit Contractor, the provider must follow that entity's appeal process and/or inquiry protocol.

(2) For adverse actions imposed by the Surveillance and Utilization Review (SUR) Unit, the provider must:

   a) Contact the SUR Unit to discuss the adverse action
   b) Request a redetermination, and
   c) Have received the redetermination findings letter from the SUR Unit

Upon application by the provider, the Deputy Directory or Director may, in its sole discretion, waive this level of review.

 (f) For all other adverse actions, the provider must submit a written inquiry to Gainwell Technologies by accessing the Delaware Medical Assistance Portal for Providers to submit a Secure Correspondence. Providers should select the appropriate message category for their claims inquiry. Provider Enrollment appeals must be submitted via the Provider Appeals Mailbox.

5. DEPUTY DIRECTOR'S REVIEW
(a) To initiate an appeal, the provider must submit the DMAP Provider Appeals Form (located directly after this policy) to the Deputy Director within sixty (60) calendar days of the date indicated on one of the following documents.

   (1) The written correspondence from the State-contracted entity documenting the adverse action decision; or
   (2) The redetermination findings letter from the SUR Unit.

(b) The provider may include directly-related documentation to support the written appeal being submitted to the Deputy Director.

(c) During the review, the Deputy Director may seek clarification or elaboration on any of the issues in dispute and allow the provider to submit additional documentation.

(d) The Deputy Director's decision shall be based on the written submissions. The decision shall be final and no further appeals are afforded by the DMAP except as noted in 6(a).

6. DIRECTOR'S REVIEW
(a) Only decisions involving an adverse action of $25,000 or greater may be advanced to the Director. The provider must mail a written request for a Director's review to the Director within thirty (30) calendar days from the date on the notice of the Deputy Director's decision.

(b) The Director will give twenty (20) calendar days prior notice of the time and place for a hearing convenient to all parties.

   (1) The notice shall describe the subject matter of the proceedings;

   (2) The notice shall cite the law or regulation giving the agency authority to act:

   (3) The notice shall inform the party of the right to present evidence, to be represented by counsel and to appear personally or by other representative; and

(4) The notice shall inform the parties of the agency's obligation to reach its decision based upon the evidence received.

(c) Upon the application of any party, the Director, in its sole discretion, shall consider the appointment of a Hearing Officer to preside over the Director's review.

(1) The hearing must include an opportunity for the provider or his/her representatives to:
- a) Appear before the Hearing Officer to refute the basis for the decision;
- b) Be represented by counsel or another representative;
- c) Review documentation;
- d) Be heard in person, to call witnesses, and to present documentary evidence; and
- e) Cross-examine witnesses.

(2) At least five (5) days prior to the hearing, the provider must submit to the Hearing Officer, a list of witnesses he/she intends to call at the hearing.
(3) If a provider fails to appear at a scheduled hearing, the Hearing Officer may immediately dismiss the appeal and issue a decision against the provider.
(4) At any point during the review process, the provider may request and review all documentation pertinent to the appeal that is in the possession of DMMA.

(d) The Hearing Officer shall have the power to:

(1) Exclude plainly irrelevant, immaterial, insubstantial, cumulative, and privileged evidence;
(2) Limit unduly repetitive proof, rebuttal and cross-examination;
(3) Call witnesses who are DMMA employees, and provide other sources of evidence in the custody and control of DMMA, either initiated by the Hearing Officer or at the request of any party.
(4) Upon the request of any party, the Hearing Officer will order DMMA staff to use reasonable efforts to obtain and produce, to the parties, evidence not in the custody of any party. All parties shall cooperate with the Hearing Officer's orders.

(e) The Hearing Officer's decision is final and no further appeals are afforded by the DMAP.

(1) The Hearing Officer shall make its decision based upon the entire record of the case.
(2) The decision shall include, where appropriate:
- a) A brief summary of the evidence;
- b) Findings of fact based upon the evidence;
- c) Conclusions of law;
- d) Any other conclusions required by law of the agency; and
- e) A concise statement of the Hearing Officer's determination or action on the case.
- (f) A record from which a verbatim transcript can be prepared shall be made of all hearings in all contested cases. Transcripts shall be made at the request and expense of the requesting party.

Delaware Health and Social Services

DIVISION OF MEDICAID & MEDICAL ASSISTANCE
PROVIDER APPEAL FORM

Provider Name	NPI		TAXONOMY
Provider Address	City	State	Zip
Provider Contact Person	Telephone Number		
DMAP Member Name	DMAP Member Number (MID)		
Date(s) of Service	Date of SUR Redetermination Findings, Provider Inquiry Reply, or State-Contracted Entity Adverse Action Decision and/or resolution (Enclose copy of written correspondence)		

Reason for appealing adverse action. Additional pages or documentation may be submitted, if necessary.

Statement of remedy sought. If possible, include the billed amount on your claim for each disputed item. Additional pages or documentation may be submitted, if necessary.

In order to appeal an adverse action, submit this completed form within 60 days of the date of the letter of non-enrollment or the date of the Provider Inquiry Reply to:

Deputy Director
DHSS/DMMA
PO Box 906
New Castle, DE19720

All documents, written statements, exhibits, and other written information that support the appeal must accompany this request for appeal. A copy of this completed form must be attached to any additional information you submit to the Deputy Director.

Providers of medical services to members of the DMAP should be reminded that payment of claims are made from federal and/or state funds, and the falsification or concealment of a material fact (related to DMAP claims for services) may be prosecuted under federal and/or state law.

Provider Signature	Date

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**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF MEDICAID &
MEDICAL ASSISTANCE

SURVEILLANCE AND UTILIZATION REVIEW UNIT
TELEPHONE: (302) 255-9646

7.0   Appendix B – Referral for Fraud and Abuse Form

SUR Referral Form

To make a referral to the SUR Unit for suspected fraud, waste or abuse, or a quality of care issue regarding either a Medicaid provider or a member, please complete the form below as completely and accurately as possible. Fields marked with an asterisk (*) are required fields. Please email completed form to the SUR Unit at SURreferrals@delaware.gov or fax the completed form to 302-255-4425, Attn: SUR Unit. Completed forms can also be mailed to: DMMA, Lewis Building, PO Box 906, 1901 N. Dupont Highway, New Castle DE 19720 Attn: SUR Unit. Referrals for suspected fraud, waste or abuse may also be reported by calling 1-800-372-2022.

1. *Is this a referral regarding: ☐Provider(s) ☐Member(s) ☐Both

2. For referrals regarding providers, please provide the following information (if possible):

    Last name, First name   NPI#

    _____   _____

    _____   _____

    _____   _____

3. For referrals regarding members, please provide the following information (if possible):

    Last name, First name /DOB   MID#

    _____   _____

    _____   _____

    _____   _____

4. *Type of referral: ☐Quality of Care   ☐Possible fraud, waste or abuse
                                  ☐Other (please specify) _____

5. *Explanation of problem (*please provide as much detail as possible. Detail should include description of problem, dates of service, claim numbers, etc*):

6. *Name/Title of person sending referral: _____

7. *Contact information for person sending referral (*please provide at least one*):
    a. Email address:
    b. Phone number:
    c. MCO (if so, please indicate which one _____)

8. *Date of referral:

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DELAWARE MEDICAL ASSISTANCE PROGRAM

8.0   Reserved

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	Reporting Medicaid Member Abuse and Fraud

9.0   Appendix D – Reporting Medicaid Member Abuse and Fraud

The Division of Medicaid & Medical Assistance distributes the following information in pamphlet form to members in Delaware:

REPORTING MEDICAID MEMBER FRAUD AND ABUSE

WHAT IS FRAUD AND ABUSE?

Fraud is the intentional attempt to obtain services for which the member is not entitled. Abuse is the attempt to obtain services, which are medically unnecessary.

EXAMPLES OF POSSIBLE FRAUD ARE:

- Lending a Medicaid card
- Altering a Medicaid card
- Altering prescriptions

EXAMPLES OF POSSIBLE ABUSE ARE:

- Consistent use of the emergency room for non-emergency services
- Excessive use of controlled substances
- Seeing multiple doctors without medical need

POSSIBLE ACTIONS RESULTING FROM REPORTING SUSPECTED FRAUD OR ABUSE:

- Investigation by the Delaware Medicaid Surveillance and Utilization Review (SUR) Unit. SUR monitors utilization of services to detect and investigate fraud and abuse.
- Counseling members regarding appropriate use of the medical care system
- Referral to the Medicaid Restricted Member Program (Lock-in). This program requires selection of a primary physician and one pharmacy for at least a one year period and monitors

utilization by member.

- Referral to Welfare Fraud Unit. Investigates and prosecutes welfare fraud. DHSS Campus, New Castle

WHAT CAN YOU DO?

DMAP encourages individuals to report suspected cases of possible Medicaid fraud or abuse to via the Report Fraud link on the Provider Portal or to the:

Division of Medicaid & Medical Assistance,

Surveillance and Utilization Review (SUR) Unit

Lewis Building

P.O. Box 906

New Castle, DE19720

Telephone:

- New Castle County (302)255-9500

- Kent and Sussex County (302)739-2123

All information is confidential. Anonymous referrals are accepted.

ABOUT THE DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Medicaid is one of the key programs offered by the Division.

OTHERS INCLUDE:

Delaware Healthy Children Program (DHCP)

Delaware Prescription Assistance Program (DPAP)

Long Term Care Medicaid Programs

Home & Community Based Services

Chronic Renal Disease Program (CRDP)

Qualified Medicare Beneficiary Programs (QMB, SLMB, QI-1)

Children's Community Alternative Disability Program (CCADP)

Breast & Cervical Cancer Program (BCCP)

MISSION

The mission of the Division of Medicaid & Medical Assistance is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner.
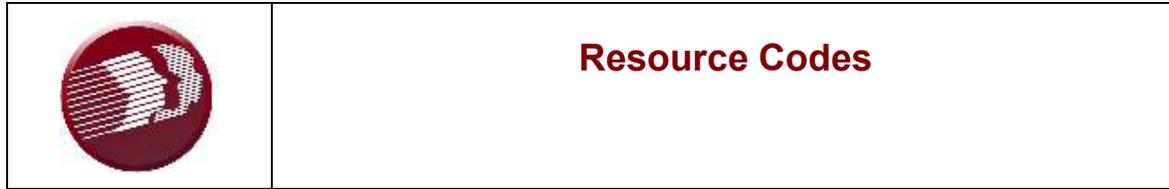
	Resource Codes

10.0   Appendix E – Resource Codes – Valid through 12/31/2016

A carrier code is a five-character numeric or alphanumeric NEIC code and 4-character location code. If a particular carrier code cannot be found on the National Carrier Code Link on the Gainwell Technologies web site the provider will need to call Gainwell Technologies, Provider Relations (1.800.999.3371). Instructions to accessing the Gainwell Technologies web site are described in the EVS section of this manual. It is advised that all providers first check the corresponding coverage code for a policy type before calling Gainwell Technologies or billing the insurance carrier. For an explanation of coverage codes, please refer to Appendix F.

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	Coverage Codes

11.0 Appendix F – Coverage Codes – Effective 01/01/2017

11.1 Coverage Codes – Effective 01/01/2017

A coverage code is a 2-character numeric code that the DMAP assigns to different types of policies. The coverage code gives a general description of services. Refer to the chart below for definition of coverage.

New Coverage. Code	New Description	New Coverage Code	New Description
01	Drug	16	Chiropractic
02	Physician Visit-Office	17	Surgical
03	Dental	18	Diagnostic Medical
04	Inpatient	19	Physical Therapy/Occupational Therapy/Speech Therapy (PT/OT/SP)
05	Outpatient	20	Accident
06	Nursing Home	21	Cancer Policy
07	Vision	22	Workmen's Compensation
08	DME Rental	23	Emergency Services
09	DME Purchase	24	Blood Work
10	Home Health	25	Medicare HMO
11	Mental Health Outpatient	26	Medicare Part A
12	Mental Health Inpatient	27	Medicare Part B
13	Psychiatric Care - Outpatient	28	Medicare Part D
14	Psychiatric Care - Inpatient	29	Medicare Part C
15	Rehabilitation	30	Medicare supplement – No drugs

11.2   Coverage Codes – Valid through 12/31/2016

A coverage code is a 4-character numeric code that the DMAP assigns to different types of policies. The coverage code gives a general description of services. Refer to the chart below for definition of coverage.

New Coverage. Code	New Description	New Coverage Code	New Description
0001	Full coverage	0022	Reserve for future use
0002	Full coverage without dental	0023	Full coverage without office visits, dental, vision or drugs
0003	Full coverage without dental & drugs	0024	Full coverage without vision or drugs
0004	Full coverage without vision	0025	Full coverage- No dental – no vision – No drugs
0005	Full coverage without dental & vision	0026	Full coverage without office visits or drugs
0006	Accident policy	0027	Medicare HMO
0007	Hospital policy	0028	Medicare drug
0008	Surgical policy	0030	Full coverage without office visits, vision or drugs
0009	Accident & hospital policy	0031	Full coverage without office visits, vision or dental
0010	Cancer policy	0032	Full coverage without office visits and dental
0011	Dental policy	0033	Full coverage without office visits, dental & mental health services
0012	Drug only	0034	Full coverage without dental, vision & mental health services
0013	Vision	0035	Mental health policy only
0014	Medicare Part A	0036	Nursing home policy only
0015	Medicare Part B	0037	Workmen's Compensation policy only
0016	Medicare supplement – No drugs	0038	Blood Bank policy
0017	Hospital with medical-surgical riders	0039	Medical-surgical policy without office visits, dental, vision, drugs
0018	Medicare supplement with drugs	0040	Part A Medicare supplement
0019	Full coverage without office visits	0041	Part B Medicare supplement
0020	Medicare Part D		
0021	Full coverage – No drugs – No LTC		

	Family Planning and Related Services Benefit Package

12.0   Appendix G – Family Planning and Related Services Benefit Package

12.1   Services and Procedures Covered

Code	Abbreviated Description
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection
11975	Insertion, implantable contraceptive capsules (For dates of service through 12/31/2011)
11977	Removal with reinsertion, implantable contraceptive capsules (For dates of service through 12/31/2011)
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of intrauterine device (IUD)
58600	Ligation or transection of fallopian tubes
58611	Ligation or transection of fallopian tubes
58615	Occlusion of fallopian tubes by device
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (For dates of service through 12/31/2012)
J7300	Intrauterine Copper Contraceptive
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7307	Etonogestrel (contraceptive) Implant System, including implants and supplies
S0610	Annual gynecological examination; new patient. This code is effective for dates of service on and after 7/1/02
S0612	Annual gynecological examination; established patient. This code is effective for dates of service on and after 7/1/02
FP	Family Planning. This modifier is to be used with codes S0610 and S0612 for dates of service on or after 7/1/02.

It is the responsibility of the practitioner to use the above codes or their future equivalence when billing the DMAP.

12.2   Services and Procedures Covered When Paired With a Diagnoses of Contraceptive Management For Family

The following services and procedures are covered when the diagnosis on the claim is contraceptive management (ICD-9-CM diagnosis codes V25-V25.09, V25.11, V25.13–V25.2 and V25.4-V25.9).

Code	Abbreviated Description
11976	Removal, implantable contraceptive capsules
11981	Insertion, non-biodegradable drug delivery implant (For dates of service 1/1/2012 and after)
58301	Removal of intrauterine device (IUD)
80002-80019	Automated multichannel tests
80090	TORCH antibody panel
81000-81020	Urinalysis
81025	Urine pregnancy test, by visual color comparison methods
85013	Blood count; spun microhematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
86255	Fluorescent antibody; screen, each antibody
86592	Syphilis test; qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test; quantitative
86631	Antibody; Chlamydia
86632	Antibody; Chlamydia, IgM
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86694	Antibody; herpes simplex, non-specific type test
86695	Antibody; herpes simplex, type I
86701-86703	Antibody; HIV
86781	Antibody; Treponema Pallidum, confirmatory test (e.g., FTA-abs)
87081	Culture, bacterial, screening only, for single organisms
87110	Culture, chlamydia,
87206	Smear, primary source, with interpretation; fluorescent and/or fast stain for bacteria, fungi, or cell types
87207	Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, herpes viruses)
87850	Neisseria gonorrhoeae (gonorrhea testing)
88141-88155	Pap Smears
88164-88167	Pap Smears
88302	Level II Surgical Pathology
99201-99215	Office visits
JXXXX codes	Injectables in one of the following therapeutic classes: antibiotics, anti virals, anti fungals, anti protozoans
J1050	Injection, medroxyprogesterone acetate, 1 mg.
WW821	Federally Qualified Health Center Encounter Per Day. This code is closed effective for dates of service prior to 7/1/02 For dates of service on and after 7/1/02 codes 99201-99215 should be used.

It is the responsibility of the practitioner to use the above codes or their future equivalence when billing the DMAP.

	Medical Necessity

13.0   Appendix H – Medical Necessity Definition

Medical Necessity is defined as:

The essential need for health care or services (all covered State Medicaid Plan services, subject to age and eligibility restrictions and/or EPSDT requirements) which, when delivered by or through authorized and qualified providers, **will:**

- Be directly related to the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability (the physical or mental functional deficits that characterize the member's condition), and be provided to the member only.

- Be appropriate and effective to the comprehensive profile (e.g. needs, aptitudes, abilities, and environment) of the member and the member's family.

- Be primarily directed to treat the diagnosed medical condition or the effects of the condition on the member, in all settings for normal activities of daily living.

- Be timely, considering the nature and current state of the member's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time.

- Be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds.

- Be the most appropriate care or service that can be safely and effectively provided to the member, and will not duplicate other services provided to the member.

- Be sufficient in amount, scope and duration to reasonably achieve its purpose.

- Be recognized as either the treatment of choice (i.e. prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided.

- Be rendered in response to a life threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.

in order that

- The member might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community, and facility environments and activities.

**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF MEDICAID &
MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Attestation Form

**Appropriateness of the
Qualified Clinical Trial**

14.0   Appendix I – Appropriateness of the Qualified Clinical Trial Medicaid Attestation Form

Participant Name: _____   Medicaid ID#: _____

Qualified Clinical Trial
National Clinical Trial Number (from clinicaltrials.gov): _____

Principal Investigator Attestation

Principal Investigator Name: _____

I hereby attest to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

☐ The Principal Investigator is also the Health Care Provider and hereby attests to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

Signature: _____   Date: _____
              (*signature of principal investigator*)   (*month, day, year*)

Health Care Provider Attestation

Health Care Provider Name: _____

☐ I hereby attest to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

Signature: _____   Date: _____
              (*signature of health care provider*)   (*month, day, year*)

Submit this form through the DMAP Portal. Visit the DMAP Document Repository for How-To: Submit a Medical Prior Authorization (PA) Request through the Portal and other resources.

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	DELAWARE MEDICAL ASSISTANCE PROGRAM

15.0   **Reserved**

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	DELAWARE MEDICAL ASSISTANCE PROGRAM

16.0   Reserved

	RECOMMENDED CHILDHOOD VACCINATION SCHEDULE UNITED STATES - JANUARY –DECEMBER 2012

17.0   Appendix L – Childhood Vaccination Schedule

17.1   Table for Ages 0-6

FIGURE 1. Recommended immunization schedule for persons aged 0 through 6 years — United States, 2012 (for those who fall behind or start late, see the catch-up schedule [Figure 3])

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

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	RECOMMENDED CHILDHOOD VACCINATION SCHEDULE UNITED STATES - JANUARY –DECEMBER 2012

17.2   Footnotes for Ages 0-6

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

At birth:

- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)–positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after receiving the last dose of the series.
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing ≥2,000 grams, and HepB vaccine plus HBIG for infants weighing <2,000 grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).

Doses after the birth dose:

- The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3).
- The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])

- The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.
(Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. *Haemophilus influenzae* **type b (Hib) conjugate vaccine.** (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.

5. Pneumococcal vaccines. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
  — All children aged 14 through 59 months
  — Children aged 60 through 71 months with underlying medical conditions
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

7. Influenza vaccines. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
- For children aged 6 months through 8 years:
  — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
  — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.

8. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
- Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.

9. Varicella (VAR) vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. Hepatitis A (HepA) vaccine. (Minimum age: 12 months)

- Administer the second (final) dose 6 to18 months after the first.
- Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf .
- A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.

11. Meningococcal conjugate vaccines, quadrivalent (MCV4). (Minimum age: 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM])

- For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
- For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
- For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.
- See *MMWR* 2011;60:72–6, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf , and Vaccines for Children Program resolution No. 6/11-1, available at http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf , and *MMWR* 2011;60:1391–2, available at http://www.cdc.gov/mmwr/pdf/wk/mm6040.pdf , for further guidance, including revaccination guidelines.

    This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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RECOMMENDED CHILDHOOD VACCINATION SCHEDULE UNITED STATES - JANUARY –DECEMBER 2012
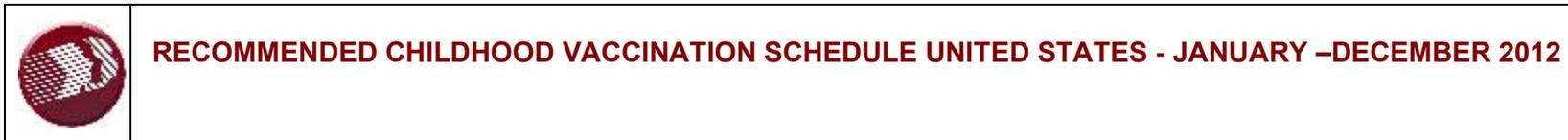
17.3   Table for Ages 7-18

FIGURE 2. Recommended immunization schedule for persons aged 7 through 18 years — United States, 2012 (for those who fall behind or start late, see the schedule below and the catch-up schedule [Figure 3])

Vaccine ▼ Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, diphtheria, pertussis[1]	1 dose (if indicated)	1 dose	1 dose (if indicated)	Range of recommended ages for all children
Human papillomavirus[2]	See footnote[2]	3 doses	Complete 3-dose series	
Meningococcal[3]	See footnote[3]	Dose 1	Booster at age 16 years	
Influenza[4]	Influenza (yearly)			
Pneumococcal[5]	See footnote[5]			Range of recommended ages for catch-up immunization
Hepatitis A[6]	Complete 2-dose series			
Hepatitis B[7]	Complete 3-dose series			
Inactivated poliovirus[8]	Complete 3-dose series			
Measles, mumps, rubella[9]	Complete 2-dose series			Range of recommended ages for certain high-risk groups
Varicella[10]	Complete 2-dose series			

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

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RECOMMENDED CHILDHOOD VACCINATION SCHEDULE UNITED STATES - JANUARY –DECEMBER 2012

17.4   Footnotes for Ages 7-18

1. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for Boostrix and 11 years for Adacel)

- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid–containing vaccine are needed.
- Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid–containing vaccine.

2. Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]). (Minimum age: 9 years)

- Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
- The vaccine series can be started beginning at age 9 years.
- Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
- See *MMWR* 2010;59:626–32, available at http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf .

3. Meningococcal conjugate vaccines, quadrivalent (MCV4).

- Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
- Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.

- Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
- See *MMWR* 2011;60:72–76, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf 🅿, and Vaccines for Children Program resolution No. 6/11-1, available at http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf 🅿, for further guidelines.

4. Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).

- For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No.RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf 🅿.
- Administer 1 dose to persons aged 9 years and older.
- For children aged 6 months through 8 years:
  — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
  — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.

5. Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).

- A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf 🅿.
- Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.

6. Hepatitis A (HepA) vaccine.

- HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf 🅿.
- Administer 2 doses at least 6 months apart to unvaccinated persons.

7. Hepatitis B (HepB) vaccine.

- Administer the 3-dose series to those not previously vaccinated.

- For those with incomplete vaccination, follow the catch-up recommendations ([Figure 3](#)).
- A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).

- The final dose in the series should be administered at least 6 months after the previous dose.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
- IPV is not routinely recommended for U.S. residents aged18 years or older.

9. Measles, mumps, and rubella (MMR) vaccine.

- The minimum interval between the 2 doses of MMR vaccine is 4 weeks.

10. Varicella (VAR) vaccine.

- For persons without evidence of immunity (see *MMWR* 2007;56[No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
- For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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	RECOMMENDED CHILDHOOD CATCH-UP VACCINATION SCHEDULE UNITED STATES - JANUARY – DECEMBER 2012

17.5   Table for Ages 0- 6 and 7-18

TABLE. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind --- United States, 2012

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with the accompanying childhood and adolescent immunization schedules (Figures 1 and 2) and their respective footnotes.**

		Persons aged 4 months through 6 years			
Vaccine	**Minimum age for dose 1**	**Minimum interval between doses**			
		Dose 1 to dose 2	**Dose 2 to dose 3**	**Dose 3 to dose 4**	**Dose 4 to dose 5**
Hepatitis B	Birth	4 weeks	8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks		
Rotavirus[1]	6 weeks	4 weeks	4 weeks[1]		
Diphtheria, tetanus, pertussis[2]	6 weeks	4 weeks	4 weeks	6 months	6 months[2]
Haemophilus influenzae type b[3]	6 weeks	4 weeks if first dose administered at younger than age 12 months **8 weeks (as final dose)** if first dose administered at age 12–14 months **No further doses needed** if first dose administered at age 15 months or older	4 weeks[3] if current age is younger than 12 months **8 weeks (as final dose)[3]** if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months **No further doses needed** if previous dose administered at age 15 months or older	**8 weeks (as final dose)** This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[4]	6 weeks	4 weeks if first dose administered at younger than age 12 months **8 weeks (as final dose for healthy children)** if first dose administered at age 12 months or older or current age 24 through 59 months **No further doses needed** for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months **8 weeks (as final dose for healthy children)** if current age is 12 months or older **No further doses needed** for healthy children if previous dose administered at age 24 months or older	**8 weeks (as final dose)** This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated poliovirus[5]	6 weeks	4 weeks	4 weeks	6 months[5] minimum age 4 years for final dose	
Meningococcal[6]	9 months	8 weeks[6]			
Measles, mumps, rubella[7]	12 months	4 weeks			
Varicella[8]	12 months	3 months			
Hepatitis A	12 months	6 months			
		Persons aged 7 through 18 years			
Tetanus, diphtheria/tetanus, diphtheria, pertussis[9]	7 years[9]	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human papillomavirus[10]	9 years	Routine dosing intervals are recommended[10]			
Hepatitis A	12 months	6 months			
Hepatitis B	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated poliovirus[5]	6 weeks	4 weeks	4 weeks[5]	6 months[5]	
Meningococcal[6]	9 months	8 weeks[6]			
Measles, mumps, rubella[7]	12 months	4 weeks			
Varicella[8]	12 months	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

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	RECOMMENDED CHILDHOOD CATCH-UP VACCINATION SCHEDULE UNITED STATES - JANUARY – DECEMBER 2012

17.6   Footnotes for Ages 0-6 and 7-18

1. Rotavirus (RV) vaccines (RV-1 [Rotarix] and RV-5 [Rota Teq]).

- The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- If RV-1 was administered for the first and second doses, a third dose is not indicated.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.

- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

3. *Haemophilus influenzae* type b (Hib) conjugate vaccine.

- Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, human immunodeficiency virus (HIV) infection, or anatomic/functional asplenia.
- If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax) and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.

4. Pneumococcal vaccines. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV if 3 doses of PCV were received previously, or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
- A single dose of PCV may be administered to certain children aged 6 through 18 years with underlying medical conditions. See age-specific schedules for details.

- Administer PPSV to children aged 2 years or older with certain underlying medical conditions. See *MMWR* 2010:59(No. RR-11), available at h[ttp://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) .

5. Inactivated poliovirus vaccine (IPV).

- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
- IPV is not routinely recommended for U.S. residents aged 18 years or older.

6. Meningococcal conjugate vaccines, quadrivalent (MCV4). (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])

- See Figure 1 ("Recommended immunization schedule for persons aged 0 through 6 years") and Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years") for further guidance.

7. Measles, mumps, and rubella (MMR) vaccine.

- Administer the second dose routinely at age 4 through 6 years.

8. Varicella (VAR) vaccine.

- Administer the second dose routinely at age 4 through 6 years. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

9. Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccines.

- For children aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, Tdap vaccine should be substituted for a single dose of Td vaccine in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Tdap vaccine dose should not be given.
- An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.

10. Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).

- Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if patient is not previously vaccinated.
- Use recommended routine dosing intervals for vaccine series catch-up; see Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years").

Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines) or by telephone (800-CDC-INFO [800-232-4636]).

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	DIVISION OF MEDICAID & MEDICAL ASSISTANCE **PRIOR AUTHORIZATION FORMS**

18.0   Appendix M – DMMA Prior Authorization Request Travel Forms

18.1   Prior Authorization Request for Related Travel Expenses

MEMBER INFORMATION:

Name : _____

Address:_____

Phone number: _____ Medicaid ID#:_____ Date of Birth:_____

Dates related travel expenses are required? _____to_____

LODGING ARRANGEMENT INFORMATION:

Facility where escort will stay: _____

Address:_____

Phone number: _____

ESCORT INFORMATION:

Name: _____

Address: _____

Phone number: _____ Escort's Social Security number:_____

FACILITY INFORMATION:

Name of facility in which treatment and/or medical evaluation will be received:

_____Address:_____

_____

Phone number: _____

MEDICAL INFORMATION:

1.   Attach a detailed medical history from the attending practitioner documenting the medical necessity of the services to be received.
2.   Attach a letter from the attending practitioner that documents that the treatment and/or medical evaluation to be received is not available in Delaware.

MAIL THE COMPLETED FORM AND ALL REQUIRED INFORMATION TO:
Medical Review Team
P.O. Box 906, Lewis Building
New Castle, DE 19720 OR
FAX TO: (302) 255- 4425

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	DMMA Tamper Resistant Prescription Pad Guidelines

19.0   Appendix N – DMMA Tamper Resistant Prescription Pad Guidelines

19.1   Tamper-Resistant Prescription Pad Checklist

☐ The prescription blank should describe the security features on the front or back of the document.

☐ Evaluate the prescription for a background print that indicates security paper.

☐ Hold the prescription to a light source; look for a watermark on the front or back.

☐ If no watermark can be seen, make a photocopy of the prescription. The copy will illustrate the word "VOID," "ILLEGAL," or a similar word to indicate the original was on tamper-resistant paper.

☐ The blank should have a double check for the quantity ordered. This could mean the quantity is specified as numeric (e.g., 10) and has a quantity range check-off box. Normal ranges are 1-24, 25-49, 50-74, 75-100, 101-150, 151 and over.

☐ Quantities can have both alpha and numeric representation (e.g., 10 and "ten").

☐ Each blank should have only one medication. This prevents the addition of medications after the initial prescription is written.

☐ An area with thermochromic ink (sensitive to heat and changes color) will demonstrate an authentic prescription. The specified area will change colors when tightly held between two fingers or rubbed quickly. These areas normally are colored and change to white.

☐ Prescriptions may have a serial number. Pharmacy personnel should review the number and check that they are not repetitive.

☐ There may be duplicate or triplicate blanks. To verify if the original has been altered, the pharmacy will call the practice.

☐ Check the back of the prescription for a pattern break that may indicate it has been cut and taped.

THE EXAMPLES ABOVE ARE NOT ALL-INCLUSIVE. THIS LIST IS MEANT TO PROVIDE EXAMPLES FOR EACH OF THE THREE REQUIREMENTS.

Unauthorized copying

Prevention of erasure or modification

Prevent counterfeit prescription forms

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	Delaware Health and Social Services **Delaware Medical Assistance Program**

20.0   Index – Addresses and Phone Numbers

20.1   Delaware Medical Assistance Program State Office

ADMINISTRATION

Mailing Address	Street Address
Division of Medicaid & Medical Assistance	Division of Medicaid & Medical Assistance
Delaware Medical Assistance Program	Delaware Medical Assistance Program
Lewis Building	Herman M. Holloway, Sr. DHSS
P.O. Box 906	Campus
New Castle, DE19720	Lewis Building
Telephone Number: (302) 255-9500	1901 N. DuPont Highway
Fax Number: (302) 255-4454	New Castle, DE 19720

FISCAL AGENT

Mailing Address for Gainwell Technologies, Provider Services	Street Address
Gainwell Technologies	Gainwell Technologies
P.O. Box 909	645 Paper Mill Road
Manor Branch	Suite 1015
New Castle, DE 19720-0909	Newark, DE 19711
Telephone Number: Provider Services: 1-800-999-3371	
Fax Number: (302) 454-7603	

20.2   Medicaid Eligibility Offices and Contact Information

Medicaid eligibility offices and contact information is available at the following link
https://assist.dhss.delaware.gov/ContactUs.aspx

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	Delaware Health and Social Services

20.3   Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)

DIRECT SERVICES

New Castle County	Kent/Sussex Counties
DSAAPD	DSAAPD
University Plaza	Milford State Service Center
256 Chapman Road	18 North Walnut Street, First Floor
Oxford Building, Suite 200	Milford, DE 19963
Newark, DE 19702	
Phone #: (302) 453-3820 or 800-223-9074	Phone #: (302) 422-1386 or 800-223-9074
Fax #: 453-3836	Fax #: 422-1346
TTY #: 453-3837	TTY #: 422-1415

ADMINISTRATION

DSAAPD
Second Floor Annex
1901 N. DuPont Highway
New Castle, DE 19720
Phone #: (302) 255-9390 or 800-233-9074
Fax#: (302) 255-4445

20.4   Division of Developmental Disabilities Services (DDDS)

Administration
DDDS
Woodbrook Professional Center
1056 S. Governors Avenue
Suite 102
Dover, DE 19904
Phone #: (302) 744-9600

Additional contact information for the Division of Developmental Disabilities (DDDS) is available at the following link: https://www.dhss.delaware.gov/dhss/ddds/contact.html

20.5   Division of Substance Abuse and Mental Health (DSAMH)

DSAMH
Director, Licensing and Certification Unit
1901 N DuPont Highway
Main Administration Building
New Castle, DE 19720
Phone #: (302) 255-9399 or (302) 255-9441