



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF MEDICAID &
MEDICAL ASSISTANCE

Delaware Medical Assistance Program

Managed Care Organization Joins Delaware Medicaid: **AmeriHealth Caritas**

AmeriHealth Caritas will begin serving as a managed care organization (MCO) for Delaware Medicaid on January 1, 2018. Many of you may be in the process of or have already contracted with AmeriHealth Caritas.

If you have not, you can learn more about becoming a participating provider by contacting them using the information below.

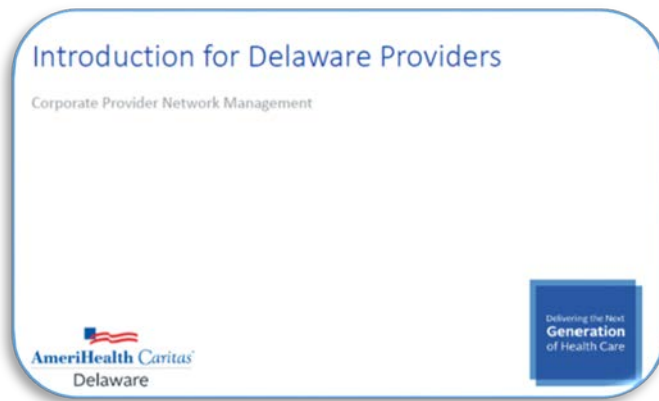
Website

<http://www.amerhealthcaritasde.com>



Becoming a Provider - An Introduction

<http://becomeaprovider.amerhealthcaritas.com/pdf/delaware/provider-intro.pdf>



Phone
1-844-460-9578

Email
providerrecruitmentdelaware@amerhealthcaritas.com

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What's New: From the Provider Portal home page, click [Provider News](#) to open the **How To Corner**. Review documents related to your interests.

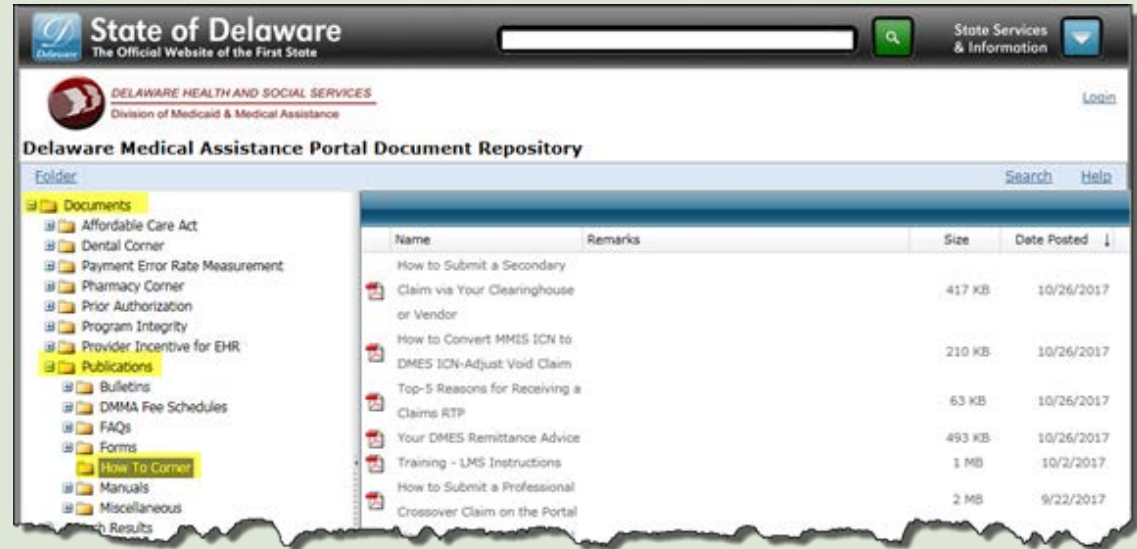
Recent Titles

- [How to Submit a Secondary Claim via Your Clearinghouse or Vendor](#)
- [How to Convert MMIS ICN to DMES ICN - Adjust/Void Claim](#)
- [How to Submit a Professional Crossover Claim on the Portal](#)

Top Tip

- [How to Download the Remittance Advice \(RA\) to Excel*](#)

*Reminder: RAs are available on the [Provider Portal](#) each **Monday** after 12:00 noon ET



Manual & Form Updates

General Policy Manual: Rev Date: 11/1/2017. Section Revised:

- 13.0 Appendix H – Medical Necessity definition updated to align MCO contract language and DMAP policies
Revision Date: 9/1/2017. Sections Revised:
- 1.22.1.5 - Updated Third Party Liability billing instructions and policy in compliance with the Delaware Medicaid Enterprise System (DMES)
- 4.0 - Updated Third Party Liability billing instructions and policy in compliance with the Delaware Medicaid Enterprise System (DMES)
- 10.0 - Added resource code clarification
- 11.0 - Added coverage code effective and end date updates

DSHP Plus Change Form: Rev Date: 11/21/2017

- AmeriHealth Caritas added to the form
- No LOC added as an option beneath "Member Discharging To:"

FQHC Provider Specific Policy Manual: Rev Date: 10/1/2017. Section Revised:

- 3.1.3 – Clarification added regarding the appropriate billing of Long Acting Reversible Contraception devices

Pharmacy Provider Specific Policy Manual: Rev Date: 10/1/2017. Section Revised:

- 2.1.8 – Clarification added regarding the prohibition of cash payment for DMAP covered services

LTC Comprehensive Medical Report A Rev Date: 10/20/2017

- The line *Meets an Acute Hospital Level of Care* has been removed

Preadmission Screening & Resident Review Important Information: Hospital Discharge Exemption

The Division of Medicaid and Medical Assistance (DMMA) Preadmission Screening & Resident Review (PASRR) Unit monitors all PASRR referrals and identifies trends, both in compliance and non-compliance, with the various aspects of PASRR. We want to take this opportunity to reiterate the correct use of the Hospital Discharge Exemption, often referred to as the 30-Day Hospital Exemption or Convalescent Exemption.

The hospital discharge exemption is the only true exemption from the requirements of PASRR. The exemption applies to individuals who are discharged from a hospital into a Medicaid-certified nursing facility (NF) who:

- Are being admitted to the NF for treatment of the same condition they were hospitalized for, **and**
- Discharge from the NF is planned within 30 days of admission, **and**
- Are not a danger to themselves or others

The Exemption should not be used or accepted if all three of these criteria are not met. If an individual admitted to a NF under the hospital discharge exemption stays in the NF longer than 30 days, PASRR must be completed by calendar day 40. Follow the standard processes for completing PASRR in these circumstances.

Please call the DMMA PASRR Unit if you have any questions at 302-424-7120.

EHR News

EHR Incentive Payment Program: MAPIR Portal Is Open for Program Year 2017

The Electronic Health Record (EHR) Incentive Payment Program's Medical Assistance Provider Incentive Repository (MAPIR) portal is open for program year 2017. The last day to enter an attestation in MAPIR will be **April 2, 2018**.

- All Providers attesting to Meaningful Use (MU) will use a 90-day MU period
- Please do not delay until the last day to begin your application!
- There will be deadlines for submission of documentation in support of the application
- All supporting documents must be retained in case the practice is audited next year
 - Failing an audit may result in recoupment of the EHR incentive payment

Please review the following education document for Program Year 2017 updates:

- https://medicaidpublications.dhss.delaware.gov/dotnetnuke/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=722&language=en-US&PortalId=0&TabId=94



Receiving Error Code 1005 - REFERRING PROVIDER MISSING OR NOT ENROLLED?

You may need to enroll as an Ordering, Referring, & Prescribing (ORP) Provider

Section 6401 of the Affordable Care Act (ACA) states ORPs are required to enroll solely for purposes of ordering and referring services for Medicaid recipients. ORPs are physicians or other professionals that only order or refer items or services for Medicaid beneficiaries. These providers do not submit claims for reimbursement for any services provided but are **required to enroll** solely for the purposes of ordering and referring services for Medicaid beneficiaries.

Ordering and referring providers are required to complete a limited-capacity enrollment form so that DMAP may identify the providers who write only orders, referrals, and prescriptions. Enrollment is required so that payments can be made for claims related to member services.

Important: This requirement *does not apply* to providers who are enrolled with the Delaware managed care organizations (MCOs).

Division of Professional Regulation Went Electronic!

As of November 1, 2017, the Delaware Division of Professional Regulation (DPR) began sending notices regarding professional licenses **by email only**.

- Paper letters, including renewal notices, are no longer being mailed

DPR is currently in the process of mailing notifications to licensed health care professionals.

To be sure you receive important notices about your license, **add or update your email** on the Division's website at <https://dpronline.delaware.gov/>.

Need more information? Visit: <http://dpr.delaware.gov/faqs/>

Explanation of Benefits (EOB) Code 0171 on your Remittance Advice (RA)

Are you receiving the following Explanation of Benefits (EOB) Code 0171 on your Remittance Advice (RA)?

- CLAIM OR ADJUSTMENT RECEIVED BEYOND 365-DAY FILING DEADLINE

Refer to the section 1.19 Claims Submission–Timeliness in the [General Policy Manual](#) for specific requirements related to filing. The timely filing proof, described in policy 1.19, **must be uploaded** as an “attachment”. This applies whether you have submitted your claim:

- electronically through the Provider Portal
- through a vendor/clearinghouse
 - for an X12 transaction, enter ‘ADD’ in the NTE01 (Note Reference Code) field and enter the referenced Internal Control Number (ICN) in the NTE02 field -- **this will eliminate the need to upload an attachment**
- on paper

Reminder: Go green and use the Portal or X12 EDI for your claims submission rather than submit paper claims.

Delaware Cancer Treatment Program: Revised Application

In an effort to continue to streamline processes, the Delaware Cancer Treatment Program (DCTP) has revised its application packet. Please click [here](#) to download a copy of the revised application packet.

The program is available to Delaware residents who:

- Were residents of Delaware when diagnosed with cancer
- Were diagnosed with cancer on or after July 1, 2004
- Have no comprehensive health insurance or maximum out-of-pocket expense is more than 15 percent of income (does not include premiums)
- Do not receive benefits through the Medicaid breast and cervical cancer treatment program
- Meet income guidelines (up to 650 percent of the Federal Poverty Level)
- Are not eligible for health insurance

For more information on DCTP, please call 1-800-996-9969 or click [here](#).

Need to Submit a Prior Authorization (PA) for DCTP? Please send to fax#:

302-454-0223

Delaware Works to Prevent, Recognize & Treat Substance Exposure in Infants

Delaware and the nation are struggling with an addiction epidemic, a fact that is well known. Less well known is that the addiction epidemic is impacting pregnant women and their infants in increasing numbers.

Delaware's law, the Medical Practice Act, requires certified medical providers to give written, verbal, and posted warnings to pregnant women regarding possible problems, complications, and injuries to them and/or to the fetus from consuming or using alcohol or cocaine, marijuana, heroin, and other narcotics during pregnancy (Delaware Code, Title 24, Chapter 17 (Medical Practice Act), Subchapter V, §1769A).

Responding to input from OB/GYN providers, the Division of Public Health (DPH) announced new guidance and educational materials on the dangers of substance abuse while pregnant, and how to screen pregnant women for potential addiction and connect them with treatment.

To view these materials visit:
<http://tinyurl.com/helpishereDE>

For more info visit:
<http://tinyurl.com/OBGYNResources>

Vaccines for Children Program Vaccine Storage-Handling

Beginning January 1, 2017, all new enrolled providers using a combo household refrigerator for vaccine storage must have a separate stand-alone freezer in order to be approved for frozen vaccine deliveries.

Beginning January 1, 2018, the use of the freezer section of combo household refrigerator for frozen vaccine storage will be prohibited. The refrigerator portion of the unit may be used for refrigerated vaccine storage if all the storage unit requirements are met. A separate stand-alone freezer unit will be required for frozen vaccine storage.

Beginning January 1, 2018, continuous temperature monitoring will be a requirement. Continuous temperature monitoring devices must meet the criteria for current calibration certification.

Please contact Vaccines for Children (VFC) Program with questions or concerns at 1-800-282-8672 or visit: <http://www.dhss.delaware.gov/dph/dpc/immunize.html> and <http://tinyurl.com/storage-handlingtoolkit>.

TECHNICAL DENIAL

What is a technical denial?

A technical denial is a denial of the entire paid amount of a claim in instances when the care provided to a member cannot be substantiated due to a health care provider's nonresponse to the Division of Medicaid Medical Assistance (DMMA) Surveillance Utilization Review (SUR) Unit requests for medical records, itemized bills, documents, etc.

Technical denials are issued for the following reasons:

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

What happens if a Provider fails to respond to a medical record request?

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

What happens when a technical denial is issued?

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

Upon completion of the review, the technical denial will be reversed, and a findings letter will be issued. Information on requesting a timely Re-Determination Review is located in Appendix A of the DMAP General Policy Manual. Please review the General Policy Manual:

https://medicaidpublications.dhss.delaware.gov/dotnetnuke/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=227&language=en-US&PortalId=0&TabId=94



Need Assistance?

Surveillance Utilization Review Unit @ 302-255-9500
Option 0

DMMA Program Integrity SUR Unit
Herman Holloway Campus
1901 N. DuPont Highway
New Castle, De 19720

Toll-Free Telephone: 1-800-372-2022
Hot Line (After Hours Voice Mail Only)
1-800-372-2022 select option #1
Email: SURreferrals@state.de.us

ATTENTION ALL PROVIDERS!

Pharmacy Preferred Drug List (PDL) for Medicaid 2018 Is Available

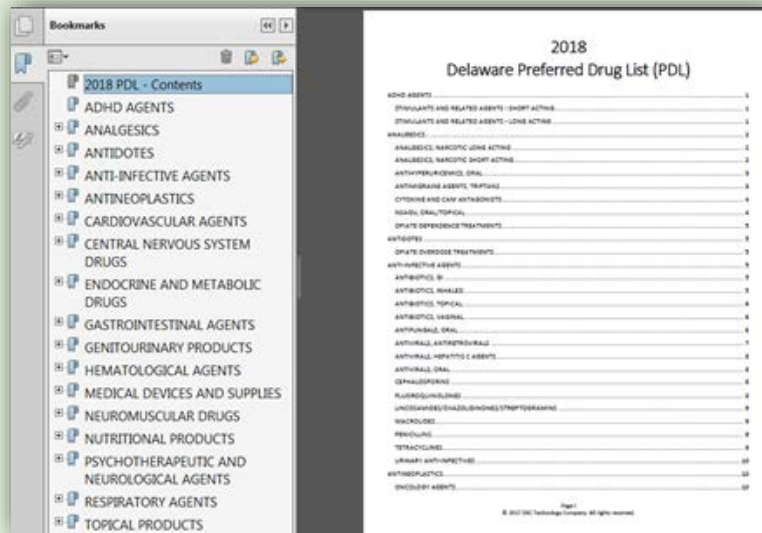
These changes affect coverage for Highmark Health Options, AmeriHealth Caritas and traditional Medicaid members.

The new PDL, effective January 1st 2018, is posted at the link below for preview. Please download and replace the existing file. Note the new format changes to the PDL, such as:

- Drug classes are grouped by therapeutic class
 - For example, Anti-infective, Cardiovascular agents, Topical Products
- New classes in 2018
 - Movement Disorder and Oncology
- New distinction by labeler's five-digit codes within a class
 - For example, Stimulant and related agents – Long acting methylphenidate ER 24 tablets (labeler 00591 or 62175)

2018 PDL Link

http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=738



For any further clarification on this change, please contact Pharmacy Services at 1-800-999-3371 select option 0, select option 1.

Pharmacy Corner

Your Portal has an area for Pharmacy benefits for Medicaid members. Click [Pharmacy Corner](#) from the Delaware Medical Assistance Portal homepage or from the Provider Portal homepage.



Authorization to Dispense Naloxone

Pursuant to Delaware Senate Bill 219, Delaware greatly expanded access to naloxone (also known by the brand name “Narcan”) a safe and effective medication designed to reverse opiate-induced overdose and prevent death.

Senate Bill 219 allows first responders [law enforcement, firefighters, Emergency Medical Services (EMS)] to administer the drug to individuals suspected to be experiencing an opioid overdose.

Examples of indications for dispensing naloxone are:

1. Previous opioid intoxication or overdose.
2. History of nonmedical opioid use.
3. Initiation or cessation of methadone or buprenorphine for opioid use disorder treatment.
4. Higher-dose (>50 mg morphine equivalent/day) opioid prescription.

Early Periodic Screening, Diagnosis & Treatment Corner

EPSDT Corner



The Vaccines for Children Program - 20 Years of Protecting America's Children

The Vaccines for Children (VFC) Program offers vaccines at no cost for eligible children through doctors enrolled in the program. The Vaccines for Children (VFC) Program provides vaccines to children whose parents or guardians may not be able to afford them. This helps ensure that all children have a better chance of getting their recommended vaccinations on schedule. These vaccines protect babies, young children, and adolescents from 16 diseases.

Who Is Eligible for the VFC Program?

Any child that is younger than 19 years of age and meets one of the following requirements:

- Medicaid-eligible
- Uninsured
- American Indian or Alaska Native
- Underinsured*

What Is "Underinsured"?

Underinsured means the child has health insurance, but it:

- Doesn't cover vaccines, or
- Doesn't cover certain vaccines

**Underinsured children are eligible to receive vaccines only at Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHCs). If you need help locating an FQHC or RHC, contact your state or city's [VFC Program Coordinator](#).*

What Is the Cost?

There is no charge for the vaccines given by a VFC provider to eligible children. But, there can be some other costs with the visit:

- Doctors can charge a set (or standard) fee to administer each shot
- There can be a fee for the office visit
- There can be fees for non-vaccine services, like an eye exam or blood test

There is no charge for any vaccine given by a VFC provider to eligible children.

Support to Providers

DMAP publishes a regularly updated [General Policy Manual](#) and a [Practitioner Provider Specific Policy Manual](#) containing information on the EPSDT program.

These manuals include information on periodicity schedules, medical necessity, required services, and other EPSDT guidelines.

Payment Error Rate Measurement

New Payment Error Rate Measurement (PERM) Cycle



On July 1, 2017, Delaware started a new cycle of the Payment Error Rate Measurement (PERM) audit required by the Centers for Medicare & Medicaid Services (CMS).

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

All states are required to participate every three years on a rotating basis.

DMMA and DXC had a PERM Kick-Off Meeting on September 5, 2017 with: CMS; Lewin, the statistical contractor; and CNI Advantage, the Data Processing (DP) and Medical Record (MR) Review contractor for this cycle.

UPDATE: The first quarter of paid claims data was submitted to Lewin for validation early in November. It is anticipated that MR requests will be sent by CNI to providers that were selected in the PERM audit by mid- to late-January.

IMPORTANT: Providers need to be on the lookout for MR requests sent out by CNI and respond promptly.

Providers **must** submit proper medical record documentation supporting the paid claim(s) selected within 60 days of the request. The required documentation must include sufficient information to validate that services were provided, that they were medically necessary, and were consistent with the specified diagnosis during the time of claim payment. The MR requests will continue quarterly throughout 2018 on a rolling basis.

CMS will collect the Federal Financial Portion (FFP) back from the State for claims that paid incorrectly or where proper documentation is not submitted by providers timely. Consequently, DMMA will need to recoup the payment from the provider as a PERM Recovery.

CMS will host PERM provider webinar educational sessions. These sessions will offer an opportunity for the provider community to learn more about the PERM process, provider responsibilities, and best practices during the PERM review. More information will be sent through Notify Me alerts once they are scheduled.

Questions?

If you have any questions or concerns regarding this program, please contact Susan M. Mateja, Planning and Policy Administrator, DMMA:
1-302-857-5055

Dental Update

The [Dental Policy Provider Specific Manual](#) has been updated, Revision Date 11/10/2017. Section Revised:

- 4.1.3.5 – Added clarifications to the Caries Risk Assessment Policy to align with DMES requirements

For more information on the Dental Caries Provider Risk Assessment, please visit the Dental Corner on the [Portal](#).

Note: Please also see the Dental News [Volume 2, Number 1](#).

Dental Fee Schedules Posted & Claim Adjustment Coming Soon

DMAP posted dental fee schedules on the Portal.

- [1/1/2017 - 3/31/2017](#)
- [4/1/2017 - 6/30/2017](#)
- [7/1/2017 - 6/30/2018](#)

DMAP will be processing a Future Mass-Adjustment of claims due to rate changes. Claims included in this process are for dates of service beginning July 1, 2017 and forward.

This information will appear on a future Remittance Advice (RA) and the claim numbers will begin with a '52'. There will be further communication about the timing of this Mass-Adjustment of claims for dates of service 7/1/2017 in the near future.

How-to!

Step-by-step instructions to submit claims on the Portal

How to: Submit a Dental Claim *with* Third-Party Liability (TPL)



How to: Submit a Dental Claim *without* TPL



Phone & Fax Contacts

Provider Contacts

1-800-999-3371

Provider Pharmacy option 0, option 1
 **Fax 302-454-0224

Provider Services option 0, option 2
 **Fax 302-454-7603

Provider Incentive Program option 0, option 3
 **Fax 302-454-7603

Provider Enrollment option 0, option 4
 **Fax 302-454-7603

Member Contacts

1-800-996-9969

1095B Tax Forms option 3

Client Pharmacy option 2

Delaware Cancer Treatment Program (DCTP)
 **Fax 302-454-0223

Delaware Healthy Children Program (DHCP) &
Health Benefits Manager (HBM)
 **Fax 302-454-1074

Managed Care

Highmark Health Options

Members: 1-844-325-6251

Pharmacies: 1-844-325-6253

Providers: 1-844-325-6253

Fax Prior Authorization forms: 1-855-476-4158

UnitedHealthcare Community Plan of Delaware

Members: 1-877-877-8159

Pharmacies: 1-800-842-4195

Providers: 1-800-842-4195

Fax Prior Authorization forms: 1-866-940-7328

Contact Us!

Secure Correspondence

Log in to the Provider Portal

<https://medicaid.dhss.delaware.gov/provider/Home/tabid/135/Default.aspx>

Email* Us

delawarepret@dxc.com

**Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox*

Electronic Data Interchange (EDI) Department*

DelawareECSTGroup@dxc.com

1-800-999-3371, Option 0, Option 2

Stop Medicaid Fraud Now!



To Submit Anonymously

Call 1-800-372-2022

Or [click here](#)