



DELAWARE MEDICAL ASSISTANCE PROGRAM

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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

Provider Specific Announcements

Federal Prohibition on Payment for Provider-Preventable Conditions Effective 7/1/2011

On June 6, 2011, CMS published final Federal regulations to implement section 2702 of the Affordable Care Act prohibiting states from paying for any medical care directly related to provider-preventable conditions (PPC). This rule is effective as of July 1, 2011. Under this final regulation, provider-preventable conditions are not covered services, and the DMAP cannot make payments or will recover payments for services related to provider-preventable conditions. 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). HACs include the full list of Medicare's HACs, except for deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients.

Hospital Acquired Conditions include:

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.

Please note that no reduction in payment for a provider-preventable condition will be imposed on a provider where it has been determined that the condition for a particular patient existed prior to the initiation of treatment by that provider. Also, providers will be 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. This may be a departure from your current practice. Under this Federal regulation, DMAP is required to incorporate the prohibition on payment for PPCs in all provider contracts. More information on the contract addendum and reporting requirements will follow.

Update on Nebulizers

A Prior Authorization (PA) is no longer needed for purchased nebulizers.

If a replacement nebulizer or a rented nebulizer is needed within the five-year period, a PA is required.

Provider Specific Announcements

Chaperone Rule

Delaware's law requiring a chaperone to be present when a minor is being treated in an outpatient setting took effect July 1, 2011. The law applies to all physicians and physician assistants (PAs). A chaperone must be present when the minor is under the age of 16 and he or she is disrobed or partially disrobed or undergoing any physical examination involving the breasts, genitalia, or rectum.

A chaperone may include a parent, guardian, other caretaker of the patient, or adult staff member of the physician's practice. The staff member must be 18 years of age or older and acting under the direction of the healthcare professional doing the exam or the healthcare professional's employer. The adult staff member should be the same gender as the patient when practicable.

The minor patient may decline the presence of a third person only with the consent of a parent, guardian, or other caretaker. The patient may request a private consultation with the physician or PA without the presence of a third party after the physical examination.

The physician or PA must note in the child's medical record the name of each person present when the treatment was provided.

Physician offices must provide written notice to patients and their parents, guardians, or caretakers of this requirement. The notice must be conspicuously posted in the office. **A sample notice you can print and display is available at www.MedicalSocietyofDelaware.org.** This sample has minimum required language - feel free to add information to personalize the notice.

For billing or other
provider questions,
call **Provider Relations**
at
1-800-999-3371.

National Correct Coding Initiative

On September 1, 2010, the Centers for Medicare & Medicaid Services (CMS) published directions to the State Medicaid Directors on the implementation of the Patient Protection and Affordable Care Act of 2010. Part of the instructions in section 6507 were to implement the mandatory state use of National Correct Coding Initiative (NCCI) effective for claims filed on or after October 1, 2010.

NCCI is a CMS program that consists of coding policies and edits/audits to reduce the improper billing of services that are unlikely to occur for the same client on the same day or that should not be billing in addition to another service that is more comprehensive. The Division of Medicaid and Medical Assistance will be integrating McKesson's ClaimCheck product into the MMIS to fulfill the NCCI requirements. Please watch for updates as we approach implementation.

Coming soon - HIPAA 5010 and NCPDP Version D.0!

Beginning January 1, 2012, ALL providers and vendors MUST submit ALL X12 transactions in HIPAA 5010 format. NCPDP claims transactions MUST be submitted in an NCPDP vD.0 format.

DMMA has approved the following website for all providers to access the latest information regarding these new transactions. To view Frequently Asked Questions (FAQs), visit <http://www.dmap.state.de.us/information/5010faq.html>.

Links are also included to draft HIPAA Guidelines (<http://www.dmap.state.de.us/information/5010/hipaa.html>) and NCPDP information for the Delaware Medical Assistance Program (<http://www.dmap.state.de.us/information/5010/ncpdp.html>). Please visit these sites regularly to ensure you have the most up-to-date information.

Provider Specific Announcements

DMAP Goes Green

In order to act in an environmentally responsible manner and reduce costs, the Delaware Division of Medicaid and Medical Assistance (DMMA) is initiating a paper reduction project.

As a result of this new project, effective September 1, 2011, Delaware Medical Assistance Program (DMAP) will no longer generate paper checks for Medicaid claims payment, or mail paper remittance advices (RAs). Payments will be deposited electronically into providers' bank accounts. Remittance advices will be posted to the DMAP website and will look exactly like the RAs currently received through the mail. They may be viewed at <http://www.dmap.state.de.us/home/index.html>.

The master user will need to give permission to a subordinate to access the "download" link.

- Only four (4) weeks of RAs will appear on the website. All files older than four (4) weeks will be purged.
- The RA is a PDF format. You can print or save the file to your LAN.
- The create date on the "File Download" screen will populate a Saturday date; however, the RA will have a Monday date.
- If you do not currently receive a paper RA, you will not be able to download an RA from the DMAP website.

To sign up for electronic funds transfer, go to <http://www.dmap.state.de.us/downloads/forms.html> and select EFT (New Request). If you have previously signed up but are not receiving your funds electronically, please make sure we have your most current information. If changes are needed, select EFT (Change Request). Complete the appropriate form and return using the fax number or address on the form.

DMMA is also encouraging providers to submit as many claims as possible electronically rather than on paper. Most claims sent on a single claim form with no attachments can be submitted electronically.

Please contact Provider Relations at 1-800-999-3371, option 0, option 2, with any questions about EFT and electronic RAs and to learn about submitting your claims electronically.



Electronic Health Record (EHR) Incentives

DMAP now has a link on its webpage that is a gateway to more Delaware EHR information. Check it out!

The HP Provider Incentive Payment (PIP) Team can be reached by phone (1-800-999-3371 option 0, option 3) or email (Delawarepipteam@hp.com).

Contact Quality Insights (Delaware's Regional Extension Center) at <http://www.dehitrec.org/Pages/default.aspx> or by phone 1-866-475-9669, ext. 4010.

Provider Specific Announcements

Payment Error Rate Measurement

The Center for Medicare and Medicaid Services (CMS) published regulations that require States to measure the accuracy of payments made to providers for Medicaid and the State Healthy Children Insurance Program (SCHIP). The project is entitled "Payment Error Rate Measurement (PERM)." The Division of Medicaid & Medical Assistance (DMMA) participated in the pilot projects and will start Delaware's third PERM cycle in October 2011.

As part of the initiative, a random sample of paid claims is selected for review in the following areas for both Medicaid and SCHIP: Fee-for-Service, Managed Care, Eligibility. Providers must submit medical record documentation pertinent to the claim(s) selected within 60 days. Documentation must include enough information to determine that services were provided, were medically necessary, and were consistent with the diagnosis.

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

If you have any questions or concerns regarding this project, please contact Susan M. Mateja, Planning and Policy Administrator, DMMA, at (302) 857-5055.

Pharmacy Specific Announcements

Dispense As Written (DAW) Codes

During a recent internal audit on prescriptions to follow up on our last pharmacy audit, we noticed pharmacy providers are still continuing to submit inappropriate Dispense As Written codes on claims. For clarification purposes, the NCPDP definitions are listed below for

the codes that can cause incorrect claim payment on DMMA claims. Providers are urged to only submit DAW codes when they are applicable. Erroneous submissions will have severe repercussions. DMMA will retrospectively review these claims and reprocess them, resulting in a recoupment. Pharmacy providers who have a high rate of these submissions will be reviewed for purposeful intent and possibly have to respond to fraud charges. Because the issue with DAW codes is with DAW 1 and DAW 6, an explanation of each follows.

NCPDP definitions:

DAW 1 - Substitution Not Allowed by Prescriber - Value used when the prescriber indicates, in a manner specified by prevailing law, that the product is Medically Necessary To Be Dispensed As Written. DAW 1 is based on prescriber instruction and not product classification.

DAW 6 - Override - Value used by various claims processors in very specific instances as defined by that claims processor and/or its client(s).

Explanations:

DAW 1 - A physician specifies that a brand drug is to be dispensed when a generic of the same drug is available. DMMA limits this override to drugs with a narrow therapeutic index. All other multi-source drugs for which a client requires the brand product will require documentation of medical necessity.

DAW 6 - Should only be used on claims for brand drugs and under the following conditions: the Preferred Drug List (PDL) indicates that a brand is preferred over a comparable generic drug. This code should never be used on a claim for a generic drug.

Brand drugs where a DAW 6 is acceptable are noted on the PDL by being typed in bold-face writing.

PDL Drugs DAW 6:

- Astelin
- Alphagan
- Benzaclin
- Cozaar
- Depakote Sprinkle
- Differin
- Effexor-XR
- Focalin / XR
- Imitrex Nasal Inhaler
- Miacalcin Spray
- Marinol
- Naftin
- Tindamax

Pharmacy Specific Announcements

Prior Authorization (PA) Tips

To submit a Prior Authorization request or a Letter of Medical Necessity to Pharmacy Services for medication authorization, list name, strength, and exact medication dose. Failure to provide this information will result in the request pending or denying. Incomplete PA request forms can also result in authorization delays or denials. Verify that all required fields and information are completed on the form, including

- Provider's NPI
- Client's complete name and date of birth
- Client's MID (**Medicaid ID#**)
- Diagnosis, name of medication, dosing
- Any required lab values or documentation

DMMA provides a website for downloading the current PA request forms at

<http://www.dmap.state.de.us/information/paforms.html>

Deadline for State Approved Prescription Pad Vendors Moved to March 1

The State of Delaware has postponed the date to implement new State-approved prescription pads to March 1, 2012 (from July 1, 2011). The new regulations will require physicians to purchase prescription pads from vendors registered with the Division of Professional Regulation and also set forth requirements for designing, ordering, printing, delivering, and using the prescription pads. A list of registered vendors will be available from the Division by October 1, 2011. The new requirements do not apply to prescriptions generated in a licensed medical facility for patients being treated in that facility. For more information, call 302-744-4500 or email customerservice.dpr@state.de.us.

Clarification Code 5-Change in Therapy

DMMA has several approaches for providers to respond to drug utilization review (DUR) alerts. DUR is used to verify medical necessity of the claim. Medications are reviewed for overutilization and therapeutic duplication. The primary information source is the prospective alerts system, which uses NCPDP clinical codes. These interactive claim denials provide clinical information that may:

- Encompass claims filled at other pharmacies and allow collaboration between several pharmacy providers.
- Offer insight to medications dispensed at other pharmacies (to access appropriateness of the prescription being reviewed and provide counseling opportunities).

The information can be used by the pharmacist, and appropriate DUR NCPDP response codes are permitted to allow the claim to be reimbursable. DMMA responded to the provider community's request for interactive communication on claims where exceptions can be made in the form of a clarification code (e.g., code 5 indicating a therapy change).

- This code was intended to decrease unnecessary administrative burden on pharmacy providers when there was no therapy duplication.
- Section 2.2.3 of the Pharmacy Billing Manual states that this code **must only be used** when there is a therapy change. The NCPDP 5.1 claim layout specific to DMMA also clarifies that 420-DK should only be populated if there is a therapy change.

Both manuals state that money may be recouped if codes are used incorrectly. In a retrospective claim review, we found that providers are submitting clarification code 5 repeatedly to allow duplicate therapy to be dispensed. Several therapeutic categories were selected where duplicate therapy is costly to the program and may prove harmful to the client. All claims submitted with clarification code 5 will be reviewed. Those submitted erroneously will be recouped. Please review your procedures with all employees to remind them to submit this code only when appropriate for actual changes in therapy where previous prescriptions have been terminated. In addition, any suspected fraud will be referred to the Department of Justice Medicaid Fraud Control Unit.

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

New Assistive Technology Caregiver Resource Center at New Castle Easter Seals Site

CARE Delaware, a program of the DE Division of Services for Aging and Adults with Physical Disabilities, is pleased to announce the opening of their fifth caregiver resource center at the Easter Seals Resource and Technology Demonstration Center, 61 Corporate Circle, New Castle. The newest caregiver resource center is designed to support the thousands of Delawareans providing care for a loved one, neighbor, or friend. This is the first Delaware center to have both low- and high-tech assistive devices available for viewing and borrowing, to make caregiving a little bit easier. Devices such as pill splitters, grabbers, scooters, portable ramps, magnifying devices, books and print materials about home design as you age, and so much more will be housed in this beautiful, spacious center.

Call Nancy Ranalli or Joyce Medkeff at (302) 221-2033 or (302) 221-2076 to schedule an appointment or to ask a question. CARE Delaware offers four other caregiver resource centers throughout the state and welcomes your visits and calls: Newark Senior Center at (302)737-2336, Wilmington Senior Center at (302) 651-3401, Modern Maturity Center in Dover at (302)734-1200, Georgetown and other CHEER sites at (302) 854-2886.

What's New?



Provider Manual Updates

The following provider manual revisions were posted to the DMAP website What's New page: www.dmap.state.de.us. Notification also appeared on Remittance Advice Banner Pages and the DMAP e-Mail Notification System.

DME Policy Provider Specific Manual

Revision Date: 7/14/11

Sections Revised: 8.6

Added row to Additional Miscellaneous Supplies section.

Revision Date: 6/24/11

Section Revised: 12.0

Removed obsolete Certificate of Medical Necessity (CMN) forms no longer used by Medicare.

General Policy Manual

Revision Date: 6/24/11

Sections Revised: 1.6

Added guidance on how DMAP will handle FDA issued consent decree(s) for drug or device manufacturers.

Revision Date: 5/3/11

Section Revised: 1.10

Updated the section on Fraud or Abuse Reporting.

Revision Date: 4/20/11

Sections Revised: 6.0

Updated provider appeals procedures.

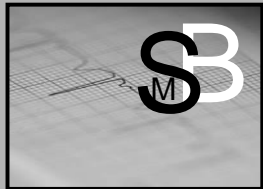


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