



DELAWARE MEDICAL ASSISTANCE PROGRAM

■ PART C ■ RENAL ■ MEDICAID ■ VFC ■ DHCP ■ DPAP

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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

Dental Providers



DSP Asthma Care Coordination

Supernumerary Tooth Extractions

When billing for the extraction of supernumerary teeth, providers should use CDT code **D7999 - unspecified oral surgery procedure**, by report. Do not enter a tooth number in the claim's "tooth field." Rather, in the Remarks Section on the claim (**Field 61**)

- Indicate that the extraction is for a "supernumerary"
- Indicate the location or area of the tooth from which the supernumerary was extracted, using the following valid tooth numbers: 1-32 or A-T.
- If you extract more than one supernumerary tooth, indicate the total number of teeth extracted on one claim line and list the location/tooth area for all of the extracted teeth in the Remarks Section.

Contact Provider Relations if you have questions.

Reminders to Participating Orthodontists:

- Models submitted with cases to be considered for coverage must be properly disinfected prior to packaging and shipping. Shipping models that are not properly disinfected violates standard infection control procedures that are applicable to all dental practices.
- Please remember to trim models to professional standards so they can be articulated for evaluation. We are unable to evaluate models that are not of diagnostic quality and are not properly trimmed.
- When we cannot evaluate models, due to contamination or because they are not of diagnostic quality, we destroy those models and request that providers resubmit new models for evaluation. We treat cases that require the submission of new models as new cases and place them at the end of the queue for review.

We appreciate your cooperation. Please contact the DMAP Dental Administrator at **302-255-9604** with questions.

Diamond State Partners (DSP) has implemented an Asthma Care Coordination program, designed to address early identification, outreach, and engagement of DSP members with asthma diagnosis. The program will address, where possible, other challenges that may affect those with the diagnosis. Such challenges include, but are not limited to, physician-patient relationships, co-morbid conditions, home environmental and lifestyle concerns, knowledge of community resources, and transportation.

Members have an opportunity to "opt out" of the program once notified by letter and given 10 days to respond. The program is set up with a Medical Social Worker and Registered Nurse team that work directly with members who agree to be in the program. This team will educate members to maximize self-care and minimize/eliminate the need for emergency department care for non-emergency asthma symptom relief. DSP expects to reduce the need for hospitalization to manage out-of-control or preventable symptoms. In addition to speaking directly to members, where permitted and necessary, the team will help members reach out to their physicians and community resources.

The referral process is simple. Providers call DSP's **Member Services at 1-800-390-6093** and provide the following basic information:

- **Member name**
- **Member ID number**
- **Member phone number**
- **Member address**
- **Member established asthma diagnosis**
- **Provider NPI**
- **Provider contact name**
- **Provider contact number**

If you prefer, fax the above information to 302-454-7603, Attn. DSP. DSP appreciates your assistance in making this a successful program for members with asthma diagnoses.

Provider Specific Announcements

Billing for Digital Mammography

The age range for code G0202 and diagnostic digital mammography codes G0204 and G0206 has been updated to reflect a minimum age of 40 and a maximum age of 110. DMMA will monitor claims submitted on these codes for appropriate diagnoses.

PERM REMINDER

All providers should continue to submit medical record documentation requested for the Payment Error Rate Measurement (PERM) program to the Federal Contractor Livanta, LLC.

If you have any questions about this project, contact Susan M. Mateja, Policy Administrator, DMMA at (302) 857-5055.

Part C Billing Update

Birth to 3 Early Intervention System, the administrative program (within the Division of Management Services) for Part C of IDEA in Delaware, has stepped up its campaign to collect all private insurance information for Part C eligible children. This information is entered into the State Medicaid Management Information System (MMIS). Providers are a critical source of this information as they are the most frequent point-of-contact for clients and, therefore, have access to the most up-to-date private insurance information. In addition to relying on providers to report all new or changed insurance information to EDS, Birth to 3 staff are continuing to collect insurance information from other sources, including data matching from claims and Child Development Watch staff.

When Third Party Liability (TPL) information exists in the MMIS, claims will hit the appropriate insurance edits to verify that claims meet all criteria for proper coordination of benefits (COB). For claims where TPL pays 40 percent or more of a claim, electronic billing is still acceptable. For claims where TPL pays less than 40 percent or denies payment, an appropriate paper claim with attachments must be filed.

In the past, some providers who filed paper (i.e. UB-04) claims with attachments were under the impression these attachments were acceptable but believe that now, suddenly, the same type of attachments are “not working.” In reality, for claims where TPL was not in the system, attachments were not examined, because the claims did not hit the edits. If the insurance is now in the system (where it wasn’t before), a claim will be denied if it does not meet all criteria, including appropriate EOBs, RAs, or denials. Also, **for each claim number on an EOB, a separate UB-04 must be filed.**

Provider resources and related manuals available at <http://www.dmap.state.de.us> outline these criteria. Additionally, **after verifying client information in the DMAP, providers should fax updated insurance information to EDS at 302-454-7603.**

Providers can contact EDS Provider Relations with any questions about Part C claims, or Carolyn Morris (carolyn.morris@state.de.us) with the Birth to 3 Office.

Please note: Part C is not Medicaid, even though claims are processed through EDS.



Provider Specific Announcements

Medicaid Integrity Program Provider Audit Fact Sheet

November 2008

Background

The Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program (MIP) and directed the Centers for Medicare and Medicaid Services (CMS) to enter into contracts to review Medicaid provider actions, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.

Who are the “Audit MICs”?

Audit Medicaid Integrity Contractors (Audit MICs) are entities with which CMS has contracted to perform audits of Medicaid providers. The overall goal of the provider audits is to identify overpayments and to ultimately decrease the payment of inappropriate Medicaid claims. At the direction of CMS, the Audit MICs will audit Medicaid providers throughout the country. The audits will ensure that Medicaid payments are for covered services that were actually provided and properly billed and documented. Audit MICs will perform field audits and desk audits. Audits have begun in CMS Regions III & IV and will be expanded to all States and Territories. The audits are being conducted under Generally Accepted Government Auditing Standards.

Which providers will be subject to audit?

Any Medicaid provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional, as well as managed care entities.

What should a provider do if it receives a Notification Letter that it has been selected for audit?

Gather the requested documents as instructed in the letter. CMS contractors have the authority to request and review copies of provider records, interview providers and office personnel, and have access to provider facilities. Requested records must be made available to the Audit MICs within

the requested timeframes. Generally, providers will have at least two weeks before the start of an audit to make their initial production of documents to the Audit MICs. In obtaining documents, Audit MICs will be mindful of state-imposed requirements concerning record production. Moreover, Audit MICs may accommodate reasonable requests for extensions on document production so long as neither the integrity nor the timeliness of the audit is compromised. The Audit MICs will also contact the provider to schedule an entrance conference. Notification Letters will identify a primary point of contact at the Audit MIC if there are specific questions about the Notification Letter or the audit process.

What process will follow the completion of the audit?

The Audit MIC will prepare a draft audit report, which will first be shared with the State and thereafter with the provider. The State and the provider will have an opportunity to review and comment on the draft report's findings. CMS will consider these comments and prepare a revised draft report. CMS will allow the State to review the revised draft report and make additional comments. Thereafter, CMS will finalize the audit report, specify any identified overpayment, and send the final report to the State. The State will pursue the collection of any overpayment in accordance with State law. Providers have full appeal rights under State law. The Audit MICs will be available to provide support and assistance to the States through the State adjudication of the audit.

Who are the Audit MICs?

Umbrella contracts have been awarded to Booz Allen Hamilton, Fox & Associates, IPRO, Health Management Solutions (HMS), and Health Integrity, LLC. Booz Allen Hamilton was awarded the task order to conduct audits in CMS Regions III & IV. HMS was recently awarded a task order for CMS Regions VI & VIII.

For more information on the Medicaid Integrity Program, please e-mail
Medicaid_Integrity_Program@cms.hhs.gov.

Pharmacy Specific Announcements



Getting You the Best Information

Our Pharmacy Call Center appreciates your calls and wants to make them as efficient as possible for you. Here are some tips from our call center representatives:

- When calling with your request, please remember to check the chart for the client's card and **have the client's Medicaid Identification (MID) number ready.**
- When calling with your prior authorization request, please remember to **have the client's chart and information pulled** to help you answer our questions.
- Some prior authorization requests are using the Unison number and even indicating next to it that it is the Unison number. The MID is listed as the MMC number on the bottom right side of the card. **You will need to use the MID for Medicaid claims** since the Unison number only works for Unison correspondence.
- **Medicaid is the payer of last resort.** Please contact Medicare to request prior authorizations for Medicare dual eligibles. These should be billed to Medicare by the pharmacy.

Any questions?

**Call the pharmacy provider line at
1-800-999-3371.**

E-Prescribing

D_elaware Receives SafeRx Award

Surescripts, the country's largest electronic prescribing network, recently announced its 4th Annual SafeRx awards, highlighting the top 10 states that send prescriptions electronically. The SafeRx awards were created to raise awareness of how E-Prescribing improves patient safety with a more secure, accurate, and informed process for prescribing medications.

Adoption of the technology is increasing as physicians across Delaware realize the long-term benefits of E-Prescribing. For 2008, the state of Delaware ranked an impressive 5th in the nation. Delaware sent 7.7 percent of its prescriptions electronically in 2008, for a total of 366,447 prescriptions. These numbers represent 92 percent annual growth from 2007. Surescripts also reported that by year-end 2008, 22.85 percent of Delaware physicians were routing prescriptions electronically, representing an annual growth of 110 percent from the previous year.

To learn more about the SafeRx awards and to view the complete state-wide report, visit www.surescripts.com/safe-rx-awards.html. This site has some great resources, such as access guides for physicians, buyer's guide worksheets, initiatives and incentives, and a wealth of other data to assist with E-Prescribing adoption.

For more information or assistance with E-Prescribing, please contact Brenda Wilson at 302-607-0744 or b.wilson@eds.com.



Division of Services for Aging and Adults with Physical Disabilities

Delaware Money Management Program

The Money Management Program bill was signed into Delaware law on July 12, 2001. The Delaware Money Management Program (DMMP), co-sponsored by the Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) and the AARP Foundation, offers support to low-income seniors and adults with physical disabilities who have difficulty budgeting, paying bills, and keeping track of financial matters. DMMP recruits volunteers to assist individuals who do not have family or friends to step in and help.

Volunteers must undergo fingerprint, criminal background, and abuse registry checks and submit three references for review. The AARP Foundation provides insurance in the event of client losses and volunteer liability. The program operates in many states, and there have been few instances of volunteers taking advantage of vulnerable clients. DMMP serves 35 clients with 45 active volunteers. Volunteers are trained and supported by the two programs, and the AARP Foundation staff conducts monthly reviews of financial statements.

Volunteers meet with clients several times a month in the client's home to provide checkbook balancing and bill paying services. Sometimes, volunteers agree to become representative payees when the client is determined to be incapable of handling his own financial affairs. The benefit check is deposited directly into a bank account from which the payee pays the client's bills. This support allows clients to continue living in the community, secure in the knowledge that a trained volunteer is overseeing financial matters for them.

Examples of clients helped by DMMP:

Mary (not her real name) is a 46-year-old woman who is blind, has cerebral palsy, diabetes, and is bedridden. She was in a nursing home, but decided to take advantage of a program that allows eligible nursing home residents to live in the community with supports. One of Mary's major concerns is her finances. She is mentally very sharp, but being visually impaired requires assistance with sorting and organizing bills for payment and mailing, writing

checks, balancing her checkbook, and budgeting. Mary's DMMP volunteer has taken on these responsibilities. The women get along great, each looking forward to spending time with the other.

Rufus (not his real name) is an 81-year-old gentleman who uses a wheelchair to get around. He spent 20 years in the state mental hospital with what we now know as learning disabilities. He has no family and is dependent on social services. Initially, Rufus was adamant about not opening the checking account needed to participate in DMMP. Unfortunately, he was robbed several times after cashing his Social Security check and keeping the money in his apartment. With gentle persuasion, he eventually agreed to the checking account and a representative payee. The representative payee is a volunteer approved by Social Security to receive an individual's benefit check, which is deposited in a checking account set up specifically for the client with the representative payee dispersing funds. Now, Rufus gets his benefits without having to pay for check cashing. He also does not have to pay to have checks written for his various other bills.

If someone you know experiences one or more of these issues, they may need assistance.

- Having difficulty balancing a checkbook/handling day-to-day financial affairs
- Occasionally bouncing checks due to the inability to manage a checking account
- Leaving bills unpaid or having utilities shut off
- Being under threat of eviction/foreclosure
- Having difficulty reading/writing due to poor vision, injury, or disability
- Being a victim of financial exploitation or financial abuse
- Having a serious illness that leaves little time to manage financial affairs.

Call **800-223-9074** for more information or to volunteer your time and talents.

What's New?



Provider Manual Updates

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

Ambulatory Surgical Center Provider Specific Manual

Revision Date: 5/26/09

Sections Revised: 5.1

Update to reflect change in how rates are paid.

Dental Provider Policy Specific Manual

Revision Date: 4/08/09

Sections Revised: Revision Table

Added the required CDT end user licensing agreement as a pop-up dialogue box.

EVS Manual

Revision Date: 5/27/09

Section Revised: 1.4

Defines e-prescribing providers ability to access patient eligibility information.

General Policy Manual

Revision Date: 7/14/09

Sections Revised: 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.

Revision Date: 6/30/09

Sections Revised: Section 14, Appendix I

Changes and clarification made to the various MCBR forms and instructions.

Revision Date: 7/6/09

Section Revised: 1.21.5.1.7

Added intestinal transplants as a covered service.

Revision Date: 6/26/09

Added Provider Taxonomy to Appendices

Revision Date: 5/27/09

Sections Revised: 3.4

Defines e-prescribing providers ability to access patient eligibility information.

Revision Date: 5/21/09

Sections Revised: 1.21.1

Added minimum documentation requirement specifics.

Sections Revised: 1.13.2

Reimbursement clarification.

Revision Date: 4/30/09

Sections Revised: 1.23

Clarification of income limits for SLIMBs and QI1s.

Hospice Provider Specific Manual

Revision Date: 4/30/09

Section Revised: 1.1.4 - Clarified the wording which addresses how providers are paid for servicing institutionalized individuals.

Hospital Outpatient & Outpatient Crossover Claims Guidelines for including NDC information

Date: 5/20/09

List of guidelines for including NDC information on hospital outpatient and outpatient crossover claims

Pharmacy Billing Manual

Revision Date: 6/5/09

Section Revised: 2.2.1

Clarification and instruction provided to verify eligibility in emergency situations.

Pharmacy Provider Specific Manual

Revision Date: 6/26/09

Effective 07/01/2009 updated the Estimated Acquisition Cost (EAC) for traditional and independent pharmacies.

Revision Date: 6/5/09

Section Revised: 3.3.2

Clarification and instruction provided to verify eligibility in emergency situations.

Practitioner Provider Manual

Revision Date: 7/13/09

Sections Revised: 30.0 Appendix O

Corrected the wording to the Periodicity schedule regarding the number of visits for early childhood years, between the ages of 2 and 3.

Rehabilitation Agency Provider Specific Manual

Revision Date: 6/4/09

Sections Revised: 4.2.1

Updated the incorrect UB92 wording to the correct wording, UB04.

Renal Dialysis Facility Provider Specific Manual

Revision Date: 6/4/09

Sections Revised: 5.2.1

Effective July 1, 2009, providers who bill using a Renal Dialysis taxonomy must bill their charges using the lesser of the facility's usual and customary (U & C) charges or 100% of the Medicare reimbursement rate.

For billing or other provider questions,
call Provider Relations at
(302) 454-7154

or

1-800-999-EDS1 (3371).

If you do not have a vendor and would like to bill electronically, call us. DMAP offers free software to all Medicaid providers, so "go electronic" today!

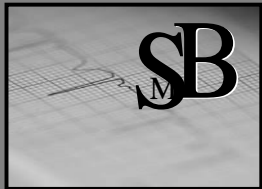


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