



# DELAWARE MEDICAL ASSISTANCE PROGRAM

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# MEDICAID SPECIAL BULLETIN

[www.dmap.state.de.us](http://www.dmap.state.de.us)

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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

# Provider Specific Announcements

## Diamond State Health Plan Plus

The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) and Division of Medicaid & Medical Assistance (DMMA) are collaborating on development and implementation of Diamond State Health Plan Plus (DSHP Plus) which integrates Nursing Facility services and Home and Community Based Services (HCBS) into the existing managed care delivery system. This new delivery system of long-term care services is scheduled to begin in April 2012. The initiative will increase access to community-based services, improve care coordination, create a budget structure that facilitates the shift of resources from institutional to community-based services, and give consumers more choice and a greater voice.

Most of the Medicaid-eligible population in Delaware is currently enrolled in the Diamond State Health Plan (DSHP) for health care services. DSHP is a managed care model of service delivery with two managed care organizations responsible for managing health care needs and ensuring health services are delivered. DSHP will be expanded to include long-term care services. This means individuals enrolled in DSHP Plus will have access to the current benefit package in the DSHP (e.g., acute care services, in-patient hospitalization, out-patient visits, behavioral health services, etc.) as well as an expanded package of long-term care services which will include personal care services, respite care, case management, consumer directed attendant care, day habilitation, assisted living care, nursing facility care, transition services from a facility to the community, and other supports. The extended package will include services currently provided by the Elderly and Disabled (E&D) Waiver and the Aids Waiver, at a minimum. DSHP Plus will include the following populations:

- Medicaid eligible individuals residing in nursing homes
- Individuals enrolled in Medicaid's Elderly and Disabled (E&D) Waiver
- Individuals enrolled in Medicaid's AIDS Waiver
- Individuals in the community who are dually eligible for Medicaid and Medicare

Eligible individuals have a choice of two managed care plans, Delaware Physicians Care Incorporated or UnitedHealthcare Community Plan. Each plan will be paid by DMMA on a capitated basis. Clients in existing programs will be transitioned to DSHP Plus. Their current services will be provided by the managed care organizations. The State will retain oversight of the program and plans through careful monitoring.

For additional information, visit the DMMA website at <http://dhss.delaware.gov/dhss/dmma/dshpplus.html>. The website provides a link to the DSHP Plus e-mail box for questions or comments.

The contact information for the Managed Care Organizations is:

Delaware Physicians Care Incorporated  
Ryan Forman  
Manager, Network Development  
[FormanR@Aetna.com](mailto:FormanR@Aetna.com), 302-894-6629

UnitedHealthcare Community Plan  
Andrea Potts  
[Andrea.Potts@uhc.com](mailto:Andrea.Potts@uhc.com), 302-729-4184

## Electronic Health Records Incentive Program!

Eligible Professionals (EPs - physicians) may receive up to \$63,750 over three years through the Medicaid Electronic Health Records (EHR) Incentive Program. The EP must register and attest to Adopting, Implementing or Upgrading a certified EHR system. The EP must be enrolled in DMAP. To determine eligibility for EHR incentive payments, contact the Provider Incentive Payment (PIP) team at [delawarepipeteam@hp.com](mailto:delawarepipeteam@hp.com) or 800-999-3371, option 0, option 3. The Delaware Regional Extension Center at [www.dehitrec.org](http://www.dehitrec.org) may also assist practices in determining whether they meet the criteria for incentive payments.

# Provider Specific Announcements

## Durable Medical Equipment

Walkers and commodes, if billed once in a lifetime, no longer require a prior authorization.

## Practitioners with Prescriptive Authority Treating Patients with Cancer

When prescribing medication for the management of oncology patients, please include the cancer diagnosis code on the prescription. If the diagnosis is included on the drug claim at the pharmacy, the prior authorization process may be avoided. Oncology patients can receive analgesic medications in an expedited manner if this information is provided.

## Disclosure

Effective 01/01/2012, ALL providers will be required to submit their annual Provider Disclosure Statement. If providers do not complete the disclosure form in 35 business days, they will not be able to participate in the Delaware Medical Assistance Program.

This form can only be submitted on-line via the DMAP website. Call HP Provider Relations at 1-800-999-3371 for further information.

## Consolidation of Phone Lines:

Effective November 11, 2011, we eliminated the local telephone number (302-454-7154) for Provider Services and the Pharmacy Team.

Providers can continue to contact Provider Services at **1-800-999-3371**, option 0, option 2 (or option 0, option 1 for Pharmacy).

**Please note:** Provider Services and the Pharmacy team are still located in Delaware.

## HIPAA 5010 Update Attention Billing Providers

The DMAP website has added a new webpage. Our new feature "DID YOU KNOW" has been added to the 5010 FAQ section of the DMAP website. This webpage will be updated as we approach the remaining months prior to the implementation date of January 1, 2012 for all HIPAA 5010 transactions.

Please visit

<http://www.dmap.state.de.us/information/5010faq.html> regularly to avoid billing/reimbursement issues after the 1/1/2012 cutover.

## 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 started 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.

# Dental Specific Announcements

## Dental Contact

DMMA has hired Gabrielle Hilliard as our new dental administrator. She comes to us with a wealth of dental knowledge and will be an asset to DMAP and dental providers alike. She can be reached at 302-255-9604 or [Gabrielle.Hilliard@state.de.us](mailto:Gabrielle.Hilliard@state.de.us) and would love to hear from you!

## Attention All Dental Providers:

Updated dental policy changes can be found on the DMAP interactive website, [www.dmap.state.de.us](http://www.dmap.state.de.us). All providers should maintain a copy of the Dental Provider Specific Policy Manual and take note of all updates. Updates can be located under the header titled "information" and on the side bar titled "what's new" of the DMAP interactive website, [www.dmap.state.de.us](http://www.dmap.state.de.us). Make sure you use the current prior authorization forms.

- The following codes no longer need prior authorization: D2950, D2951, D2952, and D2954. Code D2950 was mistakenly left off of the "What's new" on line section.
- Effective 10/01/2011, codes D8210 and D8220 will no longer be a covered service.
- Prior authorization and a copy of an FMX or panorex is now required for extraction of teeth 1, 16, 17, and 32.
- Any extractions or exposures on permanent teeth related to orthodontic care must be prior authorized. These services are not covered unless the orthodontia has been approved by Medicaid.
- Dental prior authorizations cannot be sent via fax. Please mail prior authorizations to the Dental PA Unit or email them to [Gabrielle.Hilliard@state.de.us](mailto:Gabrielle.Hilliard@state.de.us). If you email a prior authorization, the x-rays need to be attached to the prior authorization form and sent as a jpeg or pdf. Use the patient's name in the message, not in the header. The subject line may contain DPA and the tooth number. All prior authorizations must be sent securely to comply with the HIPAA mandate.
- Effective May 6, 2011, it is no longer necessary to submit prior notification to DMMA regarding outpatient facility and anesthesia charges for dental procedures under age 21 for codes 41899 and 00170. This policy change applies to both the outpatient hospital and treating dentist or oral surgeon and only for these two procedure codes. The medical necessity of these services will be reviewed on a post-payment basis.
- Always check and verify eligibility prior to every service performed. Customer eligibility can change from day to day; it is the dental provider's responsibility to verify eligibility. Prior authorization does not guarantee customer eligibility; it validates medical necessity.

# Dental Specific Announcements

## Root Canal Therapy

Root canal therapy (RCT) is only covered when medically necessary. Generally, root canal therapy is necessary when the pulp is infected, when the patient has experienced trauma or fracture which has damaged the pulp, or when the tooth is cracked or severely broken and would likely compromise the health of the pulp. While RCT does not require prior authorization, please note that RCT is not considered to be medically necessary simply as a precursor to the placement of a crown when the above-mentioned conditions do not exist, or where a tooth has a poor prognosis for being retained or is expected to be extracted as part of an alternate treatment option as determined by the DMMA dental consultant. DMMA may deny or void claims where the RCT has been determined not to be medically necessary.

# Physician Specific Announcements

## Pain Medicine Taxonomy

The Pain Medicine taxonomy (208VP0000X) is available for all new and current practitioners and their groups. This taxonomy enables DMMA to identify providers who focus on treating clients with chronic pain conditions. These clients have specific procedures and pharmaceutical needs. Practices that focus on this area of medicine will differ from a general practice or internal medicine.

If your specialty area focuses on managing patients with pain, you are urged to identify yourself and your claims with the appropriate taxonomy. DMMA will look at prescribing patterns with a high rate of controlled substances. Practitioners whose NPI is identified on prescription claims will be compared to their peers. Outliers from the norm of each specialty will be part of further reviews.

Procedure codes used explicitly for pain management will be identified as such. Claims submitted without the identified taxonomy will be further reviewed, delaying payment until the review is completed.

## Internet Prior Authorization Requests

As part of the DMAP Go Green initiative, we encourage you to request prior authorizations via the DMAP website. The website offers the following benefits at your fingertips:

- No paper required
- Fewer legibility issues or problems with client identification numbers
- Reduced administrative time (no more dialing the fax number and waiting for an acceptance or calling in)
- Ease of use (dropdown boxes for making selections)
- Secure submission of request
- Verification of prior authorization status

Currently, 54 criteria forms can be accessed via Interactive Services on the DMAP website.

### How do I submit PA requests for medications?

The DMAP Website has instructions posted for submitting pharmacy PA requests at:

<http://www.dmap.state.de.us/information/Pharmacy/PACR.instruct.submit.pdf>

### How do I check my PA request status?

The DMAP Website has instructions posted for checking the status of pharmacy PA requests at:

<http://www.dmap.state.de.us/information/Pharmacy/PACR.instruct.status.check.pdf>

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

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

To submit a PA request or 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

# Pharmacy Specific Announcements

## 72-Hour Emergency Supply

Prior authorization requests will be evaluated within one business day by Medicaid's clinical staff. If required, one 72-hour emergency supply can be dispensed and billed to Medicaid, if a request is submitted after business hours, and if the medication is essential for continuation of therapy. Please allow an emergency supply of the medication for these situations.

Eligibility should always be verified in emergency situations. Eligibility can be verified via the POS device, the voice response system at 800-999-3371, or through the Interactive Services tab on the DMAP Website at <http://www.dmap.state.de.us/home/index.html> regardless of the type of claim.

The above three sources provide either an eligibility or ineligibility response along with a verification number.

## Attention Pharmacy Providers:

Pharmacy providers are required to submit the diagnosis code if a prescriber has provided the information on a prescription. The ICD-9 code is essential to the prior authorization (PA) process. Without an appropriate ICD-9 diagnosis code, claims for medications requiring PA will not pay without a manual review.

## Part D COB Codes

For Medicare Part D Coordination of Benefit codes for pharmacy claims, use the following:

- 99 for "Other Payer ID Qualifier" field
- PDP9999999 for "other Payer ID" field
- Please remember to enter rejection code received

## 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](http://www.dmap.state.de.us). Notification also appeared on Remittance Advice Banner Pages and the DMAP email Notification System.

### Clinic Provider Policy Specific

Revision Date: 8/18/11  
Section Revised: 10.17  
Added proper billing code effective 10/01/2010.

### Dental Provider Specific Manual

Revision Date: 9/21/11  
Sections Revised: 8.0  
Adjustments completed for accuracy based on the changes dated 09/09/2011.

Revision Date: 9/9/11  
Sections Revised: 5.0, 8.0, 3.2 and 10.0  
Removed the prior authorization requirement for the following codes: D2951, D2952, and D2954. D8210 and D8220 are no longer covered dental services. Updated guidance for the following codes, D7140, D7210, D7220, D7230, D7240, and D7241. Reduced age limit to 5 years old for D0330. Added billing guidance for orthodontists when client(s) lose eligibility. Updated the Interceptable Orthodontic Prior Authorization Request form to include the following requirement, a panorex and photograph.

### Home Health Provider Manual

Revision Date 8/29/11  
Sections Revised: 5.2  
Updated the face-to-face policy. The policy changes in 5.2 override the policy updates published on 04/20/2011.

### Outpatient Hospital Provider Manual

Revision Date: 9/9/11  
Sections Revised: 3.2  
Effective May 6, 2011, it is no longer necessary to submit prior notification to DMMA regarding outpatient facility and anesthesia charges for dental procedures under age 21 for codes 41899 and 00170.

### Pharmacy Billing Manual

Revision Date: 8/5/11  
Section Revised: 2.7.1  
Updated the DMAC Pricing Inquiry Worksheet for Generic Drug.

# Data Breaches

## Provider Notification Requirements Following a Data Breach

All providers and insurers face the difficult task of safeguarding against HIPAA and HITECH Act-covered information data breaches. A data breach is an intentional or unintentional security incident in which sensitive, protected, or confidential data is copied, transmitted, viewed, stolen, or used by an individual unauthorized to do so. Data breaches may involve individual financial information, protected health information, or personally identifiable information, etc. Breaches of medical data may include incidents such as theft or loss of digital media such as computer tapes, hard drives, or computers containing such media without encryption, etc. The ramifications of a data breach for a patient are significant and can result in identity theft, account fraud, financial loss, and reputational impact where health conditions were previously confidential. The ramifications for providers or other covered entities can also be significant since, under Federal provisions, providers may incur fines ranging from \$100 to \$50,000 per violation, with maximum fines ranging from \$25,000 to \$1.5 million, the differences being due to accidental data breaches versus willful neglect. DMMA reminds its participating providers of the critical need to become familiar with State and Federal requirements for protecting patient data and reporting breaches of patient information.

## Medicaid and State Requirements

The Medicaid Trading Partner Agreement provides for the following: "The Trading Partner will institute and adhere to security procedures to prevent unauthorized access to data, data transmissions, security access codes, and any and all other private or protected data or records. Further, the Trading Partner will promptly notify HPES of any unlawful use or unintended disclosure of Protected Health Information or any unauthorized attempt to obtain access to or otherwise tamper with protected data." When a data breach has occurred, it is DMMA's expectation that the Trading Partner will immediately notify HP Provider Relations at 1-800-999-3371, option 0, option 2. The provider should provide information on what data was breached, whether DMMA clients were included, the nature of the breach, what actions have or are being taken to notify patients about the breach, and what actions are being taken to implement a security plan to prevent future data breaches.

Providers should also reference State law at Title 6, Chapter 12B – Computer Security Breaches, for further guidance on reporting and notifying individuals about breaches of security of computerized personal information. Individuals and commercial entities conducting business in Delaware must conduct good faith investigations to determine whether personal information has been misused and must give notice to affected individuals as soon as possible.

## Federal Requirements

Federal regulations implemented as an interim final rule in August 2009, require HIPAA-covered entities to notify the U.S. Secretary of the Department of Health & Human Services of breaches of protected health information, depending on the number of individuals affected by the data breach. Where a data breach affects 500 or more individuals, a provider or other covered entity must notify DHHS without delay and in no case later than 60 days from the discovery of the breach. For breaches affecting fewer than 500 individuals, a provider or other covered entity must notify the Secretary of DHHS annually. All such notifications occurring in a calendar year must be submitted within 60 days of the end of the calendar year in which the breaches occurred. Notifications of breaches must be submitted electronically to DHHS. Further, the HITECH Act requires providers and covered entities to notify patients individually whenever a breach of protected health information has occurred, and when the breach involves more than 500 patients within the State, the breach must be reported to the state's local media outlets. Comprehensive information on data breaches and reporting requirements can be found at:

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html>.

Providers are urged to educate all employees on the HIPAA and HITECH Act's privacy and security provisions to keep patient data safe and secure and to implement systems and controls to protect against the unauthorized release of PHI, financial information, and personal information. Doing so will protect patients and providers from financial losses and compromised reputations.

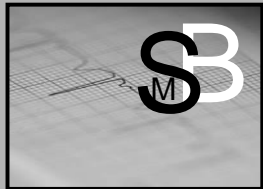


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