

DELAWARE FIRST HEALTH

Virtual Provider Forum



Agenda

01— Welcome, About Delaware First Health & Important Announcements

02— Provider Services

03— Provider Relations, Resources, Roles & Responsibilities and Access & Availability

04— Member Eligibility & Benefits

05— Billing + Claims

06— Utilization Management / Authorizations

07— *Care Management*

08— Quality Improvement

09— Q&A



01— Welcome to Delaware First Health



Welcome to Delaware First Health!
Thank you for being part of our network
of healthcare professionals. We look
forward to working with you to improve
the health of our communities, one
person at a time.

**Hello,
Delaware.
So nice to
meet you.**

A Local Health Approach from a National Leader

Delaware First Health offers a local, community centric approach to healthcare, all backed by the nation's largest Medicaid Managed Care Organization: Centene Corporation.

With Centene's deep experience serving more than 15 million Medicaid members in 30 states, Delaware First Health also brings established best practices and a wealth of knowledge to Delaware's Medicaid Managed Care program and our provider partnerships.

OUR PURPOSE

Transform the health of the community, one person at a time.

OUR APPROACH

Delaware First Health strives to improve the health of Delaware members through **focused, compassionate and coordinated care.**

Our approach is based on the core belief that quality healthcare is best delivered locally.

OUR PILLARS



Local



Whole Health



Focus on the Individual

ABOUT DELAWARE FIRST HEALTH

Our Commitment to our Partners

Our goal is to help each and every Delaware First Health member achieve the highest possible levels of wellness and quality of life, while demonstrating positive clinical results. We do that through:

- **Integrated Care** – Strong support for service integration of physical, behavioral, and Long-Term Services and Support through a high degree of healthcare collaboration and communication.
- **Coordination of Care** – Organized member care that requires the involvement of all personal, community and healthcare stakeholders to facilitate the appropriate delivery of health care services.
- **Continuity of Care** – Healthcare driven by relationships between member, health providers, and community services to ensure ongoing health care management through shared goals and multiple care settings to produce high quality, cost-effective care.

*We're proud to
be your*
**Managed
Medicaid
Partner**

As our partner, you can count on Delaware First Health to provide:

- ♦ Fast and accurate claims payments
- ♦ Transparent data sharing to improve health outcomes
- ♦ Efficient and convenient processes for providing care to our members
- ♦ Responsive Provider Relations representatives to assist with all your needs
- ♦ A strong working partnership to ensure your patients receive the quality, affordable healthcare they deserve

Important Announcements: Continuity of Care & Authorization for New Services

WELCOME TO DELAWARE FIRST HEALTH

Date: 01/01/23

We are excited to be the newest Delaware Medicaid Managed Care Organization (MCO) serving members throughout Delaware! We value developing strong relationships with our provider community and that is why we want to make the transition to a new MCO as seamless as possible. We are committed to providing excellent customer service and being attentive to your needs.

DFH is asking for your assistance to ensure that the care of our Medicaid members continues to be uninterrupted. Please educate your staff, practitioners and departments that you are a participating provider with Delaware First Health. **It is important to us that no members are denied services or turned away for any reason.** Additionally, suggesting that a member be transitioned to another Managed Care Organization (MCO) is not acceptable.

Also here are some important reminders and information now that we are live:

- **Continuity of Care** – For dates of services up to May 1, 2023, DFH will not require a prior authorization for participating and non-participating providers in the following circumstances:
 - If you have an authorization from another MCO for an outpatient service; or
 - If you are treating a member in an ongoing course of treatment; and/or
 - If you have an authorization from another MCO for in-patient services. While a request for an in-patient authorization is being waived, providers must notify DFH of admission for concurrent review and discharge planning.
- **Prior Authorization for New Services** – For new outpatient and inpatient services not previously authorized by an MCO refer to our [Pre-Auth tool](#) to determine if a prior authorization is required. For non-participating providers, please reach out to Provider Services.
- **New Provider Orientation, Provider Portal Training & Provider Q&A Sessions**– We are hosting various participating provider education and training sessions to help you understand our plan and our processes. Please visit the [Provider Training](#) section of our website to find the dates and times of these sessions and to register.

Please stay tuned for a Provider FAQs, which will be published soon, as that will provide some additional guidance. Thank you for all that you do for our members.

Important Announcements: NIA Authorization Waiver & Conditional Approval Process

Important Information Regarding Advanced Imaging, Cardiac, and Interventional Pain Management Service Authorizations

Date: 01/17/23

As Delaware's newest Medicaid Managed Care Organization (MCO), we are committed to ensuring continuity of care for all our members who may have previously been enrolled with another MCO.

NIA Magellan Services is Delaware First Health's vendor for advanced imaging, cardiac, and interventional pain management service utilization management. On behalf of DFH, NIA is waiving authorization requirements for our members through April 30, 2023, to support continuity of care. This grace period will also allow DFH providers time to familiarize themselves with [NIA authorization guidelines](#). Beginning May 1st, NIA will enforce its normal guidelines.

During this grace period, providers will receive "Conditional Approval" letters from NIA for all requested services. This conditional approval will allow providers to continue treating DFH members as necessary in their current courses of treatment through April 30, 2023, as well as be reimbursed

appropriately for those services. **However, if the requested service would normally deny under NIA's authorization requirements, these letters will outline those denial reasons even though authorization requirements are currently being waived. NIA's provider portal at [RadMD.com](#) will also display these denial reasons.** This is to help providers better understand NIA's normal authorization requirements and guidelines.

We encourage you to continue rendering appropriate continuity of care services for DFH members during this grace period with confidence. We also strongly advise reviewing NIA's authorization guidelines on [RadMD.com](#) for future service delivery.

Important Announcements: Clearinghouse Payor List

Provider Alert: DFH Not Appearing On Clearinghouse Payor Lists

Date: 01/17/23

We have been alerted that Delaware First Health (DFH) is not appearing on some clearinghouse payor lists under our Payor ID 68069 for claims or real time eligibility. We sincerely apologize for any inconvenience this may be causing and are quickly working to remedy the situation.

Availity (our preferred gateway) has published the Payor ID today and is communicating to downstream clearinghouses including Change Healthcare. Innovalon/Ability is also showing it on their payor list as of today.

If your clearinghouse has not published Delaware First Health on their list yet, you can submit your claims or eligibility requests to any of the plans under our parent company Centene to Payor ID 68069. Our internal processing will route the appropriate Delaware claims to DFH immediately upon receipt. For example, one plan you can select is Ambetter from Pennsylvania Health and Wellness.

We will update this site as soon as this issue is fixed. If you have any questions, please call Provider Services at 1-877-236-1341.



02— Provider Services



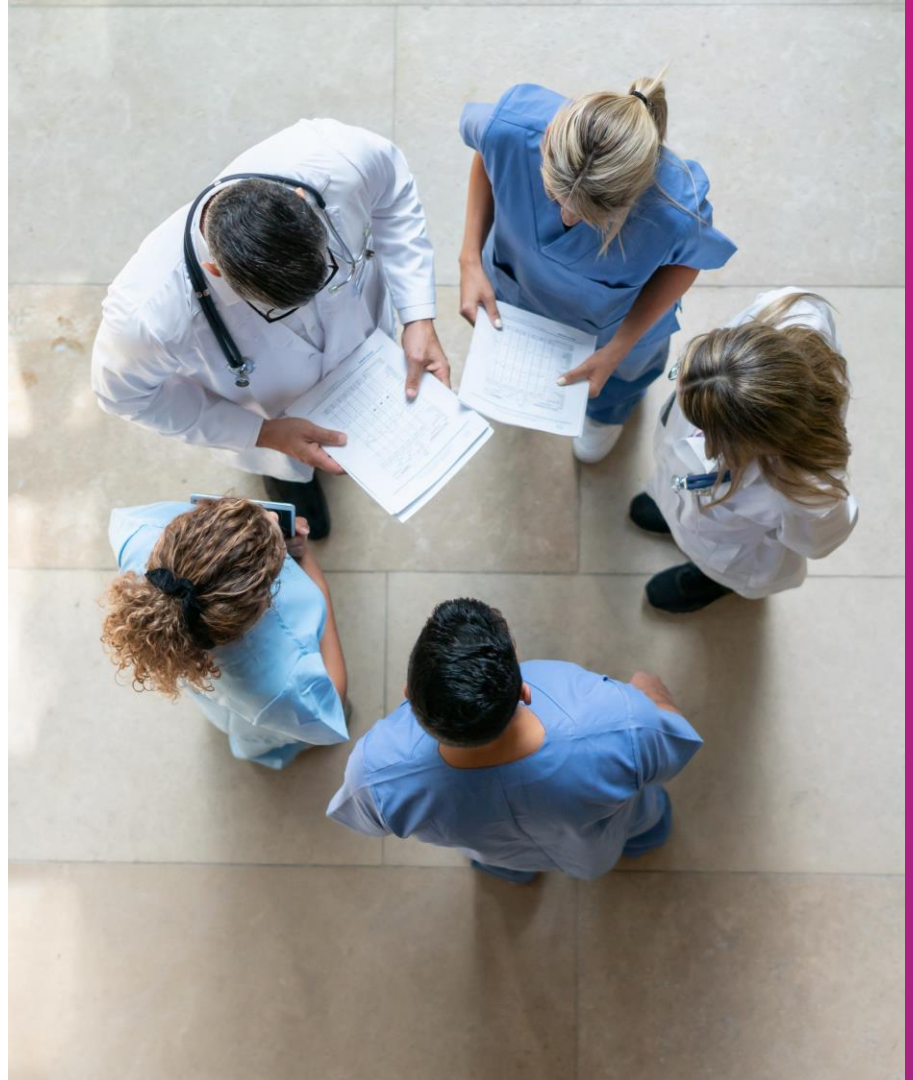
KEY CONTACT INFORMATION

Delaware First Health

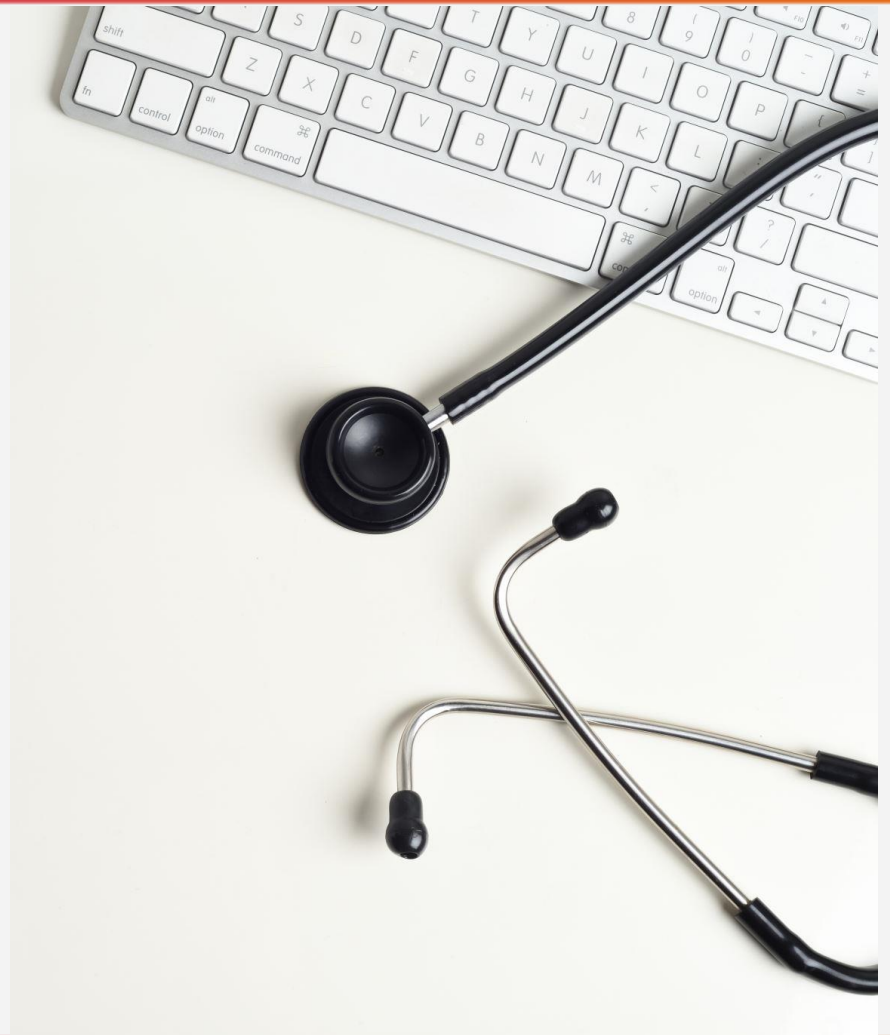
PHONE
1-877-236-1341

TTY/TDD
711

WEB + PORTAL
WWW.DELAWAREFIRSTHEALTH.COM



- The Delaware First Health Provider Services department includes trained Provider Services staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
 - Claims
 - Member Eligibility
 - General Questions
- By calling Provider Services at 1-877-236-1341, providers will be able to access real time assistance for all their service needs
- Hours: Monday – Friday, 8am – 5 pm.





03—

Provider Relations, Resources, Roles & Responsibilities and Access & Availability

Provider Relations

- As a Delaware First Health provider, you will have a dedicated Provider Engagement Administrator available to assist you
- Our Provider Engagement Administrator serve as the primary liaisons between our health plan and provider network
- Your Provider Engagement Administrator is here to help with things like:



- ✓ **Inquiries related to administrative policies, procedures, and operational issues**
- ✓ **Performance pattern monitoring**
- ✓ **Contract clarification**
- ✓ **Membership/provider roster questions**
- ✓ **Secure Portal registration and Pay Span**
- ✓ **Provider education**
- ✓ **HEDIS/Care gap reviews**
- ✓ **Financial analysis**
- ✓ **EHR Utilization**
- ✓ **Demographic information updates**
- ✓ **Initiate credentialing of a new practitioner**

FOR PROVIDERS

Login

Become a Provider



Pre-Auth Check



Pharmacy

Provider Resources



QI Program



Provider News

PROVIDER RESOURCES

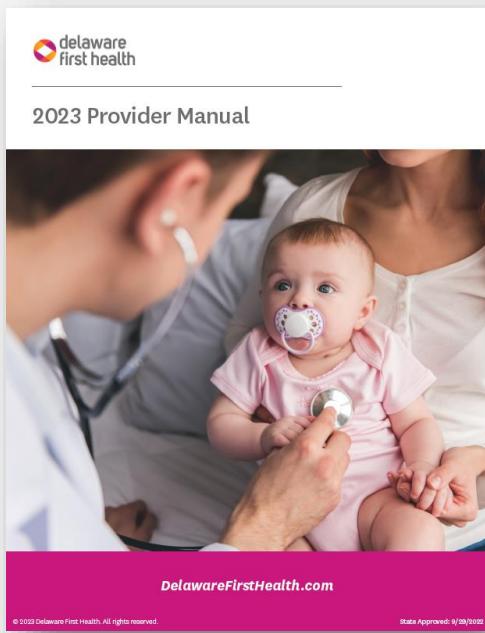
The Public Website

What's on the Delaware First Health Website?

- The Provider Manual
- The Provider Billing Manual
- Provider Trainings
- Clinical & Payment Policies
- Important Forms including:
 - Notification of Pregnancy
 - Prior Authorization forms
 - Provider Claim Appeal form
- The Pre-Auth Check Tool
- The Pharmacy Preferred Drug Listing
- Provider News
- And much more!

PROVIDER RESOURCES

Your Manuals



The Provider Manual and Provider Billing Manual are your comprehensive guides to doing business with Delaware First Health.

- ♦ The Manuals includes a wide array of important information relevant to providers including, but not limited to:
 - Network information
 - Billing guidelines
 - Claims information
 - Regulatory information
 - Quality initiatives
 - And much more!
- ♦ The Provider Manual and Provider Billing Manual can be found in the “For Providers” section of the DFH website at www.DelawareFirstHealth.com

FOR PROVIDERS

Login

Become a Provider

Pre-Auth Check

Pharmacy

Provider Resources

QI Program

Provider News

PROVIDER RESOURCES

Upcoming Provider Trainings

Delaware First Health offers multiple ongoing training opportunities for providers, including:

- Virtual Provider Forums
 - Thursday, January 26, 2023, 9 am and 1 pm
- Provider Office Hours Q& A Webinars
 - Friday, January 27, 2023, 12-1 pm
- New Provider Orientations
 - Thursday, February 2, 2023, 10-11:30 am
 - Thursday, February 9, 2023, 1-2:30 pm
- Secure Provider Portal Webinars
 - Tuesday, February 7, 2023, 11am – 12 pm
 - Tuesday, February 23, 2023, 11am – 12 pm

<https://www.delawarefirsthealth.com/providers/resources/provider-training.html>



delaware
first health

Log In

LOG IN

[Create New Account](#)



[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2021 Centene

PROVIDER RESOURCES

The Secure Provider Portal

What's on the Secure Provider Portal?

- Member eligibility & patient listings
- Health records & care gaps
- Authorizations
- Claims submissions & status
- Corrected claims & adjustments
- Payment history

Insightful Reports

- PCP reports available on secure provider portal are generated on a monthly basis and can be exported into a PDF or Excel format.

PCP Reports Include:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims

Provider Responsibilities

- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Respect members' Advance Directives and include these documents in the members' medical record.
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Office hours of operation offered to Medicaid members will be no less than those offered to commercial members.
- Provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.

**A full list of our Provider Responsibilities can be found in the Provider Manual.*

Delaware First Health believes it is our responsibility, along with our partnering providers, to ensure inclusiveness and fairness is part of all of our activities, and that meeting the unique needs of our diverse membership in a culturally competent manner promotes the best outcomes in the delivery of healthcare to our members regardless of race, ethnicity, or language.*

Cultural Competency

**Additional information about cultural competency can be found in the Provider Manual.*

Appointment Access and Availability Standards

Appointment Access & Availability Standards

Network providers must comply with all access standards. *For a complete list of standards, refer to the provider manual.*

Hospital Emergency Availability

- ♦ 24 hours / 7 days a week

Primary Care Physician Availability

- ♦ Urgent: within 24 hours
- ♦ Routine Appointment: four (4) to six (6) weeks from the date of patient's request

Behavioral Health Availability

- ♦ Urgent: within one (1) hour of presentation at service site or within twenty-four (24) hours of telephone contact with provider or Delaware First Health
- ♦ Routine Appointment: within three (3) weeks of request for an appointment

Specialty Provider Availability

- ♦ Urgent: within 24 hours
- ♦ Routine care: within thirty (30) days

Reporting Child and Dependent Adult Abuse

Mandatory Reporting of Suspected Child and Dependent Adult Abuse

Reporting requirements apply to providers who are mandatory reporters under Delaware law

Providers have a responsibility to report known or suspected child or dependent adult abuse

To report suspected child (under age 18) abuse or neglect, call the Child Abuse Hotline at 1-800-292-9582

Additional Information:

dhss.delaware.gov/dhss/dmma/medicaid.html

To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call 1-800-223-9074

Additional Information:

<https://dhss.delaware.gov/dhss/dsaapd/index.html>

Reporting Critical Incidents

Delaware First Health Providers shall report critical incidents to Delaware First Health immediately upon occurrence and no later than within twenty-four (24) hours after detection or notification. The Incident Report Form can be found at [DelawareFirstHealth.com](https://www.DelawareFirstHealth.com) under Provider Resources: Manuals, Forms and Resources. Delaware First Health shall ensure suspected cases of abuse, neglect and/or exploitation are reported to DSAMH Risk Management. Critical incidents include but are not limited to the following incidents:

- ♦ Unexpected death of a member;
- ♦ Suspected physical, mental, or sexual mistreatment, abuse and/or neglect of a member;
- ♦ Suspected theft or financial exploitation of a member;
- ♦ Severe injury sustained by a member when source of injury is unknown, and injury is suspicious, or
- ♦ injury requires transfer to acute care;
- ♦ Medication or treatment error or omission that jeopardizes a member's health or safety; or
- ♦ Inappropriate/unprofessional conduct by a provider involving a member.

Advance Medical Directives

- ♦ Delaware First Health providers are required to provide adult members with written information about the members' right to have an Advance Directive as defined in 42 C.F.R. 489.100.
- ♦ An advance directive will help the PCP understand the member's wishes about their health care in the event they become unable to make decisions on their own behalf. Examples include:
 - ◇ Living will
 - ◇ Health care power of attorney
 - ◇ "Do Not Resuscitate" orders
- ♦ Execution of an advance directive must be documented on the member's medical records.
- ♦ Providers must educate staff on issues concerning advance directives and maintain written policies that address a member's right to make decisions about their own medical care.
- ♦ A full outline of Delaware First Health's requirements around Advanced Medical Directives can be found in the Provider Manual on pages 26-28.



04— Member Benefits + Eligibility

BENEFITS + ELIGIBILITY

Member Population and Benefits

- ♦ Delaware First Health provides health coverage for enrollees of:
 - ◇ Diamond State Health Plan
 - ◇ Diamond State Health Plan-Plus (DSHP-Plus)
- ♦ Core Medicaid benefits are covered, and all services are subject to benefit coverage, limitations, and exclusions, as described in the Provider Manual
 - ◇ Link to Member Handbook:
<https://www.delawarefirsthealth.com/members/medicaid/resources/handbooks-forms.html>
 - ◇ Link to Provider Manual:
<https://www.delawarefirsthealth.com/providers/resources/forms-resources.html>

BENEFITS + ELIGIBILITY

Verification of Eligibility, Benefits and Cost Share

Providers MUST Verify Member Eligibility

- Every time a member schedules an appointment
- When the member arrives for the appointment

Panel Status

- Primary Care Physicians (PCPs) should confirm that a member is assigned to their patient panel
- This can be done via our Secure Provider Portal
- PCPs can still administer service if the member is not on their panel, and they wish to have member assigned to them for future care

BENEFITS + ELIGIBILITY

Verification of Eligibility, Benefits and Cost Share

Eligibility, benefits and member cost shares can be verified in 3 simple ways:

- ✓ Secure Provider Portal:
www.DelawareFirstHealth.com If you are already a registered user of the Delaware First Health secure portal, you do NOT need a separate registration!
- ✓ 24/7 Interactive Voice Response System: Enter the Member ID Number and the month of service to check eligibility
- ✓ Contact Provider Services: 1-877-236-1341



DRAFT

Address
City, State Zip Code

Member Name:
Member ID#: XXXXXXXXXXXX
Date of Birth:
PBM:
RXBIN: 004336
RXPCN: MCAIDADV
RXGroup: RX5500

PCP Name: XXXXXX
XXXXXX
PCP Phone Number: 1-XXX-XXX-XXXX
PCP Address: XXXXXX
XXXXXX

For a full list of copays and exceptions visit:
www.DelawareFirstHealth.com

Member Copays:

Provider Visit: \$0;
Preventative Visit: \$0;
Adult Dental Visit: \$3;
Inpatient Hospital Stay: \$0

Prescriptions:

\$10.00 or less – \$0.50
\$10.01 to \$25.00 – \$1.00
\$25.01 to \$50.00 – \$2.00
\$50.01 or more – \$3.00

**Diamond State
Health Plan**

IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

- **Member Services, 24/7 Nurse Line, Behavioral Health Line:** 1-877-236-1341 (TTY: 711)
- **Providers:** X-XXX-XXX-XXXX
- **Pharmacy Provider Support:** 1-833-236-1887 (TTY: 711)
- **Dental:** 1-877-236-1341 (TTY: 711)

DRAFT

Medical Claims:

Delaware First Health
PO BOX XXX
[city], [state] [zip]

Pharmacy Paper Claims:

Pharmacy Services
Member Reimbursements
P.O. Box 989000
West Sacramento, CA 95798

In case of an emergency, call 911 or go to the closest emergency room.
After treatment, call your PCP within 24 hours or as soon as possible.



DRAFT

Address
City, State Zip Code

Member Name:
Member ID#: XXXXXXXXXXXX
Date of Birth:
PBM:
RXBIN: 004336
RXPCN: MCAIDADV
RXGroup: RX5500

**Diamond State
Health Plan-Plus**

**Long Term Services
and Support (LTSS)**

For a full list of copays and exceptions visit:
www.DelawareFirstHealth.com

Member Copays:

Provider Visit: \$0;
Preventative Visit: \$0;
Adult Dental Visit: \$3;
Inpatient Hospital Stay: \$0

Prescriptions:

\$10.00 or less – \$0.50
\$10.01 to \$25.00 – \$1.00
\$25.01 to \$50.00 – \$2.00
\$50.01 or more – \$3.00

IMPORTANT CONTACT INFORMATION

www.DelawareFirstHealth.com

- **Member Services, 24/7 Nurse Line, Behavioral Health Line:** 1-877-236-1341 (TTY: 711)
- **Providers:** X-XXX-XXX-XXXX
- **Pharmacy Provider Support:** 1-833-236-1887 (TTY: 711)
- **Dental:** 1-877-236-1341 (TTY: 711)

**Diamond State
Health Plan-Plus**

**Long Term Services
and Support (LTSS)**

Medical Claims:

Delaware First Health
PO BOX XXX
[city], [state] [zip]

Pharmacy Paper Claims:

Pharmacy Services
Member Reimbursements
P.O. Box 989000
West Sacramento, CA 95798

DRAFT

In case of an emergency, call 911 or go to the closest emergency room.
After treatment, call your PCP within 24 hours or as soon as possible.

BENEFITS + ELIGIBILITY

Find-A-Provider

Choosing a doctor is important for our members. Delaware First Health has created a way for our members to have quick and easy access to finding a doctor in three ways.

These resources are also a great way for finding other in-network providers to assist in a member's care journey.

Online Find-A-Provider Tool

- Quick and Easy
- [LINK](#)

Provider Directory

- Updated Weekly
- [LINK](#)

Member Services

1-(877)-236-1341

BENEFITS + ELIGIBILITY

The Primary Care Provider

PCPs are the cornerstone of Delaware First Health service delivery model. The PCP serves as the “Medical Home” for the member.

- The Medical Home concept assists in establishing a member/provider relationship, supports continuity of care, and patient safety.
- This leads to elimination of redundant services, cost effective care, and better health outcomes.
- Delaware First Health offers a robust network of PCPs to ensure every member has access to a Medical Home within 30 miles or 45 minutes within the member’s primary address.
- LTSS members will have access to a Medical Home within 30 miles or 45 minutes between the appropriate facility placement.

Provider Types That May Serve as PCPs

A PCP shall be a medical Practitioner in our network including:

- Family Practitioner
- General Practitioner
- Internal Medicine
- Pediatrician
- Advanced Registered Nurse Practitioner (ARNP)
- Obstetrician or Gynecologist (OB/GYN)
- Physician Assistant

BENEFITS + ELIGIBILITY

PCP Assignment

- Delaware First Health members have the freedom to choose a PCP from our comprehensive provider network.
- Within ten (10) days of enrollment, Delaware First Health will send new members a letter encouraging them to select a PCP.
- For those members who have not selected a PCP during enrollment or within thirty (30) calendar days of enrollment, Delaware First Health will use a PCP auto-assignment algorithm to assign an initial PCP.
 - The algorithm assigns Members to a PCP according to the following criteria:
 - Member's geographic location.
 - Member's previous PCP, if known.
 - Other family Members' PCPs, if known.
 - Special healthcare needs, including pregnancy, if known.
 - Special language and cultural considerations, if known.
- Members reserve the right to change their PCP at any time. PCP's can be updated by calling our Member Services toll free at 1-877-236-1341.

Member Panel Capacity

- ♦ All PCPs reserve the right to determine the number of members they are willing to accept into their panel.
- ♦ Delaware First Health does not guarantee any provider will receive a certain number of members.
- ♦ The PCP to member ratio shall not exceed **2500** members to a single PCP.
- ♦ If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Delaware First Health Provider Services toll-free at 1-877-236-1341.
- ♦ A PCP cannot refuse to treat members as long as the provider has not reached their requested panel size.
- ♦ PCPs cannot close panels to Medicaid members alone. If a provider's panel is closed, it must be closed to all patients. If a provider's plan reopens, the provider must accept patients on a first-come, first-served basis.
- ♦ Providers must notify Delaware First Health in writing at least forty-five (45) in advance of his or her inability to accept additional Medicaid covered persons under Delaware First Health agreements.
- ♦ Any established patient who becomes a Delaware First Health member cannot be considered a new patient.

Value-Added Services

Start Smart for Your Baby®

- Prenatal and Postpartum program
- Care management to extend the gestational period and reduce pregnancy-related risks

24/7 Nurse Advice Line

- 24-hour service by calling 1-877-236-1341
- Registered Nurse available to provide health education and nurse triage for complex health issues

My Health Pays™

- A healthy rewards account program
- Innovative approach to encourage health behaviors through financial incentives

SafeLink Wireless

- No cost to Delaware First Health members
- Free smartphone
- Up to 350 minutes a month
- Unlimited texting

To learn more about all of our Value-Added Services, go to www.delawarefirsthealth.com and the “For Members” section.

BENEFITS + ELIGIBILITY

Member Grievances and Appeals

- ♦ Member grievances and appeals may be filed by the member, a member's authorized representative, or a member's provider.
- ♦ Written consent must be obtained from the Member or their authorized representative on the designated Authorized Representative Designation form located at <https://www.delawarefirsthealth.com/members/medical/resources/complaints-appeals.html>
- ♦ Refer to the Provider Manual for information on how to file a member grievance, appeal, and State Fair Hearing, along with details on timely filing deadlines.

BENEFITS + ELIGIBILITY

Whole Health Transportation

- Delaware First Health screens for transportation needs when members fill out their Health Risk Screening.
- Members identified with transportation needs will be offered transportation services through Modivcare, Lyft or DART vouchers.
- Members need to work with Member Services to receive these services.
- No prior authorization or copays will be required.
- See the table located in the Provider Manual for more details on the type of covered transportation services.

BENEFITS + ELIGIBILITY

Telehealth Services

- Delaware First Health treats telehealth services with in-network providers in the same way as face-to-face visits with in-network providers.
- Telehealth visits with an in-network provider are subject to the same co-payments, co-insurance, and deductible amounts as an in-person visit with an in-network provider.
- **Please note:** *An originating site fee is not available if the member site is the member's home.*
- Providers interested in providing telemedicine, telemonitoring and telehealth services to eligible Delaware First Health members should reference the [Delaware Medicaid Provider Procedures Manual](#).

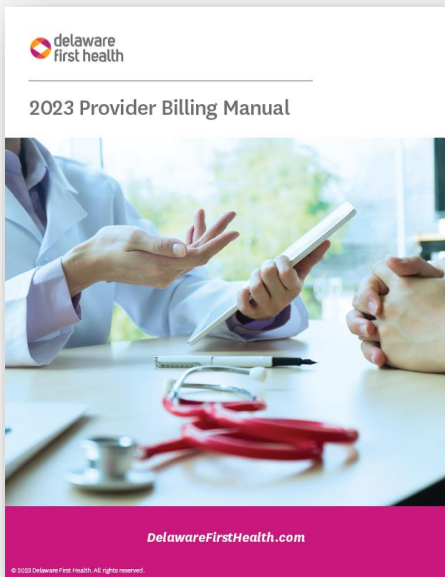


05— Billing + Claims



BILLING + CLAIMS

The Provider Billing Manual



The Provider Billing Manual includes essential information on Delaware First Health's billing guidelines and claims, including:

- Encounter data submission guidelines
 - Claims submission protocols and standards, including timeframe requirements
 - Instructions/information for clean claims
 - Claims dispute process
 - Payment policies
 - Client participation requirements
 - Cost sharing requirements
 - Third party liability and other instructions
- ♦ The Provider Billing Manual can be found in the “For Providers” section of the DFH website at www.DelawareFirstHealth.com

BILLING + CLAIMS

General Billing Guidelines

- ♦ It is important that providers ensure Delaware First Health has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:
 - Provider name (as noted on current W-9 form)
 - National Provider Identifier (NPI)
 - Tax Identification Number (TIN)
 - Medicaid Number
 - Taxonomy code
 - Physical location address (as noted on current W-9 form)
 - Billing name and address
- ♦ Providers must bill with their NPI number in box 24Jb.
- ♦ We require providers to also bill their taxonomy code in box 24Ja and the Member's Medicaid number in box 1a on the CMS-1500 form (also known as the HCFA), to avoid possible delays in processing.

BILLING + CLAIMS

General Billing Guidelines

- ♦ Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays; such claims are not considered “clean” and therefore cannot be accepted into our system.
- ♦ We recommend that providers notify Delaware First Health 30 days in advance of changes pertaining to billing information.
- ♦ Please submit this information on a W-9 form; Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.
- ♦ Providers must notify Delaware First Health in writing at least 30 days in advance of his/her inability to accept additional Medicaid covered persons under Delaware First Health agreements.

Billing + Claims

Claims Submissions

- The Delaware First Health Payor ID is 68069.
- Claims eligible for payment must meet the following requirements:
 - The member must be effective on the date of service.
 - The service provided must be a covered benefit under the member's contract on the date of service.
 - Referral and prior authorization processes must be followed, if applicable.
- Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the Provider Billing Manual.

PAPER CLAIMS

Mail to:
 Delaware First Health
 Attn: Claims Department
 P.O. Box 8001,
 Farmington MO 63640-8001

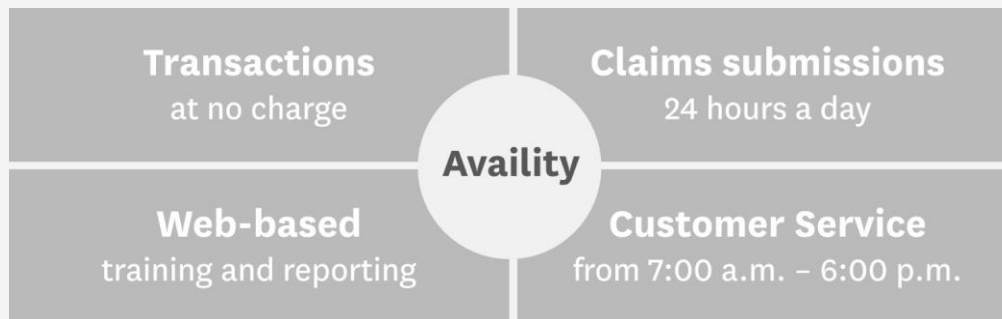
ELECTRONIC CLAIMS

The preferred clearinghouse vendor is Availity, but providers may use their own contracted clearinghouse to submit claims to Delaware First Health.

Our Claims Clearinghouse

For questions or more information on electronic filing please contact:
Delaware First Health
c/o Centene EDI Department
1-800-225-2573 ext. 6075525
EDIBA@centene.com

- ♦ Availity is the preferred clearinghouse, offering the following value services:



- ♦ Providers may use their own contracted clearinghouse to submit claims to Delaware First Health.

The following tables outline claim submission and payment timings:

Claim Type	Submission Timing
New clean claim	120 calendar days from date of service
Retroactive eligibility claims	365 calendar days from the notice date
Secondary payer	365 calendar days from primary payer claim determination
Third-party submission and no reply	After 30 calendar days of no reply, claims accepted for 12 months from date of service

Claim Type	Payment Timing
New clean claim	90% within 30 calendar days of receipt
	95% within 45 calendar days of receipt
	99% within 90 calendar days of receipt

Claim Type	Payment Timing
Claim Reconsiderations	180 day from the date of on the EOP or PRA



Payspan Contact Information:

- Phone: (877) 331-7154 x 1 (available M-F 7am-7pm)
- Email: providersupport@payspanhealth.com
- Website: www.Payspan.com



Improve cash flow
by getting payments faster



Settle claims electronically
through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs)



Maintain control over bank accounts
by routing EFTs to the bank account(s) of your choice



Match payments to advices quickly
and easily re-associate payments with claims



Manage multiple payers,
including any payers that are using Payspan to settle claims



Eliminate re-keying of remittance data
by choosing how you want to receive remittance details



Create custom reports
including ACH summary reports, monthly summary reports, and payment reports sorted by date

BILLING + CLAIMS

Claim Payment Reconsideration

A claim payment dispute involves a finalized claim in which a provider disagrees with the outcome.

1st DISPUTE STEP - RECONSIDERATION

Provider can request to have the outcome of the finalized claim be reviewed by paper or Provider Portal

Submission of request must be within 180 calendar days from the date of EOP (Explanation of Payment) or PRA (Provider Remittance Advice)

2nd DISPUTE STEP – APPEAL

Submission of request must be within 180 calendar days from the date of EOP (Explanation of Payment) or PRA (Provider Remittance Advice)

Include as much information as possible to assist with determination review

Mailing address for disputes:

Delaware First Health
ATTN: Claims Disputes
P.O. Box 8001
Farmington, MO 63640-8001

Provider Complaints: Non-Claims Related

Providers have the right to file a complaint with Delaware First Health.

- Provider complaints can be filed regarding policies, procedures or administrative processes in place by Delaware First Health.
- Provider(s) may file a complaint in writing that is non-claims related within forty-five (45) calendar days of the date of the dissatisfaction.
- Provider complaints will be acknowledged within three (3) days of receipt and be resolved within 90 calendar days.
 - If the provider(s) complaint is not resolved within thirty (30) calendar days, documentation why and a written notice of the status to the provider will be provided every thirty (30) calendar days thereafter until the complaint is resolved.

MAIL:

Delaware First Health
Attn: Complaints
P.O. Box 10353
Van Nuys, CA 90410-0353

CALL:

1-877-236-1341
(TTY: 711)
Monday – Friday
8:00 a.m. to 5:00 p.m.

PORTAL:

www.DelawareFirstHealth.com

Provider Complaints: Claims Related

- Complaints related to claims, may file a written complaint within twelve (12) months from the date of service or sixty (60) calendar days after the payment or denial of a timely claim submission.
- Provider complaints will be acknowledged within three (3) days of receipt, and be resolved within 90 calendar days.
 - If the provider(s) complaint is not resolved within thirty (30) calendar days, documentation why and a written notice of the status to the provider will be provided every thirty (30) calendar days thereafter until the complaint is resolved.

MAIL:

Delaware First Health
Attn: Complaints
P.O. Box 8001
Farmington, MO 63640-8001

CALL:

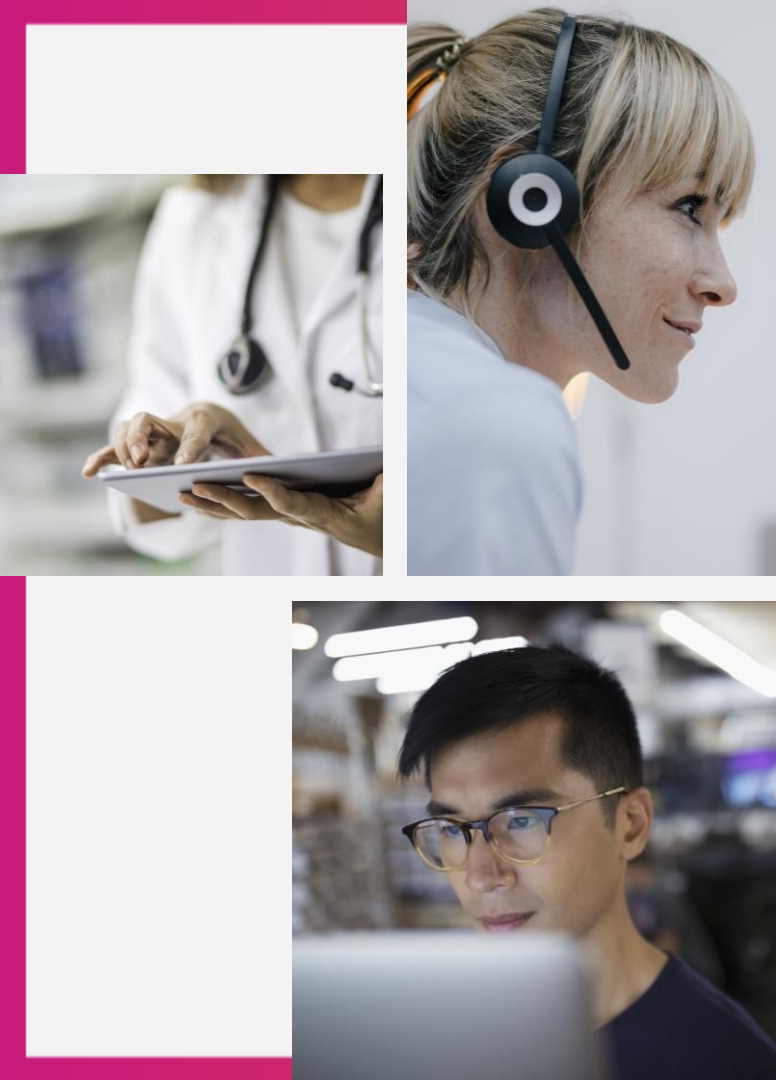
1-877-236-1341
(TTY: 711)
Monday – Friday
8:00 a.m. to 5:00 p.m.

PORTAL:

www.DelawareFirstHealth.com

2023 Provider Forum

BREAK



06— Utilization Management + Authorizations

UTILIZATION MANAGEMENT + AUTHORIZATIONS

Utilization Management

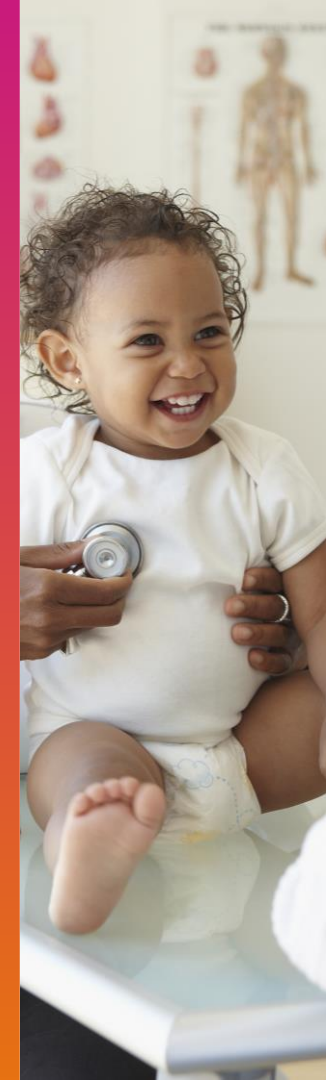
- Delaware First Health Utilization Management Program (UMP) is designed to ensure members receive access to the right care at the right place and right time.
- Delaware First Health UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends.
- The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and that meet professionally recognized standards of care
- Our program is comprehensive and applies to all eligible members, age categories, and range of diagnoses.
- It provides for aggregate and individual analysis and feedback of providers and plan performance in providing access to care, the quality of care provided to members, and utilization of services.
- The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, maternity care, and ancillary care.

UTILIZATION MANAGEMENT + AUTHORIZATIONS

Utilization Management

Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of care and/or population management for members at risk for significant health costs or ongoing care.
- Development of an infrastructure to ensure members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self-management.
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals.



PRIOR AUTHORIZATION

Is Prior Authorization Needed?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the Delaware First Health website at:
<https://www.delawarefirsthealth.com/providers/preauth-check.html>

Are Services being performed in the Emergency Department?

YES ☐ NO ☒

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member having observation services?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management or dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving hospice services?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

69436

Check

N
No

69436 - TYMPANOSTOMY GEN ANES
No authorization required.

PRIOR AUTHORIZATION

How To Secure Prior Authorization

Need prior authorization? It can be requested in the following ways:

- ✓ **Secure Web Portal** *This is the preferred and fastest method!*

www.DelawareFirstHealth.com

- ✓ **Phone**

1-877-236-1341

- ✓ **Fax**

- ♦ Medical Fax: 1-833-967-0502
- ♦ Behavioral (Inpatient) Fax: 1-833-967-0499
- ♦ Behavioral (Outpatient) Fax: 1-833-967-0498

*After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line.
Notification of authorization will be returned via phone, fax or web.*

Procedures / services that need Prior Authorization include*:

- Potentially cosmetic
- Experimental or investigational
- Outpatient radiology (e.g. CT, MRI, PET)
- Infertility
- Obstetrical ultrasound
 - One standard first trimester ultrasound and one standard second or third trimester ultrasound allowed in a 9 month period.
 - An additional detailed anatomic ultrasound is allowed per pregnancy with a high risk diagnosis, if billed by a new provider.
 - No authorization is required for these ultrasounds or any follow-up limited ultrasound (76815 or 76816) assessments for suspected concerns.
 - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Inpatient services that require Prior Authorization include*:

- All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including:
 - All services performed in out-of-network facilities
 - Behavioral health/substance use
 - Hospice care
 - Rehabilitation facilities
 - Transplants, including evaluation
- Emergency Admissions and/or Observation Stay (notification within 1 business day of admission)
- Observation Services (outpatient)
- Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one (1) business day
Observation – 24 hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than 24 hours	Requires inpatient prior authorization within one (1) day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one (1) calendar day
Maternity admissions	Notification within three (3) calendar days
Newborn admissions	Notification within two (2) business days
Neonatal Intensive Care Unit (NICU) admissions	Notification within one (1) business day
Outpatient Dialysis	Notification within two (2) business days

Utilization Determination Timeframes

Type	Timeframe
Expedited Pre-Service/Urgent ¹	72 hours
Standard Pre-Service/Non-Urgent ²	Within 7 calendar days
Concurrent Review	24 hours
Retrospective	30 calendar days

¹ Delaware First Health may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if Delaware First Health justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.

² For standard service authorization decisions, Delaware First Health shall provide notice as expeditiously as the member's health condition requires and within seven calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if: (1) The member, or the provider, requests extension; or (2) Delaware First Health justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.

PRIOR AUTHORIZATION

Correct Coding Prior Authorization

Prior Authorization will be granted at the CPT code level

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission, or the claim will deny.
- Delaware First Health will update authorizations but will **not** retro-authorize services.
 - The claim will deny for lack of authorization.
 - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

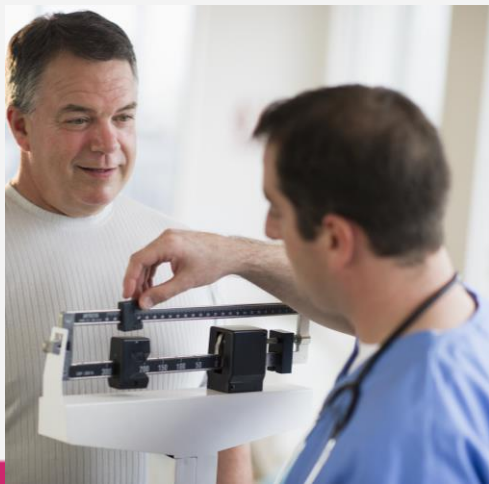
UTILIZATION MANAGEMENT + AUTHORIZATIONS

Medical Necessity Determination

- Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, **must be documented in writing**.
- The determination is based on medical information provided by the member, the member's family/caretaker, and the PCP, as well as any other providers, programs, and agencies that have evaluated the member.
- All such determinations must be made by qualified and trained healthcare providers.

What happens if Medical Necessity is not established?

- When medical necessity cannot be established, a peer-to-peer conversation is offered.
- Denial letters will be sent to the member and provider.
- The clinical basis for the denial will be indicated.
- Member appeal rights will be fully explained.



07— Care Management

Care Coordination

- ♦ Care Coordination is available to Delaware First Health members via direct provider referral.
- ♦ Care Coordination is appropriate for members with higher level needs related to physical health conditions, behavioral health conditions, and/or issues related to social determinants of health such as housing instability, food insecurity, and transportation.
- ♦ Maternity Care Coordination is offered to all members identified as pregnant or post partum.
- ♦ Delaware First Health will assign a specific Care Coordinator to each member who would benefit from such services.
- ♦ Service Coordination is available to all Delaware First Health members to assist with:
 - ◇ Appointment assistance and linkage
 - ◇ Access to wellness and community resources
 - ◇ Discharge planning

Care Management

Contact Our Team

- Providers can contact the Delaware First Health's Care Management department toll-free at 1-877-236-1341.
- Hours of operation are Monday through Friday from 8:00am – 5:00pm EST (excluding holidays).
- After normal business hours, our 24/7 nurse advice hotline staff is available to provide health education and nurse triage for complex health issues.

Our Clinical Leadership

- Clinical services are overseen by the Delaware First Health Medical Director.
- The Vice President of Population Health and Clinical Operations (VPPHCO) has responsibility for direct supervision and operation of the department.
- To reach the Medical Director or VPPHCO, please contact Medical Management toll-free at 1-877-236-1341.

Case Management Program

- ♦ Case Management is provided to all Delaware First Health members who receive Long-term Services and Supports (LTSS).
- ♦ The LTSS Case Manager's primary function is to support members and facilitate their access to LTSS and other services.
- ♦ Each LTSS member is provided a Case Manager.
- ♦ Case Managers work with members and providers to develop and implement a person-centered service plan.

Long-Term Services and Supports

DSHP Plus Long-Term Services and Supports (LTSS)

- **Member & Provider Services** – (877)236-1341 (call this number, followed by the extension below)
- **LTSS Supervisors Bridge Group** (authorization questions)
 - Stephanie Shannon, Program Coordination, ext. 2119506
 - La-Quanda Epperson, Program Coordination, ex. 8097732
- **Manager, Case Management** (case management questions)
 - Viviana Nijamkin-Acosta, Manager of LTSS, ext. 2119614
- **Director, LTSS**
 - Catella Visser - (410)920-8925
- **LTSS Department email** – dfhltss@delawarefirsthealth.com
- **LTSS Provider Relations email** – DE_ProviderEngagement@DelawareFirstHealth.com

09— Quality Improvement

Quality Improvement Program

PRIORITIES AND GOALS

Focus on Individuals

- ♦ Right Care, Right Place, Right Time
- ♦ Well-Coordinated, Timely, Accessible Care Delivery
- ♦ Member and Provider Engagement
- ♦ Home and Community Connection

Whole Health

- ♦ Prevent and Manage Top Chronic Illnesses
- ♦ Remove Barriers to Care; Make It Simple to Get Well/Stay Well/Be Well
- ♦ Coordination of Care Across the Health Care Continuum
- ♦ Behavioral Health Integration
- ♦ LTSS Quality of Life

Active Local Involvement

- ♦ Maternal-Child Health Care
- ♦ Prevent and Manage Obesity
- ♦ Address Social Determinants of Health
- ♦ Health Equity/Disparity

Quality Improvement Program

Quality Improvement Initiatives

NCQA (HEDIS, CAHPS, Accreditation)

- ♦ Partner with providers as we obtain Health Plan Accreditation and Health Equity Accreditation.
- ♦ Collaboration with providers to improve member satisfaction as measured by Consumer Assessment Of Healthcare Providers And Systems (CAHPS).
- ♦ Strategize with providers to improve the health outcomes of our members as measured through HEDIS.

Pay for Performance (P4P)

- ♦ DFH is developing a P4P to be rolled out in Q1 – 2023.

Quality Improvement Committee

- ♦ **DFH is recruiting for network practitioners** representing the range of practitioners within the network and across the regions in which the health plan operates (e.g., family practice, internal medicine, OB/GYN, behavioral health, vision/dental care providers, and other high-volume specialists as appropriate).

10—

Questions & Answers

January 18, 2023 Provider Forum

Q+A

Thank you.

