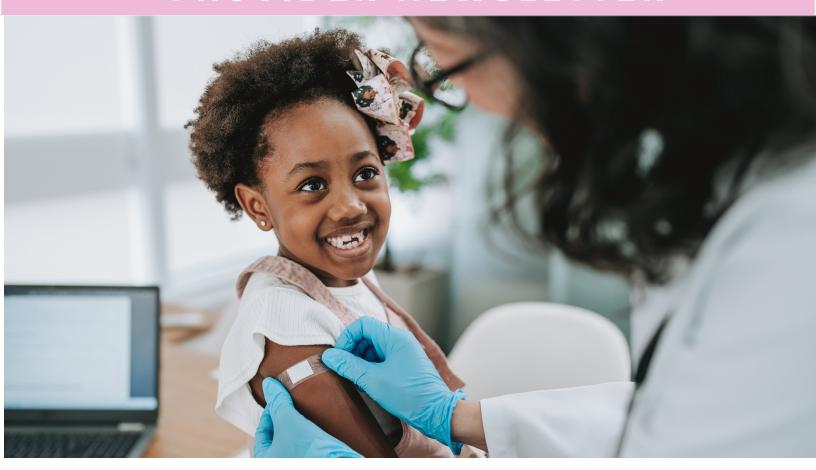


June 2025 | Volume 4

PROVIDER NEWSLETTER



Key Features:

What's New
Provider Portal Updates
Claims Corner
2026 Delaware D-SNP Changes
Member & Provider Incentives and more!

Job Opportunities General Reminders Self-Service Forms Appeals & Grievances Annual Visit Screenings

Transforming the health of communities we serve, one person at a time.

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A Message from our CEO



To our valued provider partners,

At Delaware First Health, our mission is clear: to support you in delivering the highest quality care to the individuals and families we serve. As CEO, I want you to know that ensuring you receive exceptional service from our organization is one of my top priorities. We are committed to being a responsive, collaborative, and solutions-driven partner—because when you succeed, our members thrive.

Looking ahead, I'm excited that beginning January 1, Delaware will become an exclusively aligned, highly integrated dual eligible state. This is a significant milestone for our state and a transformative opportunity for all of us. It means better coordination of care, streamlined services, and a more unified approach to supporting individuals who qualify for both Medicare and Medicaid.

We are proud to be at the forefront of this transition and even prouder to walk this path with you. Our team is working diligently to ensure that you have the tools, resources, and support needed to navigate this change with confidence. From enhanced care coordination to simplified processes and data-driven insights, we are investing in the infrastructure that helps you do what you do best—care for your patients.

One of our organization's core goals is to be the top managed care organization in member, provider, and broker satisfaction. This means listening to your feedback, continuously improving our services, and fostering a culture of excellence and accountability. We believe that by working together, we can achieve this goal and set a new standard for managed care in Delaware.

I'm grateful for your partnership, your dedication, and your trust. Let's continue to build a system that puts people first and delivers the quality, equity, and outcomes our members deserve.

With appreciation,

Bill Wilson Chief Executive Officer Delaware First Health

What's New!

Updated Preventative and Clinical Practice Guidelines

We would like to inform our provider partners that the most recent Adopted Preventive and Clinical Practice Guidelines have been posted to the provider section of our website. These guidelines reflect the latest evidence-based recommendations and support our shared commitment to delivering high-quality, effective care.

We encourage all providers to review the updated guidelines to ensure alignment with current standards of care.

To view the updated guidelines, please review our <u>Clinical</u>
<u>Practice and Preventative Health Guidelines</u>
<u>webpage</u>.

Thank you for your continued partnership!

TruCare Cloud Transition

Effective 8/1/2025, Delaware First Health (DFH) and Wellcare Delaware are transitioning to a new clinical platform, TruCare Cloud. TruCare Cloud provides efficiencies to help support our workflows and ultimately help support our members. The upgraded platform integrates with our provider facing systems as our current system, TruCare Classic does today. Please be aware of some changes to the

provider portal view.

- The authorization ID will continue to display the 4x4 alphanumeric format in the "certification number" field on the Availity Essentials portal. The
 - "certification number" is always displayed as the primary indicator for the
 - •authorization in the 4x4 format.
- If an authorization is created before O8/O1, the OP or IP will be displayed in the "reference number" field on the Availity Essentials portal as a secondary reference indicator for the authorization as it does today. The "certification number" in the 4x4 alphanumeric format will also be displayed as the primary indicator.
- If the authorization is created after 08/01, the "reference number" field will be blank and only "certification number" will be populated in Availity Essentials.

NEW Enhanced Doula Benefit

Delaware First Health (DFH) is pleased to announce an enhancement to our Medicaid doula benefit: as of July 1, 2025 our members now have access to two additional prenatal doula visits as a Value-Added Benefit (VAB). This means that after a member has received the standard three covered prenatal visits, they can receive two additional prenatal visits—up to five total prenatal doula visits to support their pregnancy journey.

We recognize the important work doulas do in their community and the vital role they have in addressing disparate maternal and infant health outcomes. We encourage our provider partners to share this benefit with patients and collaborate with doulas to ensure comprehensive, culturally competent prenatal care.

In addition to prenatal care, doula services also include attendance through labor and birth, as well as three postpartum doula visits. Members who need extra support are provided up to five additional postpartum visits when recommended by a provider—allowing for a total of eight postpartum visits.

For information on doula services, reimbursement, or how to enroll as a Medicaid doula provider with DFH, visit our <u>Doula Services webpage</u>. Please contact Dara Hall, Maternal and Child Health Director, at <u>Dara.Hall@delawarefirsthealth.com</u>.

All About Dual Eligible Special Needs Plan (D-SNP) and

Upcoming Changes in Delaware in 2026



What is D-SNP?

- Dual Eligible Special Needs Plan ("D-SNP") is a Medicare Advantage plan, designed to meet the needs of beneficiaries receiving both Medicare and Medicaid.
- Low income
- Certain medical conditions
- Unique health care needs
- D-SNPs were created in 2006 to better streamline the care of beneficiaries. D-SNPs generally offer extra benefits beyond what may be available via normal Medicare.
- Delaware First Health's D-SNP plan is offered through our affiliate plan, Wellcare.

Types of D-SNPs

- There are three types of D-SNPs that differ based on level of coordination of care of the beneficiaries.
- Coordinated. Delaware currently requires that D-SNPs are coordinated. This means that the enrollee's Medicare and Medicaid companies have to work together to coordinate the enrollee's care. Because they are different companies, the enrollee's care is not always coordinated well.
- Highly Integrated Dual Enrollment (HIDE). HIDE requires that the Medicaid company is affiliated with the Medicare company.
- Fully Integrated Dual Enrollment (FIDE). FIDE means that not only are the companies affiliated, they are the same company. The purpose of a HIDE and a FIDE is to provide better coordination of care for the enrollee.

Upcoming Changes

- Effective January 1, 2026. Delaware D-SNP integration level (level of care) increases from "coordinated" to "HIDE."
- Members enrolled in a D-SNP must be exclusively aligned meaning the dual enrollee's Medicare Advantage D-SNP must be affiliated with their Medicaid MCO. For example, Wellcare members will need to be a part of Delaware First Health. Unaligned D-SNPs (United, Humana, etc.) are currently prohibited from accepting new enrollees.
- Members enrolled in an unaligned D-SNP (meaning the Medicare Advantage plan does not have an affiliated Medicaid plan) must find a new D-SNP that is aligned.

How to Prepare for the Changes

- Check your contract to confirm you are contracted for Wellcare by checking for the Medicare/D -SNP compensation exhibit. Email your Provider Engagement Account Manager for questions.
- Talk to members under your care who are dually enrolled! If they are enrolled in a D-SNP, let them know that they will need to enroll in an aligned D-SNP (preferably Wellcare).
- If they are a dual, but not enrolled in a D-SNP, explain to them that they are missing out on additional benefits that D-SNP enrollees receive.
- Also explain to them that they will receive better care coordination by being a part of a D-SNP. Stay tuned for more updates throughout 2025 as information from the State becomes available.

Visit: <u>www.wellcarede.com</u> or contact



We are Growing our Membership Across Medicaid, Individual Marketplace and Medicare D-SNP!

It has been over a year since Delaware First Health introduced our Medicare Advantage & D-SNP plans (Wellcare) and Individual Marketplace plans (Ambetter Health of Delaware). Compared to last year, membership has increased 898% for Medicare, and 1129% for Marketplace, respectively. We could not have done it without our strong network of providers so, we thank you! Below is a brief Frequently Asked Questions (FAQ) about these products.

Frequently Asked Questions

Q. What is Delaware First Health's affiliated Individual Marketplace Exchange product?

A. Ambetter Health of Delaware is our health insurance marketplace offering which provides affordable, comprehensive solutions individuals and families who may not qualify for Medicaid or have access to employer coverage.

Q. What is Delaware First Health's affiliated Medicare & D-SNP product?

A. Wellcare is our Medicare Advantage and DSNP products which has different plans to serve all eligible populations. With the addition of our DSNP, we can better coordinate care for our members.

Q. What changes are coming in 2026 as it relates to Delaware D-SNP plans?

A. Effective January 1, 2026. Delaware's Dual Special Needs Plan ("D-SNP) integration level increases from "coordinated" to "HIDE." Members enrolled in a D-SNP must be exclusively aligned – a dual enrollee's Medicare Advantage D-SNP must be affiliated with their Medicaid MCO. For example, Wellcare members will need to be a part of Delaware First Health. Unaligned D-SNPs (United, Humana, etc.) are currently prohibited from accepting new enrollees.

Q. How do I know if I am contracted and a participating provider in Wellcare and/or Ambetter?

A. Your contract with DFH would have a schedule that says Medicare/DSNP and Commercial Exchange/Wellcare. Contact your Provider Engagement Account Manager (PEAM) who can confirm your status.

Q. I confirmed I do not have a contract. How can I join Wellcare and/or Ambetter?

A. To join any of our networks, complete the online Contract Request Form and select the appropriate networks.

Q. I would like to schedule a New Provider Orientation (NPO) or speak to my assigned provider engagement account manager.

A. Visit the "Provider Education and Training" section on the Ambetter and Wellcare provider websites to register for trainings, including NPOs. We have the same committed Provider Relations' team to support you across all of our products. Contact your Provider Engagement Account Manager with any questions.







MEDICARE

Top Marks Earned in Provider Satisfaction - Thanks to You!

81.1%
Delaware First Health
FIRST
in Overall
Provider Satisfaction
among Delaware MCOs.

At Delaware First Health, we are committed to building strong, collaborative relationships with our provider partners. To ensure we are meeting your needs and driving continuous improvement, we partnered with Press Ganey in 2024 to conduct our first independent Provider Satisfaction Survey.

We're proud to share that Delaware First Health earned an **overall provider satisfaction score of 81.1%**—outperforming competitors and placing us in the **87th percentile** of Press Ganey's 2023 Medicaid book of business. This benchmark includes **108 plans and over 17,000 respondents.**

In addition, we ranked in the 80th percentile or higher in several key areas:

- 92nd percentile Having a dedicated Provider Relations representative assigned to practices
- 87th percentile Quality of orientations and ongoing training/support
- 80th percentile Access to knowledgeable Utilization Management (UM) staff
- These results reflect our ongoing efforts to support providers with responsive, knowledgeable, and dedicated service. Thank you for your partnership—we look forward to continued collaboration and growth.

The 2025 Provider Satisfaction Survey is happening now! SAVE THE DATE SUMMER 2025 PROVIDER SATISFACTION SURVEY

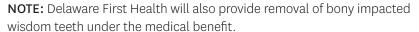


Dental Services for Pediatric Medicaid Members Effective January 1, 2025

As a reminder, pediatric members ages 20 and younger from across the state will be eligible for their Medicaid dental benefits administered by Centene Dental Services as of January 1, 2025.

Provider materials, including the Centene Dental provider manual and information on dental benefit details, claims submissions, and key contact information, will be posted in the provider web portal at centenedental.com/logon. You may also access general information of the Delaware First Health Dental Providers page.

Benefits for the Members Under	Benefits for Members Over the	
the Age of 21	Age of 21	
Dental services are now available	Dental services for members age	
for members under the age of 21	21 and older include \$1,000 of	
through Delaware First Health.	coverage per calendar year for	
No copay.	routine and basic dental services.	
	Each visit has a \$3 copay.	





Please be sure to verify member eligibility and benefits prior to rendering services by logging into the portal or calling Centene Dental Customer Service at the phone number listed below. You may also direct any related questions to customer service.

Centene Dental Paper Claims	Centene Dental P.O. Box 22687 Tampa, FL 33622-2687	
Centene Dental Electronic Claims	EDI# 46278	
Centene Dental Customer Service	1-833-236-1886	
Member ID Card Example	delaware First health Amember Name- Member 109: XXXXXXXX DOB: XX/XXXXXX DOB: XX/XXXXXX RXXIN: XXXXXXXXX RXXIN: XXXXXXXXX RXXIN: XXXXXXXX RXXIN: XXXXXXXX RXXIN: XXXXXXXX RXXIN: XXXXXXX RXXIN: XXXXXXX RXXIN: XXXXXXX RXXIN: XXXXXXX RXXIN: XXXXXXX RXXIX: XXXXXXX RXXIX: XXXXXXX RXXIX: XXXXXX RXXIX: XXXXXX RXXIX: XXXXXX RXXIX: XXXXXX RXXIX: XXXXX RXXIX: XXXX RXXIX: XXXXX RX	

LET'S GO DIGITAL!

Annual Primary Care Provider Attestation Form

PCP practices must complete a new annual form confirming:

- Panel size per PCP (across all payors)
- Cultural competency training completed within the past 12 months

This helps us monitor capacity and support culturally competent care. For more details and submissions, please access the <u>PCP Annual Attestation Form</u> on our <u>Provider Resources page</u>.

PCP Change Form

The <u>PCP Change Request Form</u> allows providers to assist members with changing their assigned PCP by completing the form signed by the member. This new form is one initiative we are working on to assist the alignment of PCP assignment with attribution.

Self-Report Practitioner Race & Ethnicity

Delaware First Health aims to create a provider network that meets our members' cultural and linguistic needs. To enhance member choice, please update your race/ethnicity and languages spoken using our forms on the <u>Provider Data Updates page</u>. This will assist our teams in connecting members with suitable providers. For groups with multiple practitioners, utilize the <u>Provider Intake Roster Template</u> found on our Manuals, Forms and Resources page.

Sign-Up for Provider Communications

Do you want to receive health plan updates and other communications via email? Simply complete our <u>Sign-up for Provider Updates form</u> to ensure we have your most current contact information. Please allow upto two weeks for the change to take effect.

Alternatively, you may choose to opt-out of receiving these provider communications via email with our NEW Opt-Out of Provider Communications Form.



Member Outreach Form

This Member Outreach Form should be used to request member outreach assistance from the Delaware First Health Member Advocacy Team. The Member Advocacy team will outreach members for various reasons:

- Missed scheduled appointments
- Frequent ER utilization
- Addressing care gaps
- Addressing barriers to Social Determinants of Health
- Connecting members to Care/Case
- Management and more!

For any questions, please outreach to: dfh_memberadvocates@centene.com

Provider Demographic Updates

Delaware First Health needs your help to ensure we have your most up to date provider information. This information is important so that our members can find you in our online Find A Provider (FAP) provider directory and to ensure data does not cause claims payment issues. Please visit our Provider Data Updates page for information on how to keep your information current.

Provider Feedback Form

Your feedback matters! We have a couple of ways for you to share your thoughts with us. Share your health plan experience with us by completing a brief online Provider Feedback Form or email our Provider Engagement@delawarefirsthealth.com to tell us what we what we are doing well and what we can do better

They're Hiring! Join in Ultrasound Express Milford, DE

Ultrasound Express is thrilled to offer a job-sharing opportunity for an Ultrasound Technologist at our Milford, Delaware location. In this fulfilling role, you'll perform both keepsake fetal ultrasounds and diagnostic ultrasounds in a calm, patient-centered environment. Whether you're seeking extra income, retired, or simply looking to work one day a week, this role is perfect for you!

Ultrasound Express is an independent diagnostic testing facility committed to making a positive impact on our patients' lives. We are looking for a compassionate, enthusiastic technologist who is passionate about

their career and dedicated to helping others.

What We Offer:

- Supportive and relaxed work environment
- Private office space for technicians
- Paid Professional Liability Insurance
- Workers' Compensation

If you're seeking a better work-life balance and eager to utilize your skills in an appreciative environment, this is the opportunity for you! We are committed to training certified technologists who bring enthusiasm and a willingness to grow, particularly in elective fetal keepsake ultrasounds.



Don't miss your chance to join a team that values your skills and dedication. Apply today and make a meaningful difference with Ultrasound Express!

Job Types: Part-time, Contracted Pay: \$40.00 - \$50.00/ hour

Expected Hours: 8-24 hours/week

Schedule: Day Shift **Work Location:** In-person

Benefits:

- Employee discount
- Flexible Schedule
- Paid time off

License/Certification: Registered Diagnostic

Medical Sonographer Required)

If you have any questions or would like more details, please visit the <u>Ultrasound Express website</u> or call: 302-422-2612

As part of our ongoing commitment to support and strengthen our community, we are seeking input from providers on workforce development needs. Your insights will help shape future initiatives, identify key areas for support, and ensure that our efforts align with the real-world challenges and opportunities you face

We are also actively exploring partnerships and future collaborations. If your organization is interested in working together to address workforce gaps, enhance training programs, or develop innovative solutions, we would love to connect.

How You Can Help:

Share your workforce needs, ideas for collaboration, or potential partnership opportunities by emailing: Workforce_dev@DelawareFirstHealth.com.

Training Opportunities for Community Health Workers in DE

Invest in your Frontline Workforce: CHW Training Programs Now Available



Are you looking to expand the skills of your care team or onboard new Community Health Workers (CHWs)? Delaware offers a range of high-quality training programs designed to equip CHWs with the knowledge and tools needed to bridge gaps in care, promote health equity, and strengthen patient engagement.

Current Opportunities Include:

Delaware CHW Certification Program

Offered through multiple training providers across the state, this program meets the core competencies required for CHW certification in Delaware. The curriculum includes modules on health promotion, cultural competency, resource navigation, communication skills, and chronic disease management.

- Format: Online and in-person; hybrid options available
- Duration: 12 14 weeks

- **Cost:** Scholarships and employer-sponsored funding may be available
- Outcome: Eligibility for state CHW certification

Specialized Training Tracks

CHWs can access additional training focused on key populations and services, including:

- Maternal and child health
- Behavioral health and substance use

- Health insurance navigation
- Social determinants of health (SDOH)

CHW - Specific Continuing Education Opportunities in Delaware

Delaware's CHW workforce can also benefit from ongoing CEU opportunities, hosted by local health departments, community colleges, and nonprofit partners.

- Delaware Division of Public Health (DPH) CHW Core Competency Training
 - Description: A certified curriculum offering foundational training for CHWs.
 - Cost: Offered at no cost.

- Details: Provides 100 hours of training covering essential CHW skills.
- Please visit: <u>www.chwadelaware.org</u> for more information.

Delaware Technical Community College CHW Program

- **Description:** A comprehensive program designed to prepare students for CHW roles.
- CEUs: Offers 25 Continuing Education Units (CEUs).
- **Duration:** 250 hours, including 210 hours of lecture and 40 hours of internship.
- Cost: \$3,495

CHECK (Community Health, Education, and Knowledge) Platform

- **Description:** An online platform providing tools and training for CHWs.
- Features: Offers core competency training, a calendar of events, and resource connec-

If you have any questions or would like more details, please visit the Ultrasound Express website or call: 302-422-2612



Availity Essentials / Secure Provider Portal

Availity Essentials

Availity Essentials has been chosen as the new, secure provider portal. (Effective October 21st, 2024*)

Manage patients administratvive tasks quickly and easily:

- Validate eligibility and benefits
- \$ Submit claims
- (§) Check claim status
- Submit authorizations
- Access payer resources

New Enhancements as of 8/18/2025 Authorization Inquiry Enhancement

Previously, authorization searches were limited to a single retrieval based solely on the authorization number. The latest release removes this restriction, allowing providers to search for multiple authorizations simultaneously. This enhancement improves provider efficiency and reduces abrasion.

1. Multiple Auth Results Returned

- Based on matching NPI & TaxID
 - •(Requested or Servicing provider)
- Includes *canceled* authorizations
- 2. Search by Member Information and Date Range
- No longer limited to Authorization Number
- From Date: Start date of auth search
- window
- To Date: Max 30-day span, up to 18 months back
- IMPORTANT: If provider information cannot be found on the authorization results will not be returned as NPI & TIN will be required for matching logic.

*Please note Availity Essentials is a phased rollout. The legacy portal will be available until the transition is completed by end-of-year 2026.

Availity Portal Navigation Assistance



Contact Availity Client Services (ACS) at 1-800-282-4548.

Assistance is available on weekdays. 8:00 a.m. to 8:00 p.m. ET (excluding holidays).

Registration and Access

For providers new to Availity Essentials, getting an account is the first step toward working on Availity. <u>REGISTER NOW.</u>

Secure Provider Portal

Our current secure provider portal is still available for other functions that our providers use today.

Visibility of Multiple TINs

One point of entry allows for quick and easy access to Delaware First Health (DFH) member information for multiple TINS/practices.

Access Daily Patient Lists From One Screen

One concise view allows primary care providers to scan patient lists for Ambetter Health of Delaware member eligibility, care gaps, and much more.

Manage Batch Claims for Free

Submit and manage claims, including batch files, for free. View detailed Electronic Funds Transfer (EFT) payment history.

Simplify Prior Authorization Process

"Smart Sheets" feature prompts for required clinical information when submitting prior authorization requests.

Streamline Office Operations:

- View patient demographics and history
- Secure messaging between provider and Delaware First Health
- Update provider demographics



Claims Corner

Helpful Links

<u>Clinical and</u> Payment Policies

Follow this link to access all new and existing clinical and payment policies

<u>Provider Forms,</u> <u>Manuals and Other</u> Reference Resources

<u>Legacy Provider</u> <u>Portal</u>

Availity Essentials
Portal Login/Registration

Provider Engagement
Account Manager
(PEAM)Territory List

Medicaid Prior
Authorization Tool

Evolent (Formerly NIA)

<u>Provider</u>

Communications & News

Stay up to date on all announcements, events, helpful resources and training opportunities.

<u>Pharmacy</u>

Auth Requirements, Forms, Drug Formulary, Opioid Dose Calculator & more!

Annual Behavioral Health Well-Check Billing Requirements

When billing for the annual behavioral health well check, follow the billing requirements noted below:

- Use CPT code 99429 with modifier "HE" and diagnosis code Z13.30 for annual behavioral health well check.
- CPT Code 99429 with HE modifier can only be billed once in a 12-month
- period for the same member.
- Billing of code 99429 with HE modifier more than once within 12 months of a previous billing of 99429-HE will result in a denial, EXzw – Maximum
 - Allowance Exceeded.

•

DMMA Practitioner Specific Policy Language Source of Truth – Section 17.5.

17.5 Billing Procedures

17.5.1 Billing Requirements

17.5.1.1 When billing for an annual behavioral health well check, providers must use the diagnosis of "annual behavioral health well check."

17.5.1.2 Providers must use the following codes when billing DMAP:

Code	Description	
99429-HE	Annual Behavioral Health Well Check	

17.5.1.3 The annual behavioral health well check must be billed with modifier "HE" (Mental Health Program) to document that the service was performed.

17.5.1.4 Code 99429-HE must not be billed within 12 months of a previous billing 99429-HE for the same beneficiary.

17.5.1.4 Billing of code 99429-HE more than once within 12 months of a previous billing of 99429-HE will result in denial of the later 99429-HE.

REMINDER: 2025 Rate Increase for Personal Care Services

Delaware First Health (DFH) is providing an update on the 2025 increased rates for personal care services (PCS) providers who bill S5125, S5130, S5150, and T1005 with and without modifier. We have updated our fee schedules to pay the increased rates effective January 1, 2025.

Please contact Provider Services call center at 1-877-236-1341 or email PCS Provider Engagement Account Manager, Beau Thompson, at: william.thompson@delawarefirsthealth.com.

Claims Corner (continued)

Taxonomy Requirements

All claims must be submitted with the billing, rendering, and attending provider's taxonomy. Claims submitted without the required taxonomy will be DENIED or REJECTED. Review the below table for placement guidance.

CMS-1500 PAPER SUBMISSION	837P ELECTRONIC SUBMISSION
Rendering – Box 24i should contain the qualifier "ZZ". Box 24j (shaded area) should contain the taxonomy code.	Rendering – Loop 2310B PRV01 = "PE"; PRV02 = "PXC" qualifier; PRV03 = 10-character taxonomy code002E.
Billing – Box 33b should contain the qualifier "ZZ" along with the taxonomy code.	Billing – Loop 2000A PRV01 = "BI"; PRV02 = "PXC" qualifier; PRV03 = 10-character taxonomy code.
CMS-1450/UB-04 PAPER SUBMISSION	837i ELECTRONIC SUBMISSION
Attending – Box 81CCb should contain the qualifier "B3" in the left column and the taxonomy code in the middle column.	Attending – Loop 2310A PRV01 = "AT"; PRV02 = "PXC" qualifier; PRV03=10-character taxonomy code
Billing – Box 81CCa should contain the qualifier "B3" in the left column and the taxonomy code in the middle column.	Billing – Loop 2000A PRV01 = "BI"; PRV02 = "PXC" qualifier; PRV03 = 10-character taxonomy code.

PLEASE NOTE: Your clearinghouse must make taxonomy placement a permanent placement on your account.

If your claim is denied for missing taxonomy, a corrected claim must be submitted within 90 calendar days of the date of the EOP. If rejected for missing taxonomy, a new claim must be submitted within 120 calendar days from the date of service and must include the taxonomy in the required fields as listed above.

Claims Dispute Process

A claim payment dispute involves a finalized claim in which a provider disagrees with the outcome. Please follow the dispute process for claim denials, following the appropriate steps as outlined below:

1ST DISPUTE STEP - RECONSIDERATION 2ND DISPUTE STEP - APPEAL Providers may file a reconsideration of a finalized claim by If you disagree with the reconsideration decision, you may mail or via our Secure Provider Portal. The reconsideration submit an appeal by mail or fax. Please include: request must include: A Provider Appeal Form Copy of the Claim in Question Claim Number Authorization Number (if applicable) Copy of the EOP Supporting documentation Supporting Documentation The submission of the request must be within 90 calen-Please include as much supporting information as possible dar days from the date of Explanation of Payment (EOP) to assist with determination review. The submission must be within 120 days of the date of service **OR** no later than 60 calendar days after the reconsideration decision, whichever Provider Remittance Advice (PRA). date is latest. Mailing Address for Reconsideration **Mailing Address for Disputes** Delaware First Health Delaware First Health ATTN: Claims Department ATTN: Claims Appeals Department P.O. Box 8001 Farmington, MO 63640-8001 P.O. Box 8001 Farmington, MO 63640-8001 Fax Number for Appeals 1-888-865-6531

Upcoming National Health Observances

National Health Observances (NHOs) are special days, weeks, or months dedicated time to raise awareness about important health topics determined by the U.S. Department of Health and Human Services (HHS) Office on Diseases Prevention and Health Promotion (ODPHP), the Centers for Disease Control and Prevention (CDC) and other organizations.

Over the next few months, the ODPHP is raising awareness about the below topics but there are many more. Please visit the ODPHP National Health Observance page for additional important health topics.

JULY

- UV Safety Month: Don't Get Burned!
- UV Safety Month is an initiative of the <u>American Academy of Dermatology</u>, the <u>Skin Cancer Foundation</u>, and the <u>American Cancer Society</u>. Learn about the harmful effects of excessive sun exposure and get tips to protect yourself and your family—available through any of the organizations listed above.
- National Minority Mental Health Awareness Month
- National Minority Mental Health Awareness Month, observed every July in the U.S., highlights the unique mental health challenges faced by racial and ethnic minorities, LGBTQ+ individuals, and people with disabilities. Awareness efforts include events, outreach, and partnerships to improve access to care. For additional resources, check out the National Alliance on Mental Illness website.
- Juvenile Arthritis Awareness Month
- Juvenile Arthritis (JA) is a serious condition affecting children.



affecting children.
Early diagnosis
and treatment
are key to better
outcomes. Juvenile
Arthritis Awareness
Month promotes

AUGUST

National Breast Feeding Month

National Breastfeeding Month, observed in August, celebrates the benefits of breastfeeding for mothers and babies. Events and activities raise awareness, offer support, and educate the public on its importance. For more information and updates, visit

the official website of the U.S. Breastfeeding Committee.

Children's Eye Health, and Safety Month

Children's Eye Health and Safety Month is observed annually in August. This month aims to highlight the importance of children's eye health and promote early detection and prevention of eye problems. For additinal resources and updates, please visit the American Academy of Opthalmology



SEPTEMBER

Suicide Prevention Month

September is Suicide Prevention Month, recognized by National Alliance on Mental Illness (NAMI) to raise awareness, offer hope, and encourage action. The focus is on helping individuals and families talk openly, recognize warning signs, and seek support. Start a conversation. Be the difference. One honest check-in can save a life. Help exists. Healing is possible. For additional resources, toolkits, opportunities and updates, please visit the National Allinance on Mental Illness website.

NEW CMS STAR Measures in 2025:Tapering Techniques for Polypharmacy Measures

Beginning in 2025, two additional CMS Stars Measures will be targeting the following:

- Polypharmacy of Anticholinergics (Poly-Ach): ≥2 concurrent anticholinergic meds in adults ≥65 for ≥30 days
- Concurrent Opioid and Benzodiazepine (COB)
 Use: ≥30 days of overlap in adults ≥18

These combinations increase the risk of falls, fractures, cognitive decline, overdose, and hospitalizations. Clinicians are encouraged to minimize or avoid these medications when possible.



Polypharmacy is common in older adults (30–35% of those 60–79 take ≥5 meds) and is linked to adverse outcomes. Deprescribing sedatives and anticholinergics can reduce harm and improve function, particularly in frail elders.

Opioid Tapering Guidelines

- ✓ Individualize the taper: Reduce total dose by 5–20% every 4 weeks; 10% per month is generally well tolerated.
- ✓ Avoid abrupt discontinuation: Sudden stops can trigger withdrawal, worsened pain, and psychological distress. Use supportive care if rapid taper is needed.
- ✓ Manage withdrawal symptoms: Use adjunctive meds like clonidine, antiemetics, NSAIDs, or acetaminophen.
- ✓ Optimize alternatives: Use acetaminophen, NSAIDs, SNRIs, gabapentinoids, topical agents, and non-drug therapies.
- ✓ Address OUD if present: Consider MAT (e.g., buprenorphine, methadone) under supervision.

Benzodiazepine (BZD) Deprescribing

- Avoid abrupt discontinuation: Gradual tapering is essential for patients on daily use >1 month.
- Start slow:
 - For long-term/high-dose users: Reduce 5–10% every 2–4 weeks; max 25% every 2 weeks. Slow further to 5–10% every 6–8 weeks if needed.
 - For short-term/low-dose users: Reduce 10-25% every 2-4 weeks.
- Monitor closely: Pause or slow taper if withdrawal symptoms appear.
 - **Taper opioids first** if both medications are being used.
- **Key Takeaway:** Tapering should be slow, individualized, and supported with alternative therapies and close monitoring to reduce risks and improve outcomes.

CAHPS Outpatient Mental Health (OPMH) Survey - and why provider support matters!

At Delaware First Health, improving behavioral health is a shared priority. One powerful way we can do that is by listening to the experience of the people we serve – and that's where the Consumer Assessment of Healthcare Providers (CAHPS) Outpatient Mental Health Survey comes in.

This standardized, nationally recognized questionnaire was developed to collect feedback from adult patients about their outpatient mental health and substance disorder services. It helps identify what's working well and where improvements are needed.

What is the CAHPS Outpatient Mental Health Survey?

The CAHPS Outpatient Mental Health Survey is designed to measure the patient experience in several areas, including:

- √ Scheduling and accessing appointments for prescriptions and counseling
- √ Communication with mental health professionals
- √ Goal setting and patient involvement in treatment planning
- √ Access to support between appointments
- ✓ Ratings of mental health providers
- ✓ Unmet needs for services
- √ Financial barriers that impact access to care

While many CAHPS surveys run throughout the year, Delaware First Health will administer this survey between July and September 2025.

A random sample of members will receive the survey from Press Ganey, an independent patient satisfaction company. It's quick, anonymous, and can be completed by mail, phone, or online.

Why It Matters for Providers

Encouraging your patients to complete this survey isn't just helpful – it can be transformational. Their responses:

- ✓ Offer insight into patient experience and satisfaction
- √ Highlight areas for clinical and operational improvement
- √ Help practices meet value-based care and quality improvement goals
- ✓ Enable benchmarking against peers and national standards
- √ Support stronger provider-patient relationships

More Than Words: The Power of Precise Documentation

As healthcare continues to evolve in 2025, comprehensive and accurate medical documentation remains a foundation of safe, effective, and equitable care. But in this era - where value-based care models, electronic records, and risk adjustment scores play increasingly central roles - what providers document has implications that reach far outside the exam room. Here are 5 points that support the importance of documentation excellence and what's at stake when it's incomplete or inaccurate.

Enables Whole-Person, Continuity-Based Care

Clear documentation gives all care providers a full view of a member's health—covering diagnoses, comorbidities, social risks, and treatment response. This supports coordinated, high-quality care that lowers readmissions and improves outcomes. For instance, noting stable diabetes ensures it's factored into care planning and evaluations.

Prevents Both Under- and Over-Coding

Poor documentation leads to under-coding, which can result in underfunded care. Over-coding, meanwhile, risks audits, compliance issues, and legal consequences.

In 2025, coding accuracy and integrity are coming under greater scrutiny. Each diagnosis must be supported by the clinical encounter and reflect the provider's medical decision-making.

Protects Providers and Enhances Compliance

Complete documentation of clinical reasoning, diagnoses, and interventions is a provider's best defense should claims review or malpractice allegations be brought. It also ensures compliance with CMS, NCQA, HEDIS, and payer requirements.

2025 Best Practices

- ✓ Document all active diagnoses and link them to assessment, treatment, or monitoring.
- ✓ Do not copy forward old or resolved conditions
- √ Use specific, ICD-10-compliant terminology
- ✓ Ensure each diagnosis has clinical evidence
- ✓ Code to the highest degree of specificity that documentation supports



Ensures Members Receive the Right Level of Support

When all current conditions are accurately documented, health plans can:

- Proactively provide care management or case coordination
- Identify gaps in care (e.g., missed screenings)
- Offer wraparound services such as nutrition, transportation, or behavioral health referrals

Accurate documentation equals more member benefits, especially for members who are managing multiple chronic conditions.

Guarantees Proper Health Plan Funding That Enables Provider Payments

Accurate documentation drives CMS risk-adjusted payments by reflecting members' true health status. Underreporting leads to underfunding for health plans and care teams. In 2025's value-based care model, complete diagnoses are key to provider reimbursement, shared savings, and care coordination.

Comprehensive and complete documentation is not a box to be checked; it's an act of advocacy. It helps ensure members receive the care, services, and support they need, while protecting providers, promoting health equity, and preserving the fiscal and operational health of your organization.

Let's document with purpose for our patients, our teams, and the future of care.

Delaware First Health Partners with Delaware Chiropractic Services Network

American College of Physicians Endorses Chiropractic Care for Back Pain Relief

An increasing number of people are seeking natural methods to manage pain due to growing concerns about the addictive qualities of opioid medications. Chiropractic care has emerged as a popular, science-based option for addressing the underlying causes of pain. This shift towards natural care is illustrated by the clinical guidelines for managing low back pain released by the American College of Physicians (ACP) and published in the Annals of Internal Medicine.

The American College of Physicians is the largest medical specialty organization in the world, representing approximately 161,000 physicians specializing in internal medicine. Back pain is one of the main reasons people visit a doctor, and it is a significant cause of disability and missed work. A 2020 study in the Journal of the American Medical Association found that low back and neck pain costs the U.S. approximately \$134.5 billion annually, making them the most

expensive health issues in the country. The ACP developed guidelines for treating low back pain to assist doctors in selecting the most effective and safest treatment options.

The guidelines recommend that doctors and patients use a non-pharmacologic (drug-free) approach as the first-line treatment for acute, sub-acute, and chronic low back pain. Many suggested therapies are available in chiropractic offices, including spinal adjustments, also known as spinal manipulation. At the time of publication, ACP president Dr. Nitin S. Damle said, "Physicians should avoid prescribing unnecessary tests and costly and potentially harmful drugs, especially narcotics, for these patients."

Chiropractors help patients feel better by restoring function and addressing underlying issues. Research shows chiropractic care yields high patient satisfaction, is effective, and reduces the likelihood of recurring back pain. It is drug-free, may help avoid surgery, and is among the safest healthcare options available.

Delaware First Health has partnered with the Delaware Chiropractic Services Network (DCSN) to provide high-quality chiropractic care. DCSN chiropractors are conveniently located throughout Delaware and collaborate effectively with your healthcare team, including your primary care physician. They are also knowledgeable about Delaware First Health policies to ensure that you receive optimal care.

Doctors of Chiropractic commonly treat conditions such as back pain, radiating pain in the legs or arms, neck pain, headaches, and issues related to extremities, including shoulder, wrist, knee, and foot pain. For information on modern chiropractic care, visit the <u>Chiropractic Services Network</u>. Please use the Find-a-Provider Tool or contact Delaware First Health at 1-877-236-1341 to find a chiropractor in your area.

Member Incentives and Value-Added Benefits

New for 2025 Diabetes Prevention Program (DPP)

"Research has shown that people with pre-diabetes who joined a structured lifestyle change program could cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old)."

Program Overview:

- CDC-led Lifestyle Change Program
 - ° A trained lifestyle coach
 - ° CDC-approved curriculum
 - Group support over the course of one year
- Focused on healthy eating and physical activity
- 26 sessions over a year
- FREE YMCA membership for 1st four months of the program (for members who enroll in DPP through the YMCA)

Program Referral Criteria

- Age 18+
- Not pregnant
- Not previously diagnosed with Type 1 or Type 2 Diabetes
- BMI 25+ (23+ for Asian Americans)

How to Refer:

Providers are encouraged to refer members to the DPP. Alternatively, members may self-refer.

- Providers referrals may be submitted via the <u>Provider Referral Link</u>
- (Self-initiated) Members may selfrefer via the <u>Self-referral Registration</u> <u>Form</u>

For more information, please visit the <u>Provider Resources page</u> or the <u>Value-Added Benefits page</u> of our website. You may also call us at 1-877-236-1341.



Delaware First Health rewards our members for focusing on their health! Our members can earn My Health Pays rewards by completing healthy activities like a yearly wellness exam, annual screenings, tests and much more. The reward dollars are added to a rewards card after we process the claim for each activity completed.

No sign up required! Cards automatically mailed to qualifying members after qualifying claims are paid.

- Cards sent in each member's name (children receive cards).
- Card arrives approximately two months after 1st qualify activity.
- Subsequent rewards are added to the existing card.

Members can use My Health Pays® rewards on:

- Utilities
- Transportation
- Telecommunications
- Childcare services
- Education
- Rent
- Shop at Walmart for everyday items (Note: this card can only be used in-person at Walmart, not online or at Walmart.com).

Website:

DelawareFirstHealth.com (My Health Pays)



Member Incentives and Value-Added Benefits (continued)

OTC Pharmacy Allowance

Program Overview: Members select from an Enhanced list of OTC items.

- \$120 per year per household (\$30 per calendar quarter).
- No prescription required.

Most Popular DFH Orders in 2024:

- Diapers and other baby products, including wipes and baby lotion
- Period Products Tampons and Pads
- · Cleansing wipes

Order Through:

- OTC Health Solutions App
- Phone
- Online

NOTE:

- Ordering information is available on the <u>DFH Value</u> Added Benefits webpage.
- This benefit does not roll over Members must use their \$30 allowance each quarter, or it will expire.
- The benefit is administered through CVS OTC Health Solutions.
- DFH Medicaid purchases cannot be made in CVS stores

My Health Pays® Rewards Activities

Priority	Member Reward	Related Provider Reward
Maternal Health	\$20 Notification of Pregnancy \$50 Prenatal Visit within 1st Trimester \$20 x 2 for 3 Prenatal Visits (Earned after the 3rd and 6th visits) \$15 Prenatal Tdap Vaccine \$15 Prenatal RSV Vaccine \$40 Postpartum Visit (7-84 days post-delivery)	\$50 Prenatal Visit (Timeliness) (PPC)
Healthy Kids	\$15 Annual Flu Vaccination (6mos+) \$50 x2 for 3 Infant Well Visits (0-15mos) \$25 x2 Infant Well Visit (15–30mos) \$25 x2 Child Lead Screening (9-18mos, 19-27 mos) \$25 Child Well Visit Increased \$25 x6 Children's Asthma Controller Med Fill	\$50 Prenatal Visit (Timeliness) (PPC)
Healthy Adults	\$20 Adult Annual Dental Visit \$25 Adult Well Visit Increased \$15 Flu Vaccination	\$50 Adult Access to Preventative Visit (AAP)
Cancer Screenings	\$25 Breast Cancer Screening (Ages 40-74. Once every two years) \$30 Cervical Cancer Screening (Ages 21-64. Once every three years) \$20 Colorectal Cancer Screening (Ages 50-75. One-time reward)	\$25 Breast Cancer Screening (BCS-E) \$25 Cervical Cancer Screening (CCS-E) \$25 Colorectal Cancer Screening 51-75yrs (COL-E)
Managing Diabetes	\$20 Diabetes HbA1c Test for Adults with Diabetes \$25 Retina Exam for Adults with Diabetes	\$35 Diabetes HbA1c <8 (GSD)
Substance Use and Behavioral Health	\$20 First Tobacco Cessation Medication Fill \$20 Behavioral Health or Substance Use Hospitalization Follow-up Visit	

Enhancing Outcomes Through Annual Visits

As part of our ongoing efforts to improve population health outcomes and meet the standards of quality care, we are emphasizing the Annual Preventive Visit as a key opportunity to engage members, identify risk, and close care gaps

Preventive visits are not only foundational for managing chronic conditions and improving quality of life—they also drive performance across multiple HEDIS® and CMS STAR measures and are essential to fulfilling Value-Based Agreement (VBA) criteria.

The Annual Preventive Visit provides a structured opportunity for:

- Screening for age- and risk-appropriate conditions
- Establishing and reinforcing the patient-PCP relationship
- Medication review and adherence monitoring
- Vaccination updates
- Chronic disease monitoring and early intervention



It also ensures that all gaps in care are addressed during a single, comprehensive encounter—contributing directly to continuity of care, better patient outcomes, and increased member satisfaction.

Primary Care Provider (PCP) Responsibilities

Primary Care Providers are instrumental in achieving quality targets and maintaining member health through the annual visit. Responsibilities include:

- Proactive outreach to schedule annual wellness exams
- Conducting age- and condition-appropriate screenings
- Reviewing and documenting social determinants of health (SDOH)
- Using evidence-based guidelines to guide testing and referrals
- Ensuring all completed services are submitted with appropriate codes

Screenings That Close Care Gaps

During the Annual Preventive Visit, please ensure the following screenings are addressed:

Screening/Test	Timeframe
Colorectal Cancer Screening	40-75
Breast Cancer Screening	50-74 (women)
Cervical Cancer Screening	21-64 (women)
Diabetic Retinal Exam	Annual
HbA1c Testing	Annual
Blood Pressure Reading	Annual
Nephropathy Screening	Annual
BMI, Tobacco, and Depression Screening	Annual
Immunizations (Flu, Pneumococcal, Shingles)	Age-specific

Enhancing Outcome Through Annual Visits

Submitting Evidence and Codes to Close Care Gaps

To ensure care gaps are closed and reflected in quality performance:

- 1. Use standard CPT, ICD-10, and HCPCS codes to document services
- 2. Submit encounter data promptly through claims or encounter submission systems
- 3. Attach supplemental data (e.g., lab results, progress notes) where required
- 4. Document clearly in the EMR and use structured data fields when available

Accurate and timely documentation ensures that all completed screenings are captured for HEDIS measurement and reimbursement purposes.

Tip: Use your EMR's gap-in-care alerts and our provider portal for real-time gap lists and coding support tools. Consider a flat file submission, or Remote Access to ensure the health plan is capturing the data from your office. Historical records can also be uploaded via the provider portal.

Need Support?

Visit the the dedicated <u>provider webpage</u> of our website for:

- Preventive care coding guides
- Gap-in-care dashboards
- Member attribution lists
- Value-based care resources

Or contact your Provider Relations Representative.

Thank you for your commitment to improving preventive care and driving meaningful health outcomes!

-Delaware First Health's Quality Team



Why Well Child Visits Matter from Birth to Age 20



Well-child visits are a vital part of every child's healthcare journey, from infancy through young adulthood. These regular check-ups are designed to monitor a child's growth, development, and overall well-being. During each visit, healthcare providers assess key milestones, perform physical exams, administer immunizations, and screen for developmental, behavioral, and emotional issues. Starting in infancy, well-child visits help ensure that babies are growing properly, meeting developmental milestones, and receiving protection from preventable diseases through vaccines. As children grow, these visits continue to offer crucial guidance on nutrition, behavior, mental health, puberty, and risk prevention. Adolescents benefit from a trusted relationship with their provider, which becomes especially important for addressing topics like substance use, sexual health, and emotional well-being

At Delaware First Health, we encourage families to stay current with these essential visits through its My Health Pays™ rewards program. Families can earn up to \$50 for completing well-child visits during the first 15 months of life (for 3 visits available twice/lifetime), \$25 for visits between 15–30 months (up to two visits/lifetime), and \$25 per year for annual well-child visits for children, teens, and young adults

Adhering to prescribed asthma medications is crucial for preventing flare-ups, reducing emergency room visits, and ensuring children can breathe easier and stay active, and Delaware First Health supports this by offering a \$25 reward for members who fill a 30-day supply of asthma controller medication. These incentives come in the form of a re loadable gift card that can be used to purchase everyday necessities such as groceries, transportation, and utilities, helping families support both their health and household needs.

Another important component of these visits is lead screening. Lead exposure can cause serious health and developmental issues, especially in young children. Delaware requires lead screenings at 12 and 24 months of age for all children enrolled in Medicaid. Delaware First Health offers an additional \$25 reward for each of these screenings one for children between 9–18 months and another for those between 19–27 months. These blood tests detect elevated lead levels early, allowing for timely interventions that may include environmental assessments and educational support services.

Delaware First Health offers valuable support for families through a combination of preventive care incentives and practical health benefits. In addition to earning rewards through the My Health Pays™ program for completing well-child visits and lead screenings, members also receive a quarterly over the counter (OTC) benefit through CVS. This benefit is typically \$30 every three months, or up to \$120 per year. This allowance can be used to purchase essential health and wellness items such as diapers, wipes, cold medications, pain relievers, and first-aid supplies, either online, by phone, or in-store at participating CVS locations. These benefits make it easier for families to stay on top of their child's health needs, reduce out-of-pocket expenses, and support wellness at home, all while reinforcing the importance of regular pediatric checkups and early detection services like lead screening.

By keeping up with recommended wellness visits, immunizations, and lead screenings, families are not only protecting their child's health but also taking advantage of valuable support and financial incentives. These visits lay the groundwork for lifelong wellness and help ensure children grow up healthy, strong, and ready to succeed. For more information on incentives and scheduling, families can visit Delaware First Health's website or call member services at 1-877-236-1341 (TTY: 711).

Partnering with You for Better Men's Health Outcomes

June is Men's Health Month — a time to raise awareness, promote preventive care, and encourage early detection. As a trusted provider, your role is vital in helping our male members stay engaged in their health.

Spotlight: Colorectal Cancer Screening

Colorectal cancer is the 2nd leading cause of cancer-related deaths in U.S. men—but highly preventable with routine screenings. This June, DFH is emphasizing:

- Colonoscopy every 10 years (starting at age 45)
- Flexible Sigmoidoscopy every 5-10 years
- CT Colonography every 5 years
- Stool DNA Tests every 1-3 years
- Fecal Immunochemical Test (FIT) every year

DFH partnered with EverlyWell to send FIT (Fecal Immunochemical Tests) to eligible members in the month of May. Your support in educating and encouraging members to complete and return their kits is crucial.

Preventive Care Checklist for Men

Ensure your patients are current on age-appropriate screenings and immunizations:

- Blood pressure, cholesterol, diabetes, prostate, and mental health screenings
- Flu shots and recommended vaccines (e.g., shingles, pneumococcal)

Early Symptoms Men Shouldn't Ignore

Encourage men to seek care for:

- Unexplained fatigue or weight loss
- Changes in bowel/urinary habits
- Blood in stool/urine
- Erectile dysfunction or mood changes

How You Can Help

- Use wellness visits to review screenings
- Normalize colon health discussions
- Promote at-home options like Cologuard®
- Encourage healthy lifestyle changes
- Submit accurate claims and documentation

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Men's Lealth

Need Resources?

Visit our <u>Provider Resources webpage</u> or contact your <u>Provider Engagement Account Manager</u> for screening guidelines, coding tools, and patient education materials.

Thank you for your partnership in promoting men's health this June—and all year long.

- Your Delaware First Health Quality Team

Social Determinants of Health (SDoH) Incentive Program

IMPROVING PATIENT OUTCOMES BY IDENTIFYING AND ADDRESSING SOCIAL NEEDS

Social determinants influence health in very direct ways. A patient's housing, food, and safety needs can create barriers blocking quality care and can contribute to poor health. Delaware First Health wants to partner with you to address social determinants of health. Together, we can identify and address social barriers and improve the health of our members.

How can these needs be identified?

You should include supplemental codes in the patient's diagnosis section on a claim form. Reporting Social Determinants of Health (SDOH) codes allow physicians, hospitals, health systems, and payers to better track patient needs and identify solutions to improve health outcomes.

How can Delaware First Health help?

Delaware First Health can connect your patients to community resources that help meet their social needs. Our toll-free Member Services number is 1-877-236-1341 (TTY: 711)

Members can seek help with:

- √ Housing or living conditions
- √ Food assistance
- ✓ Transportation issues
- √ Unsafe situations or domestic violence
- √ Affordable childcare
- √ Job/education assistance
- √ Financial assistance (utilities, rent)
- ✓ Family supplies (diapers, formula, cribs, and more)

How can you help Delaware First Health assist your patients?

- ✓ Provide them with referrals to address the identified social need and Delaware First Health's Community
- ✓ Help Line number.
- ✓ Include ICD-10 Z codes on your claim (included here as a reference for you).

Description	Codes
Occupational exposure to risk factors	ICD-10: z57.0
Problems related to education and literacy	ICD-10: Z55,Z55.5, Z55.6
Problems related to employment and unemployment	ICD-10: Z56.0
Problems related to physical environment	ICD-10: Z58.0, Z58.6, Z58.8, Z58.81, Z58.89
Problems related to housing and economic circumstances	ICD-10: Z59.0, Z59.00, Z59.01, Z59.02, Z59.1, Z59.10, Z59.11, Z59.12, Z59.19, Z59.4, Z59.41, Z59.48, Z59.8, Z59.81, Z59.811, Z59.812, Z59.82, Z59.86, Z59.87, Z59.89
Problems related to social environment	ICD-10: Z60.0
Problems related to upbringing	ICD-10: Z62.0, Z62.2, Z62.23, Z62.24, Z62.8, Z62.81, Z62.814, Z62.815, Z62.82, Z62.823, Z62.83, Z62.831, Z62.832, Z62.833, Z62.89, Z62.892
Other problems related to primary support group, including family circumstances	ICD-10: Z63.0
Problems related to certain psychosocial circumstances	ICD-10: Z64.0
Problems related to other psychosocial circumstances	ICD-10: Z65.0
CPT screening codes applicable to SDoH	CPT: 99204-99205, 99211-99215, 99241-99245, 99381-99387, 99391- 99397

Social Determinants of Health (SDoH) Incentive Program (continued)

IMPROVING PATIENT OUTCOMES BY IDENTIFYING AND ADDRESSING SOCIAL NEEDS

SDoH Community Reources

Delaware First Health is committed to building strong relationships with our Providers to ensure our members receive the best possible care. A critical component in providing care is making sure that both members and providers are aware and able to reach necessary community resources.

We continue to offer digital assistance to search for local community resources, additional programs and support at Delaware First Health's Find Help site.

Additional important Delaware First Health contacts include:

- Member Services: 1-877-236-1341 (TTY: 711), option 2
- Care Coordination: 1-877-236-1341 (TTY: 711), option 2
- **24-Hour Nurse Advice Line /Behavioral Health Crisis Line:** 1-877-236-1341 (TTY: 711), press * to connect to the Nurse Advice/Crisis Line
- As always, we welcome provider feedback to ensure we are moving forward, working together, to continue
- offering our members the best possible care. We would love to hear from you either by reaching out to our
- Provider Engagement team or via our new digital <u>Provider Feedback Form</u> located on our website under the
- provider section of our website. You may use the following resource to locate your specific <u>Provider Engagement Account Manager</u> with additional questions.

Best Practices: Include supplemental codes in the patient's diagnosis section on a claim form. Assign as many SDOH codes necessary to describe all of the social problems, conditions, or risk factors documented during the current episode of care.

Our collaborative efforts can help reduce SDoH barriers.

We're here to help, and we continue to support our providers. For additional assistance or questions, please contact Member Services or Care Coordination at 1-877-236-1341 (TTY: 711)

A Few Reminders...

Secondary Insurance & Coordination of Benefits

When DFH is the secondary payer (or when member has another primary insurance):

- No prior authorization is required if the service is covered by the primary payer.
- Prior authorization is required if the service is not a covered benefit or the benefit is exhausted by the primary payer The signed ABN or EOC (Evidence of Coverage) should be submitted with the initial authorization request
- Explanation of Benefit (EOB)/ Advanced Beneficiary Notice (ABN) must accompany the claim submission.

Interpreter Services

Delaware First Health is committed to making it easy to work with us and to providing culturally competent care to our members. In addition to calling customer service to request in-person interpretation, you can now use our self-service Interpreter Scheduling Form.

Educating Members on the Authorization & Referral Process

We've noticed that some members are uncertain about prior authorizations and referrals—often assuming they need to initiate these themselves. Please remind your teams to clearly communicate that providers are responsible for submitting prior authorizations and to explain when referrals are required.

Providing clear guidance helps reduce confusion and enhances the member experience. Thank you for your continued support!

Appeals, Grievances, Quality of Care, and Critical Incidents

As part of our shared commitment to delivering high-quality, member-centered care, we are highlighting key processes related to Appeals, Grievances, Quality of Care (QOC), and Critical Incidents. These areas are essential to promoting safety, satisfaction, and compliance across our provider network.

Appeals

Providers and members have the right to appeal coverage decisions.

- Submit appeals within the required timeframes along with supporting clinical documentation.
- If someone is filing an appeal on behalf of a member, a signed Appointment of Representative (AOR) form is required.
- Ensure all relevant medical necessity details are included to avoid delays.
- Appeals are reviewed promptly, and decisions are communicated within regulatory timeframes.

Quality of Care (QOC) Concerns

- QOC issues involve potential substandard care or unsafe clinical practices. Examples include misdiagnoses, delayed treatment, or inappropriate care delivery.
- All QOC concerns are thoroughly reviewed by clinical quality staff.
- Providers may be contacted for medical records or clarifying details during the review process.

Grievances

Grievances are expressions of dissatisfaction about any aspect of care or service, excluding benefit denials. Providers are encouraged to resolve concerns at the point of care when appropriate. Our team may contact you for information during grievance investigations. Feedback from grievances helps identify areas for service improvement.

Critical Incidents

- Critical incidents include events such as abuse, neglect, exploitation, or other serious risks to member safety.
- Providers are required to report all critical incidents immediately through the designated reporting process. Timely documentation and collaboration during investigations are essential. These reports support our efforts to maintain a safe care environment for all members.

Your Role in Ensuring Quality and Compliance

We thank you for your continued partnership in providing high-quality, safe, and compassionate care to our members. For forms (including the AOR form), or additional support, please contact:

Appeals: SM_Firsthealthappeals@CENTENE.COM

Grievances: <u>DelawareFHGrievances@DelawareFirstHealth.com</u> **Critical Incidents:** <u>DFHCriticalIncident@DelawareFirstHealth.com</u>

Utilization Management Corner

Retrospective Services Request Submission Timeframes

Outpatient - Services Ongoing

For outpatient services (OP) when services are already

being received, services received prior to the date of notification may be retrospectively reviewed for medical necessity for up to five (5) calendar days if there are extenuating circumstances, dates prior to five (5) calendar days are administratively denied.



Outpatient - Services Completed

Medical necessity reviews are conducted for outpatient post-discharge services (i.e., durable medical equipment) if notification is received within five (5) calendar days of the service date. Medical necessity reviews may also be conducted for completed outpatient services if the request is received within five (5) calendar days of the service date and there was an extenuating circumstance that prevented a timely prior authorization request.

Newborn Delivery Notification

Delaware First Health does not require physicians or healthcare providers to obtain prior authorization for the delivery of a newborn. However, notification of all deliveries is required with a Delivery Notification Form completed and faxed to Delaware First Health at 833-974-1203. Healthcare providers must use the Delivery Notification Form to notify the health plan of a mother's delivery. This form MUST be completed within three (3) business days of the mother's discharge and faxed to 833-974-1203.

Please note, an inpatient stay longer than 48

hours for a vaginal delivery or 96 hours for a cesarean delivery will require a prior authorization request faxed to 833-974-1203.



REMINDER: Elective Medical Inpatient (IP) Auth Process Change (Effective April 1, 2024)

Delaware First Health changed our elective medical inpatient authorization process to provide increased flexibility and better align with industry best practices and are as follows:

- 1. Prior authorizations for elective IP services will be approved for professional services by issuing an outpatient (OP) authorization.
 - Elective IP Prior Authorization numbers will now start with the prefix of OP instead of IP (i.e., OP123456789).
 - The authorization will indicate approval at the I level of care.
- 2. The prior authorization span for elective IP admissions has been increased to 90 days for dates of service on or after 4/1/2024.
- 3. If the planned admission date exceeds the authorized date span of 90 days, a new authorization span is required.
- 4. Authorizations for the IP stay (IP authorization) will be processed and issued at the time of admission.
 - Providers do not need an IP authorization prior to the date of service. Services can be rendered any time within the authorization time span.
 - Notification of admission is required within one business day of admit. At the time of admission notification, a new authorization number for the admission will be provided with the IP prefix (IP Authorization).
- 5. Failure to provide timely notification may result in a denial of payment for the submitting facility. As a reminder, all planned/elective admissions to the inpatient setting require prior authorization.

Prior authorization should be requested at least five (5) days before the scheduled service delivery date or as soon as need for service is identified. If prior authorization is not on file at the time of elective admission, the service is considered retrospective, and the requestor should follow the appropriate retrospective request process. Emergent admissions do not require prior authorization.

Enhancing Appeals & Grievances: Timeliness, Transparency, and Member Care

As part of our shared commitment to high-quality, person-centered care, we're sharing important updates and reminders to support your team in navigating the appeals and grievances process effectively.

Timely Appeal Submissions

To help us meet regulatory requirements and avoid delays in member care:

- Submit appeals within 60 calendar days from the denial date.
- Include all relevant clinical documentation with your initial submission.
- Use our secure Provider Portal for faster submission and real-time status updates.



Acknowledgement Letter Timelines

Please be aware that late or incomplete appeal submissions can impact the regulatory timeline for member acknowledgment letters. Timely submission helps ensure that both your office and the member receive decisions within required timeframes.

Provider Grievance Themes - Q2 Highlights

We continue to monitor member feedback and grievance trends. The top concerns in this quarter included:

- Delays in appointment scheduling
- Communication with front desk staff
- Timeliness of referrals and follow-up care
- Members receiving bills from providers

REMINDER: Members should not be billed for covered services. Please ensure billing systems are aligned with your contract and member benefit structure.

We encourage provider offices to review scheduling and communication practices to ensure a smooth experience for members.

Health Equity in Member Interactions

A small but notable number of grievances involved perceived cultural insensitivity. To support inclusive care:

- Offer interpreter services when needed
- Use plain language and culturally appropriate communication
- Participate in upcoming CLAS (Culturally and Linguistically Appropriate Services) training opportunities

Need Support?

For help with specific cases, documentation, or to schedule provider training, contact us:

By Email:

DelawareFHGrievances@DelawareFirstHealth.com SM_Firsthealthappeals@CENTENE.COM

By Phone:

1-877-236-1341

Thank you for your continued commitment to our members and community.

— Appeals & Grievances Department

Delaware First Health Appointment Availability & Access Standards

Telephone Arrangements & 24-Hour Access Expectations

To ensure timely, accessible care and a positive member experience, Delaware First Health reminds all PCPs and specialists of the following requirements:

Telephone Arrangements

Providers must:

- Respond to member calls promptly.
- Prioritize and schedule appointments, including follow-ups.
- **Reschedule** missed or canceled appointments when possible.
- Identify **special needs** during scheduling (e.g., wheelchair access, interpreter services, cognitive impairments).
- Adhere to call-back response times:
 - After-hours, non-emergent symptomatic issues: within 30 minutes
 - Non-symptomatic concerns: same day
- Maintain **continuous availability** of professional and support staff during normal hours.
- Have protocols for coverage during provider absences.
- I Document after-hour calls in a written format and transfer to the member's medical record.

Delaware First Health monitors appointment and after-hours availability through its Quality Management/Quality Improvement (QM/QI) Program.

24-Hour Access Requirements

Providers must ensure covered services are available 24/7, 365 days a year:

During Business Hours:

· Office phones must be answered directly.

After-Hours Coverage Must Include One of the Following:

- Access to a covering practitioner
- An answering or triage service
- A voice message with a second number that is answered
- Recorded messages must be in English and Spanish if serving a high Spanish-speaking population

Unacceptable After-Hours Coverage Includes:

- Phones only answered during office hours
- Voicemail-only messages
- · Messages directing patients to the ER for all needs
- Call-backs exceeding 30 minutes

After-hours coverage must connect callers to someone who can make a clinical decision or reach the provider. Calls must be returned within 30 minutes whenever possible.

Delaware First Health conducts regular monitoring through surveys and mystery shopper calls.

Wellcare Provider Appointment Availability & Access Standards

Ensuring Timely, Equitable Care for All Members

To support high-quality, person-centered care, all providers must meet established standards for appointment access, in-office wait times, and telephone responsiveness. Delaware First Health monitors compliance regularly and supports providers in meeting these expectations.

Appointment Access Standards

Members must be able to access care within the following timeframes:

Type of Appointment	Access Standard
Emergency Care	Immediate or < 24 hours
Non-Emergent but Medically Necessary Services	≤ 7 calendar days
Routine & Preventative Care	≤ 30 calendar days
PCP - Urgent	≤ 24 hours
PCP - Non-Urgent	≤ 7 business days
PCP - Routine	≤ 30 business days
PCP - After-Hours Care	24/7 Availability
Specialists - Urgent	≤ 24 hours
Specialists - Routine	≤ 30 business days
Behavioral Health - Urgent	≤ 48 hours
Behavioral Health – Post-Inpatient Discharge	< 7 days
Behavioral Health – Initial Routine Care	≤ 10 business days
Behavioral Health – Non-Life-Threatening Emergency	≤ 6 hours
Behavioral Health – Routine Follow-Up	≤ 10 business days

In-Office Wait Times: Members should not wait more than 15 minutes past their scheduled appointment time.

Telephone Arrangements & After-Hours Coverage

Primary Care Providers (PCPs) must ensure 24/7 access to care through reliable communication channels.

Acceptable After-Hours Coverage Includes:

24-hour answering service connecting members to clinical decision-makers

Answering system with paging option for call-back within 30 minutes

On-call medical professional available within 30 minutes

Unacceptable Coverage includes:

- X Phones answered only during office hours
- X Voicemail-only messages
- X Messages directing all after-hours needs to the ER
- X Call-backs exceeding 30 minutes

After-hours coverage must be accessible via the same daytime office number and connect members to appropriate clinical support.

Monitoring & Compliance

Wellcare will monitor performance through

- Quality Management/Quality Improvement (QM/QI) Program
- After-hours surveys
- Mystery shopper calls by Provider Network staff

Providers not meeting standards may be required to implement correctaive actions to ensure timely access and

Ambetter Health of DE - Provider Appointment Availability & Access Standards

Ambetter Health ensures timely access to care by following standards set by regulatory and accrediting agencies. We monitor provider compliance annually to improve access and reduce unnecessary ER visits.

Appointment Access Standards

Appointment Type	Access Standard
PCPs - Routine Visits	Within 15 business days
PCPs - Urgent Care	Within 24 hours
PCPs - Adult Sick Visits	Within 48 hours
PCPs - Pediatric Sick Visits	Within 24 hours
Behavioral Health - Non-Life-Threatening Emergency	Within 6 hours
Specialist - Routine Visit (High Volume)	WIthin 30 business days
Specialist - Urgent Care (High Volume)	Within 24 hours
Specialist - Routine Visit (High Impact)	Within 30 business days
Specialist - Urgent Care (High Impact)	Within 24 hours
Urgent Care Providers	Within 24 hours
Behavioral Health Urgent Care	Within 48 hours
Behavioral Health Initial Visit (Routine)	WIthin 10 business days
Behavioral Health Follow-up (Routine)	WIthin 10 business days
After-Hours Care	24/7 access via office number or instructions

Wait Time Standards

Members should not wait more than **30 minutes** before being taken to the exam room.

Provider Phone Call Protocol

PCPs and specialists must:

- Answer calls promptly.
- Schedule appointments per Ambetter guidelines.
- Reschedule missed appointments.
- Identify special needs (e.g., wheelchair access, language interpretation).
- Respond to calls:
 - After-hours (non-emergent): within 30 minutes
 - During office hours: same day
- Ensure staff availability during office hours.
- Have coverage protocols for provider absences.
- Document after-hours calls in medical records.

Note: No prior authorization is needed for emergent care. Providers should notify urgent care or ER of a patient's arrival.

24-Hour Access to Providers

Providers must ensire care is accessible 24/7/365.

- Office phones must be answered during business hours.
- After-hours access must include:
 - Covering physician
 - Answering service
 - Triage service or voicemail with callback number
- Spanish-speaking practices should offer bilingual messages.

Unacceptable After-Hours Coverage

Providers must ensire care is accessible 24/7/365.

- Voicemail only with no callback
- Directing all patients to the ER
- No response within 30 minutes

Quality Monitoring

• Ambetter Health of Delaware monitors appointment and after-hours availability through scheduled and unscheduled audits as part of our Quality Improvement Program (QIP).

We're Always Here to Help!



We're Always a Phone Call or Click Away

Department	Phone Number	Hours of Operation
Provider Services	1-877-236-1341, option 3	Monday - Friday
		8:00 am - 5:00pm EST
Pharmacy Services	1-833-236-1887	24hrs/7 days a week
Member Services	1-877-236-1341, option 2	Monday - Friday
		8:00 am - 5:00pm EST
Utilization Management	1-877-236-1341, option 3	Monday - Friday
		8:00 am - 5:00pm EST
24-Hour Nurse Advice Line	1-877-236-1341, press * to connect	24hrs/7 days a week
Line/Behavioral Crisis Line	to the Nurse Advice/Crisis Line	



Stay Connected

Visit our <u>provider webpage</u> to review various provider resources, Provider News, and obtain contact information for your assigned <u>Provider Engagement Account Manager</u>.

Our Support Doesn't Stop There

Our provider website contains essential information, including member surveys, health equity resources, language services and resources, provider credentialing rights, the utilization management process, how to access care management services and other sources of support for you. Read more now on our <u>Providing Quality Care page</u>.

If you have additional questions or need specific support, call Provider Services at 1.877.236.1341.