Provider Manual

2026

DELAWARE HEALTH AND SOCIAL SERVICES

AmeriHealth Caritas®

Delaware

www.amerihealthcaritasde.com

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Welcome

Welcome to AmeriHealth Caritas Delaware – a mission-driven managed care organization located in Newark, Delaware, and serving members of Delaware Medicaid, through the Diamond State Health Plan and Diamond State Health Plan PLUS programs.

By providing unparalleled access, focusing on seamless care coordination, and leveraging the strength and success of current Delaware Department of Health & Social Services' (DHSS) initiatives, we will drive quality health outcomes for the Medicaid and Children's Health Insurance Program (CHIP) populations.

This Provider Manual was created to assist you and your office staff with providing services to our members, your patients. As a provider, you agree to use this Provider Manual as a reference pertaining to the provision of medical services for members of AmeriHealth Caritas Delaware**.**

This Provider Manual may be changed or updated periodically. AmeriHealth Caritas Delaware will provide you with notice of updates; providers are also responsible to check the Plan's website, **www.amerihealthcaritasde.com** regularly for updates.

Thank you for your participation in the AmeriHealth Caritas Delaware provider network.

We look forward to working with you.

Sharing Our Mission

As our provider partner, we invite you to share our mission: To help people get care, stay well, and build healthy communities.

SECTION I
Getting Started

Section I: Getting Started

Who We Are

AmeriHealth Caritas Delaware, Inc. ("AmeriHealth Caritas Delaware" or "the Plan") is a managed care organization and a member of the AmeriHealth Caritas Family of Companies – an industry leader in the delivery of quality health care to populations covered by publicly funded programs, including Medicaid, Medicare, and State Children's Health Insurance programs. We are proud to partner with the state of Delaware to provide health care coverage for enrollees of:

- **Medicaid or the "Diamond State Health Plan" (DSHP)** The program that provides services through a managed care delivery system to individuals who receive temporary assistance for needy families (TANF), (including children who qualify for Title IV-E foster care and adoption assistance and pregnant women), individuals who receive SSI but are not eligible for Medicare, adults age 19 to 64 who are not eligible for Medicare with income levels up to 133% Federal Poverty Level (FPL), and children in DHCP.
- **Children's Health Insurance Program (CHIP) or the "Delaware Healthy Children Program" (DHCP)** The State's CHIP program, which provides health insurance for Delaware's uninsured children pursuant to Title XXI of the Social Security Act.
- **Diamond State Health Plan PLUS (DSHP Plus)** The program that provides services to SSI children and adults with Medicare, and individuals in the Medicaid for Workers with Disabilities (Medicaid Buy-in) program.
- **Diamond State Health Plan Plus Long Term Services and Supports (DSHP Plus LTSS)** The program that provides services, including long term services and supports, through a managed care delivery system to DSHP Plus members who meet nursing facility level of care or are "at risk" for nursing facility level of care, DSHP Plus members who meet the hospital level of care criteria and have HIV/AIDS, and DSHP Plus members under age 21 who meet nursing facility level of care and reside in a nursing facility.

Through our partnership with you – our dedicated providers – we intend to help our members achieve healthy lives and build healthy communities.

About Our Program

Delaware's Medicaid and Medical Assistance programs are administered through the Delaware Department of Health and Social Services (DHSS), Division of Medicaid & Medical Assistance (DMMA). AmeriHealth Caritas Delaware has been contracted by DHSS to provide covered services for enrollees of the Diamond State Health Plan (DSHP), which includes the Delaware Healthy Children Program (DHCP), the Diamond State Health Plan Plus program (DSHP Plus), and the Diamond State Health Plan Plus Long Term Services and Supports (DSHP Plus LTSS) programs throughout the State of Delaware.

Plan and Delaware DHSS Contact Information

AmeriHealth Caritas Delaware

Office Address

AmeriHealth Caritas Delaware
Christiana Executive Campus
220 Continental Drive, Suite 300
Newark, DE 19713

Provider Services Contact Information

Phone
1-855-707-5818

Fax
1-855-396-5790

Monday through Friday, 8 a.m. to 5 p.m., except State of Delaware holidays.

Delaware DMMA

Provider Services Contact Information

Phone
1-800-999-3371

For a complete listing of important contact information, refer to the *Provider Reference Guide* found in the **Provider** section of our website at **www.amerihealthcaritasde.com.**

Member Enrollment & Health Plan Selection

DHSS employs a Health Benefit Manager (HBM) who performs outreach, education, enrollment, transfer, and disenrollment of members. Potential members may enroll via the HBM by contacting: **1-800-996-9969 (TTY 711).**

The HBM explains the benefits offered by AmeriHealth Caritas Delaware and other Delaware Medicaid health plans. The HBM helps members choose a health plan that best meets their needs; if no health plan is chosen within 30 calendar days, the member will be auto-assigned to a health plan by the state.

New members have the opportunity to change health plans during the first 90 calendar days following the date of enrollment with the health plan. All members also have the opportunity to change health plans during an Annual Open Enrollment Period offered by the State.

Accepting AmeriHealth Caritas Delaware Members

AmeriHealth Caritas Delaware expects network providers to accept all voluntary and assigned members without restriction and in the order in which they enroll. AmeriHealth Caritas Delaware providers will not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual based on health status or need for services, or race, color, or national origin, sex, sexual orientation, gender identity, or disability.

Primary Care Selection & Assignment

During health plan selection, the HBM will encourage members to select a primary care practitioner (PCP) from a list of AmeriHealth Caritas Delaware participating practitioners. If no PCP is selected via the HBM, the Plan will:

- Inform the member of their right to choose a PCP within 15 business days of enrollment.
- Assist the member in selecting a PCP.
- Inform the member that each eligible family member has the right to choose his/her own PCP.
- Automatically assign a PCP to members who do not proactively choose a PCP within 30 calendar days of enrollment with the Plan.

The Plan considers the following when assigning a PCP:

- Member's relationship with PCP;
- Other family member's current or past relationships with PCP;
- Member's age;
- Language of member; and
- Geographic proximity of PCP.

Newly enrolled members receive a welcome packet from the health plan that includes a Member Handbook, and an AmeriHealth Caritas Delaware Member Identification (ID) Card that lists the member's chosen PCP and telephone number. Information about the opportunity and procedures to change PCPs is included in the member welcome packet.

Verifying Member Eligibility

AmeriHealth Caritas Delaware member eligibility varies. As a participating provider, you are responsible to verify member eligibility with AmeriHealth Caritas Delaware before rendering services, except when a member requires emergency services.

Eligibility may be verified by:

- Visiting the provider area of AmeriHealth Caritas Delaware's website,

www.amerihealthcaritasde.com, to access NaviNet, a free, web-based application for electronic transactions and information through a secure multi-payer portal.

- Calling Provider Services at **1-855-707-5818** and utilizing the automated real-time eligibility service without speaking to a representative, just follow the prompts for Member Eligibility.
- Using AmeriHealth Caritas Delaware's real-time eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system verification, including point of service (POS) devices.
- Asking to see the member's Plan ID card. Members are instructed to keep their ID cards with them at all times. The member's ID card includes:
    - The member's name, date of birth, the effective date of enrollment, AmeriHealth Caritas Delaware ID number and Medicaid ID number; and,
    - Copayment information for covered services, if applicable.
    - The Plan's name, address, and Member Services telephone number.
    - The Plan's 24-hour nurse advice/nurse triage telephone number,
    - The Pharmacy toll-free call center telephone number.
    - Procedures to be followed for emergency services.
    - For DSHP and DSHP Plus members without Medicare dual coverage, the member's PCP.
    - For DSHP Plus LTSS members, "LTSS" on the front and back of the card.

NOTE: AmeriHealth Caritas Delaware ID cards are not returned to the Plan when a member becomes ineligible. Presentation of an AmeriHealth Caritas Delaware ID card is not proof that an individual is currently a member of the Plan. You are encouraged to request a picture ID to verify that the person presenting is the person named on the ID card. If you suspect a non-eligible person is using a member's ID card, please report the occurrence to our Fraud Waste and Abuse Hotline at **1-866-833-9718.**

Member Services and Member Advocates

A dedicated, 24/7/365 Member Services unit is available to help members with any questions about their coverage and services:

Phone

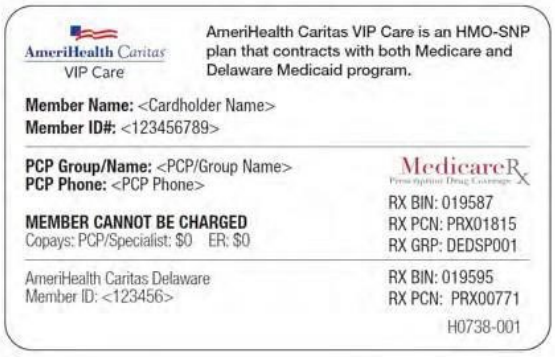
DSHP/DHCP: **1-844-211-0966 (TTY 1-855-349-6281**)

DSHP Plus/DSHP Plus LTSS: **1-855-777-6617 (TTY 1-855-362-5769)**

The Plan also employs a team of Member Advocates who are responsible for working with members, providers, and the member's case managers to assist in obtaining care for a member. Member Advocates are available to assist with scheduling appointments, navigation of the grievance and appeals process, and identification of resources necessary to help members with limited English proficiency or communication barriers. Members may call Member Services to be connected to a Member Advocate.

AmeriHealth Caritas Delaware Member ID Cards

AmeriHealth Caritas Delaware DSHP Member ID Cards



Member Rights and Responsibilities

As a provider, it is your responsibility to recognize the following member rights and responsibilities:

Member Rights:

- To be treated with dignity and respect.
- To receive health care in the comfort and convenience of a practitioner or provider office.
- To be sure others cannot hear or see them when they are getting health care.
- To have their health care records remain private, according to HIPAA rules.
- To receive free translation services as needed, including help with sign language, if hearing impaired.
- To participate in making decisions about their own health care, including the right to refuse treatment.
- To receive a full, clear and understandable explanation of treatment/service options and the risks of each option in order to make an informed decision, regardless of cost or benefit coverage.
- Female members have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. Female members have the right to designate as their PCP a participating provider or an advanced practicing registered nurse who specializes in obstetrics (OB) and gynecology (GYN).
- To have access to medical records in accordance with applicable federal and state laws.
- To choose a PCP from AmeriHealth Caritas Delaware's list of providers.
- To change a PCP and choose another one from AmeriHealth Caritas Delaware's list of providers.
- To choose an appropriate participating specialist as a PCP if there is a chronic, disabling, or life threatening health care condition.
- To file a complaint ("grievance") or appeal orally or in writing.
- To receive family planning services from the provider of choice.
- To be provided good quality care without unnecessary delay.
- To receive information on advance directives and assistance in preparing them; to choose not to have or continue any life-sustaining treatment.
- To receive a copy of the Member Handbook.
- To continue in current treatment until a new treatment plan is in place.
- To receive an explanation of prior authorization policies and procedures.
- To be aware of incentive plans for AmeriHealth Caritas Delaware's practitioners and providers.
- To receive a summary of the most recent patient satisfaction survey.
- To receive a copy of AmeriHealth Caritas Delaware's prescription drug formulary.
- To receive information about AmeriHealth Caritas Delaware, our services, our practitioners and providers and other health care workers, our facilities, and rights and responsibilities as a member.
- To make recommendations about the members' rights and responsibilities.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline,

convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.

- To seek a second opinion from a qualified health care professional within the network or out-of- network at no cost.
- To be informed of any cost-sharing obligations (excluding client participation) upon becoming a Plan member and at least 30 days prior to any change.
- To be informed within 10 days of any changes to client participation (patient liability)as determined by DHSS.
- To be informed about how and where to access any benefits that are available under other Delaware programs but are not covered by AmeriHealth Caritas Delaware.
- AmeriHealth Caritas Delaware Medicaid members have the right to receive non-emergency transportation to get health care services 24 hours a day, 365 days a year.
- To be informed regarding the potential obligations of cost for services furnished while an appeal is pending (if the outcome of the appeal is adverse to the member).
- To not be held liable for any debts in the event of AmeriHealth Caritas Delaware's insolvency.
- To request information on the structure of AmeriHealth Caritas Delaware.
- To be treated no differently by providers or by AmeriHealth Caritas Delaware for exercising the rights listed here.
- The right to fully participate in the community and to work, live and learn to the fullest extent possible.
- To have access to a full range of primary, acute, specialty services, behavioral health and long term services and supports, as needed, to achieve desired outcomes.

Member Responsibilities:

- To treat AmeriHealth Caritas Delaware employees, practitioners, and providers with respect.
- To show your Member ID card each time you visit your health care provider and make sure their office has a record that you are on Medicaid.
- To confirm that the provider is enrolled in Medicaid. Medicaid will not pay for the service or prescription if the provider is not a Medicaid provider.
- To comply with the rules of the Delaware Diamond State Health Plan and Delaware Diamond State Health Plan Plus programs and with the rules of AmeriHealth Caritas Delaware.
- To understand health conditions, participate in developing treatment/service goals and to follow the practitioner or provider's instructions for care after deciding what treatment is needed.
- To keep doctor's appointments or call to cancel at least 24 hours in advance.
- To ask questions, discuss personal health issues and listen to what treatment is needed.
- To know the difference between a true emergency and a condition needing urgent care.
- To seek medical services that are medically necessary.
- To know what an emergency is; how to keep emergencies from happening; and what to do if one does happen.
- To help get medical records from past providers.

- To report to AmeriHealth Caritas Delaware if injured in an accident or at work.
- To report to the DHSS and AmeriHealth Caritas Delaware if covered by other health insurance.
- To tell your medical provider, DHSS and AmeriHealth Caritas Delaware if anyone else is responsible for paying your medical bills.
- To report Medicaid fraud and abuse when suspected. Call the U.S. Department of Health & Human Service at **1-800-447-8477.**

Plan Privacy and Security Procedures

AmeriHealth Caritas Delaware complies with all federal and Delaware regulations regarding member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information as outlined in 45 CFR Parts 160 & 164. All member health and enrollment information is used, disseminated and stored according to Plan policies and guidelines to ensure its security, confidentiality and proper use. As an AmeriHealth Caritas Delaware provider, you are expected to be familiar with your responsibilities under HIPAA and 42 CFR, Part 2, which governs the confidentiality of alcohol and drug treatment information, and to take all necessary actions to fully comply.

SECTION II
Provider and Network Information

Section II: Provider and Network Information

This section provides information for maintaining network privileges and sets forth expectations and guidelines for PCPs, specialists, and facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all providers, including behavioral health providers and long term services and supports providers (LTSS). Additional information pertaining to behavioral health providers and LTSS providers, including specific credentialing and re-credentialing requirements are also provided in the "Behavioral Health Care" and "LTSS" sections of this *Provider Manual*.

Becoming a Plan Provider

AmeriHealth Caritas Delaware maintains and adheres to all applicable state and federal laws and regulations, Delaware Medicaid requirements, and accreditation standards governing credentialing and re-credentialing functions as defined by the National Committee on Quality Assurance (NCQA). All providers enrolled with AmeriHealth Caritas Delaware must also be enrolled with Delaware Medicaid.

Examples of Participating Network Provider Types

- Primary Care Providers (PCPs).
- Allied Health Providers.
- Maternal and Child Health Centers.
- Behavioral Health Providers.
- Ancillary and Hospital Providers.
- Other Safety Net Providers and Community Partners.
- Physician Specialists.
- Community-Based Residential Alternatives.
- Home Health Agencies.
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for behavioral health services.
- Home and Community Based Services (HCBS).
- Long-Term Services and Supports (LTSS) Providers.
- AIDs Providers.
- Acute Care Providers.

Provider Credentialing and Re-Credentialing

AmeriHealth Caritas Delaware is responsible for credentialing and re-credentialing its network of medical or physical health providers. Additional information pertaining to behavioral health providers, and LTSS providers including specific credentialing and re-credentialing requirements are also provided in the "Behavioral Health Care" and "LTSS" sections of this *Provider Manual*.
Hospital-based physicians are not required to be independently credentialed if those providers serve AmeriHealth Caritas Delaware members only through the inpatient setting and those providers are

credentialed by the hospitals. Hospital based providers include, but are not limited to, Pathologists, Anesthesiologists, Radiologists, Emergency Medicine, Neonatologists, and Hospitalists.

The following types of practitioners require initial credentialing and re-credentialing (at a minimum of every 36 months):

- Medical Doctor (MD).
- Doctor of Osteopathic Medicine (DO).
- Doctor of Dental Surgery (DDS).
- Doctor of Podiatric Medicine (DPM).
- Doctor of Chiropractic (DC).
- Doctor of Psychology (Psy.D.).
- Physical Therapist (PT).
- Occupational Therapist (OT).
- Speech and Language Therapist (SLT).
- Advanced Registered Nurse Practitioner (ARNP).
- Certified Registered Nurse Anesthetist (CRNA).
- Certified Nurse Midwife (CNM).
- Licensed Clinical Social Worker (LCSW).
- Doctor of Audiology (AuD).
- Optometrists who provide care under the medical benefit (OD).
- Behavioral Analyst (BCBA/BCABA).
- Registered Dietician (RD).
- Licensed Professional Counselor (LPC).
- Licensed Marriage and Family Therapist (LMFT).
- Substance Abuse Treatment Practitioner.

AmeriHealth Caritas Delaware also maintains criteria and processes to credential and re-credential the following ancillary and hospital provider types:

- Hospitals.
- Home Health Agencies/Home Health Hospice.
- Skilled Nursing Facilities (SNF).
- Nursing Homes.
- Durable Medical Equipment (DME)/Medical Supplies.
- Dialysis Centers.
- Hospice.
- Ambulatory Surgical Centers (ASC).
- Free Standing Radiology Centers.
- Behavioral Health Facilities.
- FQHCs/RHCs for behavioral healthcare only.
- Rehabilitative Agencies.

- Nursing Facility/Intermediate Care Facilities.
- Community Mental Health.
- Residential Care Facilities.
- Mental Hospitals.
- Community-Based Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID).
- Comprehensive Outpatient Rehabilitation Facilitates (CORFs).
- Sleep Center/Sleep Lab.
- Portable X-Ray Suppliers/Imaging Centers.

The criteria, verification methodology and processes used by AmeriHealth Caritas Delaware are designed to credential and re-credential practitioners and providers in a non-discriminatory manner, regardless of race, ethnic/national identity, gender, age, sexual orientation, specialty or procedures performed.

AmeriHealth Caritas Delaware's credentialing/re-credentialing criteria and standards are consistent with state and federal requirements and National Committee for Quality Assurance (NCQA) requirements. Practitioners are re-credentialed and facility/organizational providers are recertified at least every 36 months.

Council for Affordable Quality Healthcare (CAQH) and Online Credentialing

AmeriHealth Caritas Delaware works with the Council for Affordable Quality Healthcare (CAQH) to offer providers a Universal Provider Data source that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, providers submit credentialing information to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. All providers must be enrolled with CAQH. There is no charge to practitioners to participate and to submit CAQH applications. Practitioners are able to register for CAQH, if not already enrolled on the CAQH website at **www.caqh.org.**

Providers participating with CAQH or those who wish to participate with CAQH:

- Register for CAQH at **www.caqh.org**
- Grant authorization for AmeriHealth Caritas Delaware to view your information via the CAQH website;
- Fax or email your CAQH ID number, on the Provider Data Intake Form, to the AmeriHealth Caritas Delaware Credentialing department at:
    - **215-863-6369** or **CredentialingDE@amerihealthcaritas.com** (physical health providers);
    - **BehavioralHealthDE@amerihealthcaritas.com** (behavioral health providers).

Practitioner Credentialing Rights

During the review of the credentialing application, applicants are entitled to certain rights as listed below. Every applicant has the right to:

- Review the information submitted to support their credentialing application, with the exception of recommendations, and peer protected information obtained by AmeriHealth Caritas Delaware;
- Correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the provider provided, the Credentialing Department will notify the Health Care Provider to correct the discrepancy. The practitioner will have 10 business days to correct the erroneous information;
- Upon request, to be informed of the status of their credentialing or re-credentialing application. The Credentialing department will share all information with the provider with the exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the provider.
- Be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision; and,
- Appeal any initial or re-credentialing denial within 30 calendar days of receiving written notification of the decision.

To request or provide information for any of the above, the provider should contact AmeriHealth Caritas Delaware's Credentialing Department at the following address:

Address
Attn: Credentialing Department
AmeriHealth Caritas Delaware
200 Stevens Drive
Philadelphia, PA 19113

Phone: **1-866-423-1444**
Fax: **1-215-863-6369**

AmeriHealth Caritas Delaware Quality Assessment and Performance Improvement Program (QAPI) provide oversight of the Credentialing Committee. For more information on the QAPI, please refer to the "Quality Assessment and Performance Improvement Program" section of this *Provider Manual*.

Credentialing/Re-Credentialing for Practitioners

The following criteria must be met as applicable, in order to evaluate a qualified health care practitioner:

- Current, active, unrestrictive medical licensure, not subject to probation, proctoring

requirements or disciplinary action to specialty. A copy of the license must be submitted along with the application;

- Current, active, unrestrictive DEA license, if applicable (DEA licenses are not transferrable by State)
- Current, active, CDS/CSC license, if applicable;
- Evidence of professional liability insurance with limits of liability commensurate with State requirements;
- Current, active, Medicaid Enrollment;
- Individual NPI Number;
- Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the provider and documented in the following sources:
    - The National Practitioner Data Bank (NPDB)
    - Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
    - Medicaid and Medicare Exclusions
    - Federation of Chiropractic Licensing Boards (CIN-BAD)
    - System for Award Management (SAM)/EPPLS
    - Social Security Death Master File
    - Any other relevant State sanction and licensure databases as applicable.
- Disclosure related to ownership and management, business transactions and conviction of crimes, in accordance with federal and Delaware regulatory requirements; Owners with a 5% or more interest in the entity will be monitored through the OIG, SAM, NPPES, and the Social Security Death master file.
- Proof of the provider's medical school graduation, completion of residency and other postgraduate training;
- ECFMG Certificate for foreign medical school graduates;
- Evidence of specialty board certification, if applicable;
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the Practitioner in the past five (5) years;
- Work history containing current employment over the past (5) years, as well as explanation of any gaps in work history;
- CLIA Certificate, if applicable;
- Explanation to any affirmative answers to the Disclosure Questions on the application;
- Practitioners who require hospital privileges as part of their practice must have a hospital affiliation with an institution participating with AmeriHealth Caritas Delaware. PCPs must have the ability to admit AmeriHealth Caritas Delaware members as part of their hospital privileges. As an alternative, those practitioners who do not have hospital privileges may enter into an admitting arrangement agreement with a participating practitioner who is able to admit.

Practitioner Re-Credentialing

All providers are re-credentialed at a minimum of every 36 months, with the exception of HCBS

providers, who are re-credentialed at least annually. All items noted above under Credentialing, with the exception of education and work history, are also required at the time of re-credentialing.

All applications and attestation/release forms must be signed and dated within 305 days prior to the Credentialing Committee or Medical Director approval date. Additionally, all supporting documents must be current at the time of the decision date.

As part of the initial and re-credentialing application process, AmeriHealth Caritas Delaware will:

- Request information on practitioner and provider sanctions prior to making a credentialing or re-credentialing decision. Information from the National Practitioner Data Bank (NPDB), HHS Office of Inspector General (Medicaid/Medicare exclusions), System for Award management (SAM), Federation of Chiropractic Licensing Boards (CIN-BAD), Social Security Death Master File (SSDMF), and Excluded Parties List (EPLS) will be reviewed as applicable;
- Perform primary source verification on required items submitted with the application as required by NCQA, State, and Federal regulatory bodies;
- Performance review of complaints, quality of care issues and utilization issues will be reviewed at the time of re-credentialing;
- Maintain confidentiality of the information received for the purpose of credentialing and re-credentialing; and
- Safeguard all credentialing and re-credentialing documents by storing them in a secure location, only accessed by authorized Plan employees.

Presentation to the Medical Director or Credentialing Committee

Once all information is received and primary source verifications are completed the practitioner's file is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All non-routine (i.e., malpractice cases, license sanctions, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

Credentialing/Re-Credentialing for Ancillary/Hospital Providers

AmeriHealth Caritas Delaware verifies credentialing and re-credentialing criteria for all ancillary and hospital providers. Facility providers must meet the following criteria:

- Facility application with signature and current date from the appropriate facility officer;
- Attest to the accuracy and completeness of the information submitted to AmeriHealth Caritas Delaware;
- Documentation of any history of disciplinary actions, loss or limitation of license,

Medicare/Medicaid sanctions, or loss, limitation, or cancellation of professional liability insurance;

- Current, active, unrestrictive facility licensure not subject to probation, suspension, or other disciplinary action limits;
- AmeriHealth Caritas Delaware will confirm that the facility is in good standing with all State and regulatory bodies and has been reviewed by an accredited body as applicable;
- Current accreditation with an AmeriHealth Caritas Delaware recognized accrediting body, if applicable. If not accredited, a CMS State Survey is required. If the provider does not have either accreditation or a CMS State Survey, a Plan Site Visit must be conducted.
- Evidence of professional liability insurance with limits of liability commensurate with State requirements;
- Current, active, Medicaid Enrollment;
- Group NPI Number;
- Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the provider and documented in the following sources:
    - The National Provider Data Bank (NPDB).
    - Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).
    - Medicaid and Medicare Exclusions.
    - System for Award Management (SAM).
    - Excluded Parties List (EPLS).
    - Any other relevant State sanction and licensure databases as applicable.
- Disclosure related to ownership and management, business transactions and conviction of crimes, in accordance with federal and Delaware regulatory requirements (at the time of recertification only). All ancillary and facility owners with a 5% or more interest in the entity will be monitored through the OIG, SAM, NPPES, and the Social Security Death Master file.

As noted above, all providers are required to be recertified at a minimum of every 36 months with the exception of HCBS providers, who will be recertified at least annually. All information noted above will be collected and verified at the time of recertification.

Presentation to the Medical Director or Credentialing Committee

Once all information is received and primary source verifications are completed the practitioner/organizational providers file is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All non-routine (i.e., malpractice cases, license sanctions, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

Site Visits Resulting from Receipt of a Complaint and/or On-going Monitoring

Member Dissatisfaction Regarding Office Environment

- The Provider Services department or the Credentialing department may identify the need for a site visit due to receipt of a member dissatisfaction regarding the provider's office environment.
- At the discretion of the Provider Network Account Executive, a site visit may occur to address the specific issue(s) raised by a member. Follow-up site visits are conducted as necessary.
- For on-site reviews occurring due to a member complaint, the on-site review must demonstrate that the practitioner meets the Plan's quality, privacy and recordkeeping standards.
- If AmeriHealth Caritas Delaware standards are not met, the Account Executive develops an individualized written corrective action plan (CAP) with the practitioner's office to ensure that the area of concern is addressed.

Follow-Up Procedure for Initial Deficiencies

- The Provider Network Account Executive requests a corrective action plan from the office contact person. The corrective action plan must be submitted to AmeriHealth Caritas Delaware within one week of the visit.
- Each follow-up contact and visit is documented in the provider's electronic file.
- The Provider Network Account Executive schedules a re-evaluation visit with the provider office within 30 days of the initial site visit to review the site and verify that the deficiencies were corrected.
- The Provider Network Account Executive reviews the corrective action plan with the office contact person.
- The Provider Network Account Executive reviews the results of the follow-up visit (including a re-review of previous deficiencies) with the office contact person.
- If the site meets and/or exceeds Plan standards, a Site Visit Evaluation Form is signed and dated by both the Provider Network Account Executive and the office contact person.
- If the site does not meet and/or exceed Plan standards, the Provider Network Account Executive follows the procedures outlined below for follow-up for secondary deficiencies.

Follow-Up Procedure for Secondary Deficiencies

- The Provider Network Account Executive will re-evaluate the site monthly, up to three times

(from the first site visit date).

- If after four months, there is evidence the deficiency is not being corrected or completed, then the office receives a failing score unless there are extenuating circumstances.
- Further decisions as to whether to take action to terminate participation of a provider who continues to receive a failing Site Visit Evaluation score will be handled on a case-by-case basis by the AmeriHealth Caritas Delaware Medical Director.

Standards for Participation

By agreeing to provide services to AmeriHealth Caritas Delaware members, providers must:

- Be eligible to participate in any Delaware or federal health care benefit program.
- Comply with all pertinent Medicaid regulations.
- Treat AmeriHealth Caritas Delaware members in the same manner as other patients.
- Provide covered services to all AmeriHealth Caritas Delaware members who select or are referred to you as a provider.
- Provide covered services and not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual on the basis of health status or need for services, or race, color, or national origin, sex, sexual orientation, gender identity, or disability. All providers must comply with the requirements of the Americans with Disabilities Act (ADA) and Section 504 of Rehabilitation Act of 1974.
- Not segregate members from other patients (applies to services, supplies and equipment).
- Not refuse to provide services to members due to a delay in eligibility updates.

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, AmeriHealth Caritas Delaware may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other federal health care programs.

A sanctioned person is defined as any person or affiliate of a person who is (1) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other federal health care program; (2) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (3) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Upon request of AmeriHealth Caritas Delaware, a provider will be required to furnish a written certification to the Plan that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a sanctioned person.

A provider is required to immediately notify AmeriHealth Caritas Delaware upon knowledge that any of its employees, directors, officers or owners has become a sanctioned person, or is under any type of investigation which may result in their becoming a sanctioned person. In the event that a provider cannot provide reasonably satisfactory assurance to AmeriHealth Caritas Delaware that a sanctioned person will not receive payment from the Plan under the Provider Agreement, AmeriHealth Caritas Delaware may immediately terminate the Provider Agreement. The Plan reserves the right to recover all amounts paid by AmeriHealth Caritas Delaware for items or services furnished by a sanctioned person.

Access to Care

AmeriHealth Caritas Delaware providers must meet standard guidelines as outlined in this publication to help ensure that Plan members have timely access to care.

AmeriHealth Caritas Delaware endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. The Plan establishes mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for members should comply with the access standards defined below. The standards below apply to health care services and medical providers; please refer to the "Behavioral Health Care" section of this *Provider Manual* for the standards that apply to behavioral health care services and behavioral health providers.

AmeriHealth Caritas Delaware monitors the following access standards on an annual basis per Delaware guidelines. If a provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Network Account Executive or the Provider Services department at **1-855-707-5818.**

AmeriHealth Caritas Delaware Access Standards

Missed Appointment Tracking

If a member misses an appointment with a provider, the provider should document the missed appointment in the member's medical record. Providers should make at least three documented attempts to contact the member and determine the reason. The medical record should reflect any reasons for delays in providing health care, as a result of missed appointments, and should also include any refusals by the member. Providers are encouraged to advise AmeriHealth Caritas Delaware's Rapid Response team at **1-844-623-7090** if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.

After-Hours Accessibility

AmeriHealth Caritas Delaware members have access to quality, comprehensive health care services **24 hours a day, seven days a week.** PCPs must have either an answering machine or an answering service for members during after-hours for non-emergent issues. The answering service must forward calls to the PCP or on-call provider, or instruct the member that the provider will contact the member within 30 minutes. When an answering machine is used after hours, the answering machine must provide the member with a process for reaching a provider after hours. The after-hours coverage must be accessible using the medical office's daytime telephone number.

For emergent issues, both the answering service and answering machine must direct the member to call 911 or go to the nearest emergency room. AmeriHealth Caritas Delaware will monitor access to after-hours care on an annual basis by conducting a survey of PCP offices after normal business hours.

Monitoring Appointment Access and After-Hours Access

AmeriHealth Caritas Delaware will monitor appointment waiting times and after-hours access using various mechanisms, including:

- Reviewing provider records during site reviews;
- Monitoring administrative complaints and grievances; and,

- Conducting an annual Access to Care survey to assess member access to daytime appointments and after-hours care.

Non-compliant providers will be subject to corrective action and/or termination from the network, as follows:

- A non-compliance letter will be sent to the provider.
- The non-compliant provider will be re-surveyed within three to six months after the infraction.

1. Office Hours and Appointment Availability Standards

Participating Providers must offer hours of operation that are equal to or greater than the hours of operation offered to any other patient under commercial or any other insurance carrier. To ensure adherence to the appointment availability standards as defined below, per CMS or state requirements, the Plan will through access and availability calls.

General Appointment Availability

Provider Type	Appointment Type	Availability Standard
Primary Care Physician (PCP)	Emergency Services	Twenty-four (24) hours per day, seven (7) days per week
	Emergency Care	Same Day
	Urgent,	Two (2) calendar day
	Regular and Routine Care	Three (3)) weeks
Specialists and High-Volume / High Impact Specialists	Urgent Care	Within 48 hours
	Routine Appointments	Within three (3) weeks

Behavioral Health Appointment Availability

Provider Type	Appointment Type	Availability Standard
Behavioral Health Providers	Emergency Services	Within 24 hours of request
	Behavioral Health Crisis	Immediately including a mobile team
	Outpatient follow up for: Members being discharged from an inpatient residential setting to community placement and Member seen by a behavioral health crisis provider for a behavioral health condition	Within two (2) Business days
	Routine Outpatient Services	Within seven (7) calendar days of request with a non-prescribing clinician for an initial assessment
	Non-Emergency Outpatient Services	Within three (3) weeks of request for prescribing clinician

Maternity Care

Provider Type	Appointment Type	Availability Standard
OB/GYN/ Midwife	First Trimester	Appointments within three (3) weeks of member request.
	Second Trimester	Appointments within seven (7) calendar days of member request.
	Third Trimester	Appointments within three (3) calendar days of member request.
	High Risk Pregnancies	Appointment within three (3) calendar days of identification of high risk or immediately if an emergency exists

Panel Capacity and Notification

When members choose a provider as their PCP, they are assigned to the provider's panel of members.

The panel remains open unless the following occurs:

- The PCP is under sanction;
- The PCP has voluntarily closed his/her panel; or,
- The panel is closed by AmeriHealth Caritas Delaware due to member access issues.

AmeriHealth Caritas Delaware PCPs must have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards including CMS and/or Delaware guidance on this issue. PCPs are required to provide AmeriHealth Caritas Delaware with a quarterly report of current caseload, including non-Plan-member patients.

In evaluating the capacity of PCPs, AmeriHealth Caritas Delaware shall take into consideration both a PCP's existing AmeriHealth Caritas Delaware member load, overall member load (across all programs), Medicaid patient load, as well as its total patient load and will assess the overall patient load against community standards for any specialty involved.

AmeriHealth Caritas Delaware will also consider whether the provider is in compliance with the Access Standards set forth in this *Provider Manual*. AmeriHealth Caritas Delaware will not assign additional members to a single PCP if the Plan believes that PCP has reached the capacity to provide high quality services to Plan members.

Practitioner & Provider Responsibilities

Responsibilities of All Providers

AmeriHealth Caritas Delaware is regulated by Delaware and federal laws. Providers who participate in AmeriHealth Caritas Delaware have responsibilities, including but not limited to:

- Be compliant with all applicable federal and/or Delaware regulations.
- Treat AmeriHealth Caritas Delaware members in the same manner as other patients.
- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., vaccines for children (VFC), communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.
- Comply with all disease notification laws in Delaware.
- Provide information to AmeriHealth Caritas Delaware and/or the Delaware DHSS as required.

- Inform members about all treatment options, regardless of cost or whether such services are covered by the Plan or other programs.
- Maintain a communication network providing necessary information to any Mental Health/Substance Abuse (MH/SA) services provider as frequently as necessary based on the member's needs.
- As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment or transfer a member or otherwise discriminate against a member solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status or type of illness or condition, except when that illness or condition may be better treated by another provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the member's special needs.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Provider Agreement (to which this Provider Manual and any revisions or updates are incorporated by reference).
- Accept AmeriHealth Caritas Delaware payment or third party resource as payment-in-full for covered services.
- Comply fully with AmeriHealth Caritas Delaware's Quality Improvement, Utilization Management, Integrated Care Management, Credentialing and Audit Programs.
- Comply with all applicable training requirements as required by AmeriHealth Caritas Delaware, Delaware and/or CMS.
- Promptly notify AmeriHealth Caritas Delaware of claims processing payment or encounter data reporting errors.
- Maintain all records required by law regarding services rendered for the applicable period of time, making such records and other information available to AmeriHealth Caritas Delaware or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA Administrative Simplification and HITECH requirements.
- Immediately notify AmeriHealth Caritas Delaware of adverse actions against license or accreditation status.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.

- Notify AmeriHealth Caritas Delaware of the intent to terminate the Provider Agreement as a participating provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement.
- Verify member eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization for applicable services.
- Maintain hospital privileges when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- Report known or suspected child, elder or domestic abuse to local law authorities and have established procedures for these cases.
- Inform member(s) of the availability of AmeriHealth Caritas Delaware's interpretive services and encourage the use of such services, as needed.
- Notify AmeriHealth Caritas Delaware of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the Provider Agreement.
- Maintain oversight of non-physician practitioners as mandated by Delaware and federal law.
- Agreeing that claims data, medical records, practitioner and provider performance data, and other sources of information, may be used by the Plan to measure and improve the health care delivery services to members.

Primary Care Provider (PCP) Responsibilities

A Primary Care Provider (PCP) serves as the member's personal practitioner and is responsible for coordinating and managing the medical needs of a panel of AmeriHealth Caritas Delaware members. Advanced Nurse Practitioners, Nurse Midwives, and Licensed Physicians in the following specialties may serve as Plan PCPs:

- General Practice
- Pediatrics
- Internal Medicine
- Geriatrics
- Obstetrics/Gynecology
- Family Practice

A PCP is responsible to AmeriHealth Caritas Delaware and its members for diagnostic services, care planning and Treatment Plan development. The PCP is expected to work with the Plan to monitor treatment planning and provision of treatment.

All new AmeriHealth Caritas Delaware adult and child members with a newly-assigned PCP, who has not previously cared for the member, must receive a comprehensive initial examination and a screening for mental health and substance abuse. The mental health and substance abuse screening must be completed using a validated screening tool, approved by AmeriHealth Caritas Delaware. This screening tool can be found under the "Forms" in the provider section of our website at **www.amerihealthcaritasde.com**.

For the initial examination and assessment of a child, the PCP is required to perform the relevant screenings and services, as well as any additional assessment, using the appropriate tools to determine whether or not a child has special health care needs. All Medicaid-covered children under 21 years of age receive EPSDT services.

For on-going care, the mental health and substance abuse screening must also be administered as a routine part of every child and adult preventive health examination.

AmeriHealth Caritas Delaware PCPs are also expected to assist members with accessing substance abuse, mental health services, and long term services and supports as needed. The Rapid Response team is available to members and providers to support care coordination and access to services. Members and providers may request Rapid Response support by calling **1-844-623-7090.**

In addition, the PCP is responsible for:

- Providing continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours, seven days per week.
- Managing and coordinating the health care of a member with a participating specialist(s), and/or behavioral health provider;
- Providing covered services to all assigned members and complying with all requirements for prior authorization.
- Providing assigned members with a medical home including, when medically necessary, coordinating appropriate referrals to services that typically extend beyond those services provided by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA),ancillary services, public health services and other community based agency services.
- Adhering to Delaware's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Periodicity Schedule for members under age 21.
- Early identification of all members, including children, with special health care needs or behavioral health needs and notification to the Rapid Response team and/or referral to PROMISE regarding any such identification as soon as possible;
- Collaboration with AmeriHealth Caritas Delaware's Integrated Care Management programs to facilitate member care;
- Use of a valid and standardized developmental screening tool, approved by the Plan, to screen

for developmental delays during well-child visits, episodic visits or as a stand-alone service;

- Referral of a child, identified as having a developmental delay, to the appropriate specialist for a comprehensive developmental evaluation;
- Documentation of all diagnoses and care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas Delaware's medical record documentation requirements;
- Providing follow-up services for members who have been seen in the Emergency Department;
- Promptly and accurately reporting all member encounters to AmeriHealth Caritas Delaware;
- Releasing medical record information upon written consent or request of the member;
- Ensuring the release of medical records when a member changes PCPs. His/her medical records or copies of medical records should be forwarded to the new PCP within 10 business days from receipt of request. The State is not required to obtain written approval from a member before requesting the member's record from the PCP or any other participating provider. Providing preventive healthcare to members according to established preventive health care guidelines;
- Advising the Rapid Response team at **1-844-623-7090** if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.
- Advising AmeriHealth Caritas Delaware ninety (90) days in advance of the effective date if they elect to decline accepting additional members.
- Advising AmeriHealth Caritas Delaware at least 60 days in advance of any addition or change in office location.

OB/GYN Practitioner as a PCP

Participating Obstetricians are responsible for medical services during the course of the member's pregnancy, and for coordinating testing and referral services. Obstetricians may also provide routine primary care and treatment to pregnant members under their care. Examples of routine primary care include but are not limited to:

- Treatment of minor colds, sore throat, asthma.
- Treatment of minor physical injuries.
- Preventive health screenings and maintenance.
- Routine gynecological care.

The OB/GYN is also responsible for notifying the Bright Start® Care Managers at **1-833-669-7672** for assistance with support services needed to help a member during pregnancy.

Prenatal care providers are expected to complete the Obstetrical Needs Assessment Form (ONAF) to

assess risk for each expectant mother. The completed screening tool must be submitted to AmeriHealth Caritas Delaware as part of the authorization for obstetric services.

It is the provider's responsibility to address identified risk factors upon contact with the member and to develop appropriate action items in collaboration with the member to resolve the identified risks. Pregnancies that are considered high-risk due to physical, social or behavioral conditions must also be reported to the Plan at the time of the first visit or at the time when the high-risk situation is identified during the pregnancy. All high-risk conditions should be reported to a Bright Start® Care Manager at **1-833-669-7672.** Providers can fax reports to Bright Start® at: **1-855-558-0488.**

Specialist Responsibilities

An AmeriHealth Caritas Delaware specialist is responsible for:

- Providing specialty care as indicated by the referring practitioner;
- Reporting clinical findings to the referring PCP;
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the member, as requested by the referring practitioner;
- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas Delaware's medical record documentation requirements;
- Refraining from referring members to other specialists without the intervention of the member's PCP;
- Verifying a member's eligibility prior to the provision of services.

Compliance Responsibilities

AmeriHealth Caritas Delaware providers are required to comply with all Plan policies and with all relevant legal or regulatory standards, as set by outside legal or regulatory authorities. Although not an exclusive list, the primary areas of compliance with policies and regulations for Plan providers are:

- Americans with Disabilities Act (ADA) / Rehabilitation Act
- Health Insurance Portability and Accountability Act (HIPAA)
- Program Integrity
- Fraud, Waste & Abuse (FWA)
- False Claims Act
- Advance Directives
- Marketing Activities Guidelines
- Section 1557 of the Patient Protection and Affordable Care Act

The Americans with Disabilities Act (ADA) and the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 ("Rehab Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require the Plan's providers to make their services and facilities accessible to all individuals. AmeriHealth Caritas
Delaware expects its network providers to be familiar with the requirements of the Rehabilitation Act and the ADA and to fully comply with the requirements of these statutes.

Health Insurance Portability and Accountability Act (HIPAA)

AmeriHealth Caritas Delaware is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects its practitioners and providers to be familiar with their HIPAA responsibilities and to take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other data on a member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

Program Integrity

AmeriHealth Caritas Delaware is obligated to ensure the effective use and management of public resources in the delivery of services to its Members. AmeriHealth Caritas Delaware does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of AmeriHealth Caritas Delaware regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

- **Prospective (Pre-claims payment)**
  - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies or AmeriHealth Caritas Delaware medical/claim payment policy) are applied to prepaid claims.
  - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
    - *Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.*
  - Coordination of Benefits ("COB") - Process to verify third party liability to ensure that AmeriHealth Caritas Delaware is only paying claims for members where AmeriHealth Caritas Delaware is responsible, i.e. where there is no other health insurance coverage.
  - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.
- **Retrospective (Post-claims payment)**
  - Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation – As a Medicaid plan, AmeriHealth Caritas Delaware is the payor of last resort. The effect of

this rule is if [Plan Name] determines a member has other health insurance coverage, payments made by [Plan Name] may be recovered.
    - Please also see Section IX: Claims Submission Protocols and Standards, for further description of TPL/COB/Subrogation.
    - Data Mining – Using paid claims data, AmeriHealth Caritas Delaware identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
    - Medical Records Review/Itemized Bill review – a Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation of procedures, diagnosis or diagnosis-related group ("DRG") billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
        - *Please note if medical records are not received within the requested timeframe, AmeriHealth Caritas Delaware will recoup funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.*

- **Credit Balance Issues**
    - Credit balance review service conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
    - Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

The programs listed above for Program Integrity will interface to the providers via written communications via letters, fax and in some cases email. If you have any questions regarding the programs or the written communications about these programs and actions that you need to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

False Claims Act

The False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. When AmeriHealth Caritas Delaware submits claims data to the government for payment (for example, submitting Medicaid claims data to the Delaware Department of Human Services), we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted on our behalf from our subcontractors, and we monitor their work to ensure compliance.

Health care entities that violate the Federal FCA can be subject to imprisonment and civil monetary penalties ranging from $10,957 to $21,915 for each false claim submitted to the United States government or its contactors, including state Medicaid agencies, as well as possible exclusion from Federal Government health care programs. These minimum and maximum penalties have been updated to reflect the Civil Monetary Penalties Inflation Adjustment Interim Final Rule by the Department of Justice published on June 30, 2016, with an effective date of August 1, 2016.

The Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the False Claims Act (FCA). Penalties for violations of FERA are comparable to penalties for violation of the FCA. FERA does the following:

- Expands potential liability under the FCA for government contractors like AmeriHealth Caritas Delaware.
- Expands the definition of false/fraudulent claim to include claims presented not only the government itself, but also to a government contractor like AmeriHealth Caritas Delaware.
- Expands the definition of false record to include any record that is material to a false/fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

Program Integrity Operations Team

AmeriHealth Caritas Delaware is obligated to ensure the effective use and management of public resources in the delivery of services to its Members. AmeriHealth Caritas Delaware does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of AmeriHealth Caritas Delaware, regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third-party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

- Prospective (Pre-claims payment)
    - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies or AmeriHealth Caritas Delaware medical/claim payment policy) are applied to prepaid claims.
    - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
        - *Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.*
    - Coordination of Benefits ("COB") - Process to verify third-party liability
    - to ensure that AmeriHealth Caritas Delaware is only paying claims for members where AmeriHealth Caritas Delaware is responsible, i.e. where there is no other health insurance coverage.
    - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.
- Retrospective (Post-claims payment)
    - Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation – As a Medicaid plan, AmeriHealth Caritas Delaware is the payor of last resort. The effect of this rule is if AmeriHealth Caritas Delaware determines a member has other health insurance coverage, payments made by AmeriHealth Caritas Delaware may be recovered.
    - Please also see Section IX for further description of TPL/COB/Subrogation.
    - Data Mining – Using paid claims data, AmeriHealth Caritas Delaware identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
    - Medical Records Review/Itemized Bill review – a Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation of procedures, diagnosis, or diagnosis-related group ("DRG") billed by the provider. Other medical record reviews include but are not limited to, place of service validation, re-admission review, and pharmacy utilization review.
        - *Please note if medical records are not received within the requested timeframe, AmeriHealth Caritas Delaware will recoup funds from the provider. Your failure to*

provide medical records creates a presumption that the claim as submitted is not supported by the records.

- Credit Balance Issues
    - Credit balance review service conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
    - Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

The programs listed above for Program Integrity will interface to the providers via written communications via letters, fax, and in some cases email. If you have any questions regarding the programs or the written communications about these programs and actions that you need to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Claims Cost Containment Unit

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted by the Program Integrity department for potential recovery. Claims submitted to the Claims Cost Containment Unit for review are outside of the Subrogation and Check Reconciliation areas. Some examples of identified "waste" include:

- Incorrect billing from providers causing overpayment.
- Overpayment due to incorrect set-up or update of contract/fee schedules in the system.
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments.
- Overpayments resulting from incorrect revenue/ procedure codes, retro TPL/Eligibility.

The Claims Cost Containment Unit is also responsible for the manual review of provider initiated overpayments. Providers who self-identify claim overpayments may submit their inquiries for review to the following address:

Claims Cost Containment

PO Box 80100
London, Kentucky 40742-0100

Refunds for Claims Overpayments or Errors

AmeriHealth Caritas Delaware and DHSS encourage Providers to conduct regular self-audits to ensure accurate payment. Medicaid Program funds that were improperly paid or overpaid must be returned. If the Provider's practice determines that it has received overpayments or improper payments, the Provider is required to make arrangements immediately to return the funds to AmeriHealth Caritas Delaware or follow the DHSS protocol for returning improper payments or overpayments:

1. Contact AmeriHealth Caritas Delaware Provider Claim Services at **1-855-707-5818** to arrange the repayment. There are two ways to return overpayments to AmeriHealth Caritas Delaware:
    a. Have AmeriHealth Caritas Delaware deduct the overpayment/improper payment amount from future claims payments, or
    b. Return the overpayments directly to AmeriHealth Caritas Delaware:
        i. Use the Provider Claim Refund form when submitting return payments to AmeriHealth Caritas Delaware. A sample form can be found in the Appendix of the manual and is available on the Provider Center at **www.amerihealthcaritasde.com** under Forms.
        ii. Mail the completed form and refund check for the overpayment/improper payment amount to:
        Claims Processing Department
        AmeriHealth Caritas Delaware
        PO Box 80100
        London, KY 40742-0100

Note: Please include the Member's name and ID, date of service, and Claim ID

Special Investigations Unit – Preventing, Detecting, and Investigating Fraud, Waste and Abuse

Special Investigations Unit

AmeriHealth Caritas Delaware is a member of the AmeriHealth Caritas Family of Companies (AmeriHealth Caritas). AmeriHealth Caritas has an established enterprise-wide Program Integrity department with a proven record in preventing, detecting, investigating, and mitigating fraud, waste, and abuse. Our existing program has been developed in accordance with 42 CFR § 438.608, 42 CFR Part 455, the governing contracts between AmeriHealth Caritas and the State of Delaware, and

applicable federal and state laws. The Program Integrity department has cross-functional teams that support its activities to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with the requirements as set forth in 42 C.F.R. Part 438, Subpart H (Certifications and Program Integrity) and 42 C.F.R. § 457.950(a)(2).

The Special Investigations Unit (SIU) is housed within the Program Integrity department. The SIU team is responsible for detecting fraud, waste, and abuse throughout the claims payment processes for AmeriHealth Caritas. The SIU staff includes experienced investigators and analysts, including Certified Professional Coders, Certified Fraud Examiners, and Accredited Health Care Fraud Investigators.

Among other things, the SIU conducts the following activities:

- Reviews and investigates all allegations of fraud, waste and abuse.
- Takes corrective actions for any supported allegations after thorough investigation, including recovering overpayments that result from fraud, waste, or abuse.
- Reports confirmed misconduct to the appropriate parties and/or agencies.

Definitions of Fraud, Waste and Abuse (FWA)

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal and state law.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse – includes provider reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the health program.

Fraud & Abuse – Summary of Relevant Laws and Examples

AmeriHealth Caritas Delaware is dedicated to eradicating Fraud and Abuse from its programs and cooperates in Fraud and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Unit of the Delaware Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the federal Office of Inspector General of the U.S. Department of Health and Human Services, as well as the Bureau of Program Integrity of the Delaware Department of Human Services. As part of AmeriHealth Caritas Delaware's responsibilities, the Program Integrity department, and the SIU in particular, is responsible for identifying and recovering overpayments. The SIU performs several operational activities to detect and prevent fraudulent and/or abusive activities.

The Federal False Claims Act

The False Claims Act (FCA) is a federal law that prohibits knowingly presenting, or causing to be presented, a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. Penalties for violating the FCA include damages in the amount of up to three times the amount of the false claim plus civil penalties of $10,957 to $21,915 per false claim.

The FCA contains a whistleblower provision to encourage individuals to report misconduct involving false claims. The whistleblower provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The whistleblower provisions of the FCA protects individuals from retaliation that results from filing an action under the FCA, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

The Federal Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the FCA. Penalties for violations of FERA are comparable to penalties for violation of the FCA.

Among other things, FERA:

- Expands potential liability under the FCA for government contractors like AmeriHealth Caritas Delaware.
- Expands the definition of a false or fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like AmeriHealth Caritas Delaware.
- Expands the definition of a false record to include any record that is material to a false or fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

The Delaware False Claims and Reporting Act (DFCRA), 6 Del. Code Ann. §§ 1201-1211

The Delaware False Claims and Reporting Act, enables private citizens to file "qui tam" lawsuits on behalf of the State of Delaware if they have knowledge that an individual or entity is submitting false or fraudulent claims to Medicaid. The DFCRA imposes liability on defendants who knowingly present, or cause to be presented, a false claim for payment to state Medicaid; who knowingly make or use a false statement to collect a fraudulent or false payment; who misappropriates state property; or who conceal, avoid or decrease an obligation to pay or transmit property to the state.

Penalties for violating the DFCRA include treble damages, plus civil penalties ranging from $5,500 to $11,000 per false claim. Defendants who voluntarily disclose violations within 30 days – where no investigation is pending at the time of disclosure – and defendants who cooperate with any investigation into the violations, may have penalties reduced to not less than twice the damages.

No employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste by a public body or an instance of waste by any other employer as defined in the act. In addition, no employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee is requested by an appropriate authority to participate in an investigation, hearing or inquiry held by an appropriate authority or in a court action. A person who, under color of an employer's authority, violates this act shall be liable for a civil fine of not more than $10,000.

In addition, a whistleblower that is retaliated against may bring an action in court and seek the following relief: reinstatement, the payment of back wages, full reinstatement of fringe benefits and seniority rights, actual damages, or any combination of these remedies. A court shall also award the whistleblower all or a portion of the costs of litigation, including reasonable attorney's fees, if the whistleblower prevails in the civil action.

Examples of fraudulent/abusive activities:

- Billing for services not rendered or not medically necessary.
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients.
- Prescribing items or referring services which are not medically necessary.
- Misrepresenting the services rendered.
- Submitting a claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs.
- Retaining Medicaid funds that were improperly paid.
- Billing Medicaid recipients for covered services.
- Failing to perform services required under a capitated contractual arrangement.
- Misrepresenting dates and times of service.
- Misusing Electronic Medical Records, such as by cloning and copying so records are identical, not unique, and/or specific as required.
- Failing to have supporting documentation for billed services.

AmeriHealth Caritas Delaware receives state and federal funding for payment of services provided to our members. In accepting claims payment from AmeriHealth Caritas Delaware, providers are receiving Delaware and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse against the medical assistance program. Compliance with federal laws and regulations is a priority of AmeriHealth Caritas Delaware.

If you, or any entity with which you contract to provide health care services on behalf of AmeriHealth Caritas Delaware beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact AmeriHealth Caritas Delaware by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**.
- Emailing to **fraudtip@amerihealthcaritas.com**; or
- Mailing a written statement to:
  Special Investigations Unit
  AmeriHealth Caritas Delaware
  200 Stevens Drive
  Philadelphia, PA, 19113

Below are examples of information that will assist the Plan with an investigation:

- Contact Information (e.g. name of individual making the allegation, address, telephone number).
- Name and Identification Number of the Suspected Individual.
- Source of the Complaint (including the type of item or service involved in the allegation).
- Approximate Dollars Involved (if known).
- Place of Service.
- Description of the Alleged Fraudulent or Abuse Activities.
- Timeframe of the Allegation(s).

Providers may also report suspected fraud, waste, and abuse directly to the Delaware Division of Medicaid & Medical Assistance through one of the following methods:

Phone
General: **1-800-372-2022**
New Castle County: **302-255-9500**
Kent and Sussex County: **302-739-2123**

Email

SURreferrals@state.de.us

Fax
1-302-255-4425, Attn: SUR Unit

Mail
Division of Medicaid & Medical Assistance,
Surveillance and Utilization Review (SUR) Unit
Lewis Building
P.O. Box 906
New Castle, DE 19720

What to Expect as a Result of SIU Activities

The SIU must review all complaints that are received and, as a result, you may be asked to provide certain information in order for the SIU to thoroughly look at all complaints. The SIU utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from AmeriHealth Caritas Delaware, or on behalf of AmeriHealth Caritas Delaware, regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns

- You may also be contacted by the SIU Intake Unit to verify a complaint you filed.
- You may be contacted by an investigator in regards to a complaint they are investigating which may or may not concern you.
- As a provider you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records. Keep in mind that per your provider agreement, you are required to provide the records for review.

Provider agrees to cooperate with AmeriHealth Caritas Delaware in maintaining and providing to AmeriHealth Caritas Delaware or the Department, at no cost to them, medical records, financial data, administrative materials and other records related to services to members as may be reasonably requested by AmeriHealth Caritas Delaware and/or the Department.

After an investigation is completed there are a number of things that may occur such as a determination that the complaint was unfounded or a referral to: (1) the Bureau of Program Integrity for the Delaware Department of Human Services, (2) the Delaware Office of Attorney General, Medicaid Fraud Control Unit or (3) the federal Office of Inspector General for further investigation. You may receive an overpayment letter that outlines what was found and if monies are owed. You could also receive and education letter that outlines proper procedures that are to be followed for future reference. You could be placed on prepayment review.

Advanced Directives

All participating Plan providers are required to facilitate advance directives for individuals as defined in 42 C.F.R 489.100. The Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to providing health care when an individual is incapacitated. If a member is an adult (18 years of age or older), he/she has the right under federal law to decide what health care that he/she wants to receive, if in the future the member is unable to make his/her wishes known about medical treatment. Providers are required to document in the member's medical record and plan of care whether or not the member has executed an Advance Directive. The member has the right to choose a person to act on his or her behalf to make health care decisions for them, if the members cannot make the decision for themselves.

AmeriHealth Caritas Delaware requires its contracted providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advanced directives must be furnished by providers and/or organizations as required by federal regulations:

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.
- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

Additionally, providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.
- Implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive; state law allows any health care provider or any agent of such provider to conscientiously object.

Provider Marketing Activities Guidelines

As a contracted provider, you are permitted to share the following with Plan members:

- General and factual information about AmeriHealth Caritas Delaware and your participation in the Plan's network.
- Plan-provided member education materials that have been approved by the Plan and the Delaware DHSS.
- Contact information for the Delaware Health Benefits Manager (HBM).

As a contracted provider, you are prohibited from participating in the following activities:

- Conducting any mass marketing to individuals or the general public with the intention of inducing patients to join a particular Medicaid plan or to transfer from one plan to another. Mass marketing includes use of any mass media outlets such as radio, television, and newspaper advertisements.
- Using written or oral methods of communication with members to assert or imply that the member must enroll in a specific Medicaid health plan to obtain Medicaid benefits or in order not to lose Medicaid benefits.
- Using written or oral methods of communication with members to compare benefits or other aspects of Medicaid managed care organizations.
- Using written or oral methods of communication to share false or misleading information regarding the Plan or the provision of services, including suggesting that any particular Medicaid plan is uniquely endorsed by a government entity.
- Performing direct marketing activities or other marketing activities on behalf of the Plan, including the sale or offering of any incentives such as private insurance or gifts.
- Performing or permitting any marketing activities on behalf of the Plan at your office location.
- Using marketing materials that have not been approved by the Plan and the Delaware DHSS.
- Assisting with or making recommendations for enrollment with the Plan, except to refer prospective members to the Delaware Health Benefits Manager (HBM).

Provider Support and Accountability

Provider Network Management

AmeriHealth Caritas Delaware's Provider Network Account Executives function as a provider relations team to advise and educate AmeriHealth Caritas Delaware providers. Provider Network Account Executives assist providers in adopting new business policies, processes and initiatives. From time to time, providers will be contacted by Plan representatives to conduct meetings that address topics including, but not limited to:

- Contract Terms.
- Credentialing or Re-credentialing Site Visits.
- Health Management Programs.
- Orientation, Education, and Training.
- Program Updates and Changes.
- Provider Complaints.
- Provider Responsibilities.

- Quality Enhancements.
- Self-Service Tools.

New Provider Orientation

Upon completion of AmeriHealth Caritas Delaware's contracting and credentialing processes, the provider receives a welcome letter, which includes the effective date, AmeriHealth Caritas Delaware provider ID, and the Provider Network Account Executive's contact information. The welcome letter refers all Plan providers to online resources, including AmeriHealth Caritas Delaware provider orientation and training information and this *Provider Manual*. The *Provider Manual* serves as a source of information regarding the Plan's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to support provider compliance with all provider contract requirements. The welcome letter explains how to request a hard copy of this Provider Manual by contacting the Provider Services department at **1-855-707-5818.**

Orientation Training

AmeriHealth Caritas Delaware will conduct initial training within 30 days of placing a newly contracted provider, or provider group, on active status upon request. Orientation training topics will include:

- Medicaid Program Overview.
- Member Access Standards.
- Credentialing Processes.
- Provider Responsibilities (including Advance Directives, Fraud, Waste & Abuse, Reporting.
- Requirements, IDEA, HIPAA and Privacy, etc.).
- Cultural Competency.
- Plan Policies and Procedures.
- Utilization Management, Quality Improvement and Integrated Care Management Programs.
- Medical Necessity Criteria, Clinical Practice Guidelines, and Screening Tools.
- Medicaid Compliance.
- Covered Services, Benefit Limitations, and Value-Added Services.
- Co-Pays.
- Provider Inquiry and Complaint Processes.
- Billing, Claims Filing, and Encounter Data Reporting.
- Electronic Funds Transfer and Electronic Remittance Advice.
- Quality Enhancement Programs/Community Resources.
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements.

Mandatory Provider Trainings & Meetings

At a minimum, AmeriHealth Caritas Delaware will provide training on the following topics as required by Delaware DHSS:

- Development and implementation of provider practice that support wellness, disease management, and health education for members.
- Sensitivity to the special needs of the Medicaid population.
- LTSS provider training, as applicable.

Provider Education and On-Going Training

AmeriHealth Caritas Delaware's training and development are fundamental components of continuous quality and superior service. The Plan offers on-going educational opportunities for providers and their staff. The Plan is committed to offering appropriate training and education to help providers achieve compliance with Plan standards, and federal and state regulations. Provider training and educational programs are based on routine assessments of provider training and educational needs. This training may occur in the form of an on-site visit or in an electronic format, such as online or interactive training sessions. Detailed information is shared in advance of training opportunities and is available on the AmeriHealth Caritas Delaware website at **www.amerihealthcaritasde.com**.

Plan-to-Provider Communications

Providers will receive or have access to regular communications from AmeriHealth Caritas Delaware including, but not limited to the following:

- Provider manual.
- Provider newsletters.
- Website updates and information.
- Provider notices and announcements.
- Surveys.
- Faxes.
- Emails.
- Miscellaneous other materials.

Provider Complaint System

A complaint is a request from a health care provider to change a decision made by AmeriHealth Caritas Delaware related to claim payment, policy procedure or administrative functions, or denial for services already provided. A provider complaint is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

A provider may file a written complaint no later than 12 months from the date of service or 60 calendar days after the payment, denial, or recoupment of a timely claims submission, whichever is latest. Any complaint that is not related to claims payment (Administrative Complaints) must be submitted in writing no later than 45 days from the date of the occurrence.

Address
AmeriHealth Caritas Delaware
P.O. Box 80101
London, KY 40742-0101

Fax
1-855-347-0023.

At a minimum, AmeriHealth Caritas Delaware will take the following actions in response:

- Notify providers of receipt of complaint within 3 days of its receipt; include anticipated resolution date.
- Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions. All pertinent facts will be investigated and considered. AmeriHealth Caritas Delaware's policies and procedures will also be considered.
- Document why complaints are unresolved after 30 calendar days and send written notice of complaint status to the provider every 30 calendar days thereafter.
- A written notice of the outcome will be sent to the provider within 90 days of receipt of the complaint or within 3 business days of complaint resolution, whichever is sooner.

If any dispute regarding a claim remains unresolved following the exhaustion of the applicable provider grievance process, you must notify AmeriHealth Caritas Delaware of your intention to commence litigation or arbitration, as appropriate, at least sixty (60) days in advance of filing litigation or arbitration. Such notice is a condition precedent for any litigation or arbitration. Failure to exhaust the applicable grievance process shall be a total and complete defense to claims brought in litigation or arbitration. To the extent that applicable law requires provider claim disputes to proceed exclusively through any applicable State fair hearing or other administrative process, you must use that process and may not pursue litigation or arbitration as a substitute for that process.

Provider Contract Terminations

AmeriHealth Caritas Delaware Provider Agreements specify termination provisions that comply with the Delaware DHSS requirements. Provider terminations are categorized as follows:

- Provider Initiated
- Plan Initiated "For Cause"
- Plan Initiated "Without Cause"
- Mutual

In addition to those requirements identified in the Provider Agreement, AmeriHealth Caritas Delaware will comply with the following guidelines, based on category of termination.

Provider Initiated

1. The provider must provide ninety (90) days prior written notice to the Plan if intending to terminate from the Plan network for cause. The notice of termination for cause will not be effective if the breaching party cures the breach within the first sixty (60) days of the ninety (90) day notice period. In the event that the breaching party does not cure the breach within the sixty (60) day period, the effective date of termination will be the first of the month following the expiration of the ninety (90) day notice period.

2. The provider must provide ninety (90) days prior written notice to the Plan if intending to terminate from the Plan network without cause.
3. Under either circumstance, written notice must be delivered in accordance with the method(s) specified in your Provider Agreement and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.
4. If the provider is a PCP, the Plan will send a written notification to the members who have chosen the provider as their PCP no less than 15 calendar days after receipt of the termination notice or at least 30 days prior to the termination date, whichever is sooner.
5. If a Plan member has special health care needs and his or her treating provider gives notice of termination with the Plan, Member Services and/or Case Management staff will personally contact the member by telephone and in writing to provide assistance in securing a new provider.

Plan Initiated "For Cause"

AmeriHealth Caritas Delaware may initiate termination of a Provider Agreement if the provider breaches the Plan Provider Agreement. A "for cause" termination may be implemented when there is a need to terminate a provider's contract. Depending upon the nature of the breach, the provider may be given an opportunity to "cure" the breach and, if successful, the termination will be rescinded. However, there are instances where the breach is incapable of being cured and the termination will become effective immediately. The provider should review his or her participation agreement for the circumstances that justify an immediate for cause termination. If terminating a Provider Agreement for cause, the Plan will:

- Send applicable termination letters in accordance with the notification provisions of the Provider Agreement.
- Notify the provider, the Delaware DHSS, and the member immediately in cases where an AmeriHealth Caritas Delaware member's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the Delaware Board of Medicine or other governmental agency.
- Provide the Delaware DHSS with reason(s) for termination for cause.
- Offer appeal rights for physicians, as applicable.

Plan Initiated "Without Cause"

AmeriHealth Caritas Delaware may terminate a Provider Agreement "without cause" for various

reasons (e.g. provider relocation or dissolution of a medical practice). If this occurs, the Plan will:

- Send applicable termination letters in accordance with the notification provisions of the Provider Agreement.
- Notify the Plan network provider, the Delaware DHSS, and members in active care at least30 calendar days before the effective date of the termination.
- Fax all AmeriHealth Caritas Delaware termination letters to the Delaware DHSS.
- Offer appeal rights to physicians, as applicable.

Mutual Terminations

A mutual termination is a termination of a Provider Agreement(s) in which the effective date is agreed upon by both parties. The termination date may be other than the required days' notice specific to the Plan's Provider Agreement language.

- All mutual termination letters require signatures by both parties.
- Regarding mutual terminations of any AmeriHealth Caritas Delaware Provider Agreement, the termination date should provide a minimum number of required days in order to provide notice to members. A mutual agreement termination date should not be a retroactive date.
- AmeriHealth Caritas Delaware will notify the Delaware DHSS and members in active care at least 30 calendar days before the effective date of the termination.

Continuity of Care

Plan members who are in active treatment at the time a Provider Agreement terminates will be allowed to continue care with a terminated treating provider, pursuant to the terms of the Provider Agreement, but no less than through the earlier of:

- Completion of treatment for a condition for which the member was receiving care at the time of the termination; or,
- Until the member changes to a new provider.

AmeriHealth Caritas Delaware will allow pregnant members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider through the completion of postpartum care.

Notwithstanding the provisions in this section, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant.

For continued care, AmeriHealth Caritas Delaware and the terminated provider will continue to abide by the same terms and conditions as outlined in the Provider Agreement and in the "Quality

Assurance and Performance Improvement Program" section of this *Provider Manual*. These provisions for continuity of care set forth above will not apply to providers who have been terminated from AmeriHealth Caritas Delaware for cause.

SECTION III
Provision of Services

Section III: Provision of Services

This section provides a summary of the covered services offered to AmeriHealth Caritas Delaware members under the Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP Plus) programs.

No content found in this publication or in the Plan's participating Provider Agreement is intended to prohibit or otherwise restrict a provider from acting within the lawful scope of his or her practice, or to encourage providers to restrict medically-necessary covered services or to limit clinical dialogue with patients. Providers are not prohibited from advising or advocating on behalf of a member who is his or her patient and may discuss the member's health status, health care, treatment options (including any alternative treatment that may be self-administered), information the member needs to make a decision between relevant treatment options, the risks, benefits and consequences of treatment or non-treatment and the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. Regardless of benefit coverage limitations, providers are encouraged to openly discuss all available treatment options with Plan members.

Basic Covered Services

Basic covered services include inpatient; outpatient, telehealth services, ambulatory medical and surgical services; gynecological, obstetric, and family planning services; limited behavioral health services, LTSS and a variety of others services. Plan members may also be eligible to receive other services covered by Delaware's fee-for-service Medicaid program.

All services must be medically necessary and some services may have limitations or require authorization. For information on Prior Authorization requirements, see the "Utilization Management" section of this Provider Manual.

For the most complete and up-to-date benefit information please contact AmeriHealth Caritas Delaware Provider Services at **1-855-707-5818.**

For additional information regarding the Delaware Medicaid program policies and benefits, please visit **https://medicaid.dhss.delaware.gov/provider/Home/tabid/135/Default.aspx**

For additional information regarding the AmeriHealth Caritas Telehealth program policies and benefits, please visit **https://regulations.delaware.gov/AdminCode/title18/1400/1409.shtml**

AmeriHealth Caritas Delaware Basic Covered Services

AmeriHealth Caritas Delaware Basic Covered Services	
Services	**Coverage**
Abortion	Covered under certain circumstances (Consent form required)
Acupuncture	Not covered
Allergy Testing	Covered
Bed Liners	Covered for members ages 4 and up
Behavioral Health Outpatient Mental Health and Substance Use Disorder (SUD) Services (includes crisis intervention services)	**Adults (ages 18 and over):** Covered The first 14 days of SUD Intensive Inpatient require notification within 48 hours of admission and upon discharge. If days beyond 14 are needed, prior authorization is required. SUD withdrawal management: First 5 days require notification within 48 hours of admission and upon discharge. If days beyond 5 are needed, prior authorization is required. **Children (ages 17 and under):** 30 outpatient visits per year; visits above 30 are provided through the Department of Services for Children, Youth, and Their Families (DSCYF) **For members participating in PROMISE:** BH Outpatient services are the responsibility of the State and paid through the State's DMES

Behavioral Health Inpatient Mental Health and Substance Use Disorder (SUD) Services	**Adults (ages 18 and over):** Covered **Children (ages 17 and under):** Covered by the Department of Services for Children, Youth, and Their Families (DSCYF) **For members participating in PROMISE:** SUD Inpatient services, except for Medically managed intensive inpatient detoxification, are the responsibility of the State and paid through the State's DMES

Behavioral Health Partial Hospitalization, Intensive Outpatient	**Children (ages 17 and under):** 30 outpatient units per year; units above 30 are provided through the Department of Services for Children, Youth, and Their Families (DSCYF) **Adults (ages 18 and over):** First 30 days of SUD Intensive Outpatient require notification within 48 hours of admission and upon discharge. If days beyond 30 are needed, prior authorization is required. **For members participating in PROMISE:** BH Outpatient services are the responsibility of the State and paid through the State's
Behavioral Health Residential Treatment Facility	**Children (ages 17 and under):** Covered by the Department of Services for Children, Youth, and Their Families (DSCYF) **Adults (ages 18-20):** Covered
Blood and Plasma Products	Covered
Bone Mass Measurement (bone density)	Covered

Bony Impacted Wisdom Teeth	Covered
Care Management	Covered
Chiropractic Services	Includes manipulation and adjunctive therapy associated with the treatment of neck, back, pelvic/sacral pain, extra spinal pain and/or dysfunction and for chiropractic supportive care Does not include treatment for any condition not related to a diagnosis of subluxation or neck, back, pelvic/sacral or extra spinal pain and/or dysfunction
Colorectal and Prostrate Screening Exams	Covered
CT Scans	Covered

Dental Services (Under age 21)	**change to** Dental services are available to Delaware Medicaid members ages 20 years and younger, also known as the Pediatric Dental Benefit. As of January 1, 2025, members ages 20 and younger are eligible for: Preventative: Exams, cleaning, x-rays, fluoride, (every six months) and sealants. Restorative care: Fillings, crowns, root canals, extractions, partials, dentures. Orthodontics: Examination by orthodontist and orthodontic records. Limited and comprehensive orthodontics are only covered when specific criteria are met. **Not** covered - braces for cosmetic reasons For questions about your dental benefits, call Member Services.
Dental Services (Adult)	Covered through our dental vendor DentaQuest. Call 877-378-5295 for more information.
Diabetic Education	Covered
Diabetic Equipment	Covered (Prior authorization required if over $500.00)
Diabetic Supplies	Covered (Glucose monitors/strips)
Dialysis	Covered

Diapers	Covered (8 units combined products per day = 240 units per 30 day month without authorization) (Authorization required if service (combined) exceeds 8 units per day -240 units per 30 day month)
Doula Services	Covered
Drugs Prescribed by a Doctor	Covered

Durable Medical Equipment (DME)	Covered DME purchases less than $500.00 on the ACDE fee schedule and with a prescription do not require prior authorization All wheelchair rentals require prior authorization
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (Under age 21)	Covered
Emergency Medical Transportation (Air and Ambulance)	Covered
Emergency Room Care	Covered
Eye Exam, Medical (Conditions such as eye infections, glaucoma, and diabetes)	Covered for all members
Eye Exam, Routine	Covered for all members (Covered annually and more often if medically necessary)
(Eyeglasses or contacts every 12 months) Eyeglasses or Contacts	Covered for all members (Eyeglasses or contacts every 12 months)
Family Planning Services	Covered for any family planning provider, including those not in the AmeriHealth Caritas Delaware network (with the exception of Delaware Healthy Children Program (DHCP) members. DHCP members are required to use a participating provider for family

Genetic Testing	Covered
Glaucoma Screening	Covered
Gynecology Visits	Covered
Hearing Aids and Batteries	Covered if ages 20 and younger
Hearing Exams	Covered
HIV/AIDS Testing	Covered
Home-Delivered Meals	Covered during pregnancy and for up to 12 weeks after member gives birth
Home Health Care and Infusion Therapy	Covered
Hospice Care	Covered
Hospitalization	Covered
Imaging (CT, MR, PET, SPECT, Nuclear Studies)	Covered
Immunizations	Covered
Lab Tests and X-rays	Covered
Long Term Services and Supports (LTSS)	Covered for DSHP-Plus LTSS members (See LTSS section of this manual for eligibility and services)
Mammograms	Covered

Medical Supplies	Covered (Prior authorization required if over $500.00 per item)
Medication Assisted Therapy	COVERED For members participating in PROMISE: These services are the responsibility of the State and paid
MRI, MRA, PET Scan	Covered
Non-Emergency Medical Transportation	Eligible Delaware Medicaid members, including those in the Delaware Healthy Children's Program (DHCP), in need of non-emergency transportation should call **ModviCare at 1-800412-3778**
Nursing Home (Long Term Custodial)	Covered up to 30 days per year. (Additional days are considered long-term care; an application must be submitted to and approved by the Delaware Medical Assistance Program for long-term
Observation	Covered
Obstetrical/Maternity Care	Covered
Organ Transplant Evaluation	Covered
Organ Transplant	Covered
Orthopedic Shoes	Covered (Prior authorization required if over $500.00 per pair)

Outpatient Surgery, Same Day Surgery, Ambulatory Surgery	Covered
Pain Management Services	Covered
Pap Smears and Pelvic Exams	Covered
Parenting/Childbirth Education	Covered
Personal Care/Aide Services (in home)	Covered
Podiatry Care (Routine Diabetic Care or Peripheral Vascular Disease)	Covered
Prescription Drugs	Covered
Primary Care Provider Visits	Covered
Private Duty Nursing	Covered
Prosthetics and Orthotics	Covered (Prior authorization required if over $500.00 per item.)
Radiation Therapy	Covered
Rehabilitation (Inpatient Hospital)	Covered
Skilled Nursing Facility Care	Covered up to 30 days per year
Sleep Apnea Studies	Covered

Smoking Cessation Counseling	Covered
Specialty Physician Services	Covered
Surgical Center	Covered
Therapy (Outpatient Occupational, Physical, Speech)	Covered

Non-Covered Services

AmeriHealth Caritas Delaware will refer members to local resources for services that are not covered by the Plan, as appropriate. Providers may contact the Rapid Response team at 1-844-623-7090 for assistance with coordination of non-covered services.

Private Pay for Non-Covered Services

Providers are required to inform Medicaid members about the costs associated with services that are not covered under AmeriHealth Caritas Delaware, prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement; the provider must obtain a signed document from the member to validate the private payment arrangement.

Emergency Services

Members requiring emergency care should be advised to call 911.

AmeriHealth Caritas Delaware ensures the availability of emergency services and care **24 hours a day, 7 days a week** and is responsible for coverage and payment of emergency and post-stabilization care services regardless of whether the provider who furnishes the services has a contract with AmeriHealth Caritas Delaware. Post-stabilization services remain covered until AmeriHealth Caritas Delaware contacts the emergency room and takes responsibility for the member.

AmeriHealth Caritas Delaware will not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulted in serious impairment to bodily functions, or resulted in serious dysfunction of any bodily organ or part.

AmeriHealth Caritas Delaware will not refuse to cover emergency services based on the emergency

room provider, hospital or fiscal agent not notifying the member's primary care provider, AmeriHealth Caritas Delaware, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Any provider of emergency services who does not have a contract in effect with AmeriHealth Caritas Delaware, must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that the provider could collect if the member received medical assistance under Title XIX or Title XXI through an arrangement other than enrollment in AmeriHealth Caritas Delaware.

Definitions and requirements regarding urgent/emergent care are as follows:

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services - Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an Emergency Medical Condition.

Urgent Care - Treatment of a condition that is potentially harmful to a patient's health and for which it is medically necessary for the patient to receive treatment within 48 hours to prevent deterioration.

Out-of-Network Use of Non-Emergency Services

AmeriHealth Caritas Delaware will provide timely approval or denial of requests for authorization of out-of- network service(s) through the assignment of a prior authorization number, which refers to and documents the determination. Written follow-up documentation of the determination will be provided to the out-of- network provider within one business day after the decision.

Providers are required to inform Medicaid members about the costs associated with services that are not covered under AmeriHealth Caritas Delaware, prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement; the provider must obtain a signed document from the member to validate the private payment arrangement.

Second Opinions

AmeriHealth Caritas Delaware members have the right to request a second opinion from a qualified,

participating health care professional. Or, AmeriHealth Caritas Delaware will arrange for the member to obtain a second opinion outside the network, at no cost to the member.

Inpatient at Time of Enrollment

The managed care plan responsible for a member's inpatient care depends upon the timing of the member's Medicaid enrollment. If a member, transferring from another Medicaid plan to AmeriHealth Caritas Delaware, is hospitalized at the time of enrollment, the originating health plan is responsible for inpatient facility coverage until discharge; but, AmeriHealth Caritas Delaware is responsible for covering professional services as of the member's enrollment date and is responsible for coverage of all benefits upon discharge.
Likewise, if a member transfers from AmeriHealth Caritas Delaware to another Medicaid plan during an inpatient stay, AmeriHealth Caritas Delaware is responsible for inpatient facility coverage until discharge.

Newborn Coverage

Newborns born to mothers who are covered by AmeriHealth Caritas Delaware at the time of birth will be enrolled for coverage with AmeriHealth Caritas Delaware. The Plan will provide covered services to eligible newborns retroactive to the date of birth.

AmeriHealth Caritas Delaware shall not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother makes the decision to discharge the mother or the newborn child before that time. A participating provider is not required to obtain prior authorization for stays up to the forty-eight (48) or ninety-six (96) hour periods.

Sterilizations

Providers must submit the appropriate consent form at the same time as the claims submission for these services. Sterilizations are not covered for members less than 21 years of age. Appropriate consent forms can be found online at **www.amerihealthcaritasde.com**, or on the DMAP website.

A Member seeking sterilization must voluntarily give informed consent on the Consent form or an Awareness Form, which must accompany each claim.

Consent Form
Awareness Form

The Member must give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery. A new consent form is required if 180 days

have passed before the sterilization procedure is provided.

DMAP's Sterilization **Consent Form** and/or **Awareness Form** must accompany all claims for reimbursement for sterilization services. The form must be completed correctly in accordance with the instructions. The claim and consent forms will be retained by the Plan.

Preventive Care/Immunizations

Preventive care includes a broad range of services (including screening tests, counseling, and immunizations/vaccines).

- Providers are required to administer immunizations in accordance with the recommended childhood immunization schedule for the United States, or when medically necessary for the member's health.
- Providers are required to prepare for the simultaneous administration of all vaccines for which a member under the age of 21 is eligible at the time of each visit.
- Providers are required to participate in the Vaccines for Children Program (VFC).

AmeriHealth Caritas Delaware has adopted the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services [childhood and adolescent immunization schedule approved by: the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP)], and the adult immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP).

Immunization Schedules (Childhood, Adolescent and Adult)

- Visit the Centers for Disease Control and Prevention (CDC) at **https://www.cdc.gov/vaccines/schedules/hcp/index.html** for recommended vaccines and immunizations.
- Visit **https://www.uspreventiveservicestaskforce.org/Page/Name/tools-and-resources-for-better-preventive-care** for the Guide to Clinical Preventive Services for recommendations made by the USPSTF for clinical preventive services.

Vaccines for Children (VFC) Program

AmeriHealth Caritas PCPs are required to enroll with the Delaware Division of Public Health (DPH) to receive vaccines for members age 18 years and younger through the Vaccines for Children Program (VFC). Vaccinations covered by the VFC program will not be reimbursed by AmeriHealth Caritas Delaware; however, the Plan reimburses providers for appropriate vaccine administration to members age 18 years and younger. Providers are expected to plan for a sufficient supply of vaccines and are required to report the use of VFC vaccines immunizations by:

- Billing the Plan with the appropriate procedure code(s) and modifier.
- Reporting all immunizations to the Division of Public Health Immunization Registry.

EPSDT

Our Pediatric Preventive Health Care Program is designed to improve the health of Medicaid members from birth to under age 21 by increasing adherence to Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines through identification of growth and development needs and coordination of appropriate health care services.

All Plan PCPs are responsible to provide EPSDT services to AmeriHealth Caritas Delaware members from birth to under age 21 according to the American Academy of Pediatrics Periodicity Schedule or upon request at other times in order to determine the existence of a physical or mental condition. The most current periodicity schedules are available online at
https://brightfutures.aap.org/Pages/default.aspx

For the initial examination and assessment of a child, PCPs are required to perform the relevant EPSDT screenings and services, as well as any additional assessment, using the appropriate tools to determine whether or not a child has special health care needs.

Periodic assessments must consist of the following components:

- Health History.
- Physical Exam.
- Growth and Development Assessment.
- Vision and Hearing Screening.
- Dental Screening and Education.
- Immunizations.
- Developmental/Behavioral Screening.
- Nutrition Assessment and Education.
- Laboratory Tests including Blood Lead Testing.
- Anticipatory Guidance.
- Referral for Further Diagnostic and Treatment Services, if needed.

EPSDT providers (PCPs) are expected to provide written and verbal explanation of EPSDT services to AmeriHealth Caritas Delaware members including pregnant women, parent(s) and/or guardian(s), child custodians and sui juris teenagers. This explanation of EPSDT services should occur on the member's first visit and quarterly thereafter, and must include distribution of appropriate EPSDT educational tools and materials.

Screening Timeframes

EPSDT providers (PCPs) are contractually obligated to provide EPSDT screenings within 30 days of the scheduled due date for children under the age of two years and within 60 days of the scheduled due date for children age two and older, or within no more than two weeks after the initial request. Inter-periodic exams must also be promptly provided, as needed.

Initial EPSDT screenings must be offered to new members within 60 days of becoming an AmeriHealth Caritas Delaware member, or at an earlier time if needed to comply with the periodicity schedule. At the latest, the initial EPSDT screening must be completed within three months of the member's enrollment date with AmeriHealth Caritas Delaware. Periodic EPSDT screenings must occur within no more than two weeks of the request.

Plan PCPs are expected to assist members with accessing substance abuse and mental health services, as needed. The Plan's Rapid Response team is also available to members and providers to support care coordination and access to services. Members and providers may request Rapid Response support by calling **1-844-623-7090.**

Pharmacy Services

Pharmacy services covered by AmeriHealth Caritas Delaware are managed by the Plan's delegated vendor, PerformRx. For the most current and complete information on the provision of pharmacy services, please visit **www.amerihealthcaritasde.com**. For questions regarding pharmacy services, Plan members and providers may contact:

PerformRx Pharmacy Member Services
DSHP & DHCP: **1-877-759-6257 (TTY 885-809-9206)**
DSHP Plus/DSHP Plus LTSS: **1-855-294-7048 (TTY 885-809-9206)**

PerformRx Pharmacy Provider Services
DSHP & DHCP: **1-855-251-0966 (TTY 885-809-9206)**
DSHP Plus/DSHP Plus LTSS: **1-888-987-6396 (TTY 885-809-9206)**

Formulary

AmeriHealth Caritas Delaware utilizes the Delaware Division of Medicaid & Medical Assistance (DMMA) preferred drug list. This drug benefit has been developed to cover medically necessary prescription products. The pharmacy benefit design provides for outpatient prescription services that are appropriate, medically necessary, and are not likely to result in adverse medical outcomes.

The most up-to-date preferred drug list is available online at **https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx.**

Pharmacy Prior Authorization

The Pharmacy Services Department at AmeriHealth Caritas Delaware issues Prior Authorizations for drugs on the preferred drug list that require prior authorization. Contact Pharmacy Provider Services at **1-855-251-0966** between 8:30 am and 7:00 pm Monday through Friday (EST). After business hours, Saturday, Sunday and Holidays, please call Pharmacy Member Services at 1 -877-759-6257.

Prior Authorization procedures are as follows:

1. The prescriber contacts AmeriHealth Caritas Delaware by:
    a. Submitting a web request under Pharmacy at **www.amerihealthcaritasde.com**, or
    b. Faxing a completed Prior Authorization form to **1-855-829-2872**.
2. Pharmacy Member Services may be contacted at **1-877-759-6257** for clinical issues during non-business hours such as weekends and holidays.

Pharmacy prior authorization forms can be found at **www.amerihealthcaritasde.com.**

Emergency Supply

In the event a member needs to begin therapy with a non-covered medication before prior authorization can be obtained, pharmacies are authorized to dispense up to a 72 hour emergency supply.

- The Plan will allow a one-time fill of medication for a three-day temporary supply. Some exclusions apply.
- The temp supply code will be 333 entered into the pharmacy prior authorization field.
- The free form message with the temporary supply code will return to the pharmacy when a claim is rejected.
- Once the member utilizes the onetime temp supply, the member would require a prior authorization.
- One emergency fill per Generic Code Number (GNC) per member.

Over-the-Counter Medications

Certain generic over-the-counter medications are covered by AmeriHealth Caritas Delaware with a prescription from the prescribing physician. These include, but are not limited to, aspirin, acetaminophen, ibuprofen, cough and cold preparations, tobacco cessation products and antihistamines.

Durable Medical Equipment (DME) and Pharmacy Claims

A list of diabetic supply products able to be submitted as pharmacy claims is available at **https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx.**
All other products, such as incontinence supplies, enteral feedings, etc. should be submitted to AmeriHealth Caritas Delaware as DME claims. Here are the key things pharmacies need to know when submitting DME claims:

- PerformRx is not able to process DME claims through their pharmacy POS system.
- Pharmacies that provide DME supplies must submit claims to AmeriHealth Caritas Delaware in order for claims to be processed.
- To submit a DME claim, pharmacies and/or DME suppliers can use the CMS-1500 professional claim form and submit electronically or via paper.
    - Electronic claims can be submitted to our clearinghouse **Change Healthcare** (formerly Emdeon) or pharmacies can use another clearinghouse.
        - AmeriHealth Caritas Delaware's electronic data interchange (EDI) payer ID# is 77799.
    - Paper claims can be submitted to:
      AmeriHealth Caritas Delaware
      Attn: Claims Processing Department
      P.O. Box 80100
      London, KY 40742-0100
- A list of participating network DME suppliers can be viewed in the online provider directory at **www.amerihealthcaritasde.com.**

Pharmacy Copays

AmeriHealth Caritas Delaware charges copays for DSHP member's prescription drugs filled at the pharmacy. The copay is based on the cost of each prescription. The most that members will pay for prescription copays each month is $15.00 total. Once a member meets the $15.00 copay maximum for the month, there will be zero copays for drugs filled for the rest of the month. The copay maximum will start over on the first of each month.

Copays will be $0 for the following:

- Prescriptions for members that are under the age of 21
- Prescriptions for members that are receiving hospice services.
- Prescriptions filled for medications to stop smoking
- Prescriptions filled for opioid use disorder and overdoses
- Prescriptions filled for birth control

- Prescriptions for members receiving care or residing in an institution:
- Inpatient hospital.
- Skilled nursing facility.
- ICF.
- ICF/ID.
- State mental health institutes — except transferred resources.
- Prescriptions for pregnant women, including up to 90 calendar days after the end of the pregnancy.

Copays

Prescription Type	Copay
Brand-name prescriptions	**$3.00**
Generic prescriptions	**$1.00**

*If a generic drug costs less than $1.00, the member will pay the lesser cost of the drug.

Members must show their AmeriHealth Caritas Delaware member ID card when they get their prescriptions. For questions, call Pharmacy Member Services at **1-877-759-6257**.

Participating pharmacies are prohibited from refusing to fill prescriptions and to dispense as written when a member is unable to pay the applicable copayment amount at the time the prescription is filled.

Pharmacy and PCP Lock-In Programs

To support the reduction of fraud, waste and abuse within the Medicaid system, and to better support our members with complicated drug regimens who see multiple physicians, AmeriHealth Caritas Delaware utilizes recipient restriction (lock-in) programs for pharmacy and primary care services. Through data analysis and referrals by providers and the State, the Plan identifies members who may need additional support or who may have misused, abused or committed possible fraud in relation to the receipt of prescription drug services.

Under these programs, a multidisciplinary team uses established procedures to review member medical/pharmacy utilization for the purpose of identifying misuse, abuse or potential fraud. A member may be identified for review when any of the following criteria is met:

- Total pharmacy prescription costs (all prescriptions) greater than $300 per month.
- Member gets prescriptions filled at more than two (2) pharmacy locations within one month.
- Member has prescriptions written by more than two (2) physicians per month.
- Polypharmacy or more than eight (8) therapeutic agents per month.
- Member fills prescriptions for more than three (3) controlled substances per month.

- Member obtains refills (especially on controlled substances) before recommended days' supply is exhausted.
- Duration of narcotic therapy is more than 30 consecutive days without an appropriate diagnosis.
- Number of prescriptions for controlled substances is more than 15 percent of the total number of prescriptions.
- Prescribed dose outside recommended therapeutic range.
- Same/similar therapy prescribed by different prescribers.
- No match between therapeutic agent and specialty of prescriber.
- Fraudulent activities (forged/altered prescriptions or borrowed cards).
- More than three (3) admissions to more than one (1) hospital in any 90 days in the past six(6) months.
- More than three (3) emergency room visits within 90 days with little or no PCP intervention or follow-up.
- Same/similar services or procedures in an outpatient setting within one year.

AmeriHealth Caritas Delaware accepts referrals of suspected fraud, misuse or abuse from a number of sources, including physician/pharmacy providers, the Plan's Pharmacy Services, Member/Provider Services, the Special Investigations Unit, Case Management/Care Coordination, Special Care Unit, Quality Management, Medical Affairs and the Delaware DHSS. If you suspect member fraud, misuse or abuse of services, you are encouraged to make a referral to the Pharmacy and PCP Lock-In programs by calling the Fraud and Abuse Hotline at **1-866-833-9718.**

All referrals are reviewed for potential restriction. If the results of the review indicate misuse, abuse or fraud, AmeriHealth Caritas Delaware will place the member in the Pharmacy and/or PCP Lock-In programs, which means the member(s) can be restricted to one PCP and/or one pharmacy.

If a member is placed in the Pharmacy and/or PCP Lock-In programs, the member's assigned PCP will receive a letter from AmeriHealth Caritas Delaware identifying the restricted member by name and ID number, and, as appropriate, the pharmacy where the member must receive his/her prescription medications.

Delaware Prescription Monitoring Program (PMP)

AmeriHealth Caritas Delaware providers are required to follow all requirements of the Delaware Prescription Monitoring Program (PMP), including mandatory registration to access the PMP. The PMP system collects information on all controlled substances (schedules II-V) prescriptions. Prescribers registered with the PMP may obtain immediate access to an online report of their current or prospective patient's controlled substance prescription history. Pharmacies and prescribers are not permitted to distribute prescription history reports from the PMP system to patients.

AmeriHealth Caritas Delaware providers must query the PMP to view information about our member's usage before prescribing Schedule II or III controlled substances to them. All PMP users

must comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule requirements.

Vision Services

Covered Services

AmeriHealth Caritas Delaware will cover services within the program guidelines when the treatment has appropriate diagnoses and when medically necessary.

Diabetic Eye Exams

When billing for a member who has received his or her first diabetic retinal exam for the benefit period, which is based on a calendar year, providers are reminded to include the appropriate category II CPT® service codes (2022F, 2024F, 2026F, and 3072F) in addition to the routine eye examination CPT® codes (S0620 and S0621) when submitting claims for members diagnosed as diabetic.

- **Visual Acuities**

- Entering, with or without correction, distance and near
- Best corrected with final Subjective RX, distance and near
- Cover Test – Findings must be recorded at 20 feet and 16 inches.
- Versions/Motility Assessment
- Pupils and Pupillary Reactions
- Screening Visual Fields – Record all findings including test or instrument used
- Refraction – To include objective refraction and subjective refraction.
- External Examination/Biomicroscopy
- Lid
- Conjunctiva
- Cornea
- Crystalline lens
- Anterior Chamber Angle Quantify a
- Media Clarity
- Tonometry/Intraocular Pressure—To include method of obtaining pressures and the time of day
- Ophthalmoscopy – Direct/Indirect
- A dilated examination of the retina and the peripheral retina to be performed whenever professionally indicated
- Document all findings in the vitreous, macula, optic nerve, including numerical C/D ratio, retinal vessels, and grounds
- **Diagnosis and Treatment Plan**
- Standards for Routine Eye (Program-Specific)
- All members have benefits for an annual (every 12 months) eye health examination to evaluate a member's ocular health and determine the refractive status of the member. Eye examinations are recommended beginning at age three. This annual exam should be conducted in compliance with the AmeriHealth Caritas Delaware Eye Examination Standards and Requirements. Coverage includes the examination and the annual dispensing of spectacle frames and lens materials required to correct visual acuity one time every 12 months.

Providers should use the following CPT codes when billing for the annual comprehensive eye health examination under the routine eye care program:

- S0620: routine ophthalmological examination, including refraction; new patient
- S0621: routine ophthalmological examination, including refraction; established patient

Please note: These services include dilation and determination of refractive state. The provider may not bill separately for dilation or refraction performed on the same date of service.

Eyeglasses

Frame Requirement

Each frame dispensed must carry a minimum of a one-year manufacturer's warranty. If a member selects frames outside the covered frame allowance, the member will be responsible for the full payment of the frames. AmeriHealth Caritas Delaware may not be billed for the difference in cost. Minor adjustments are to be provided for a period of one year at no additional charge. Deluxe Frames (V2025) may be covered for children with special needs, infants with eye size under 42mm, a child with eye size over 58mm, or for safety reasons. Dispensing and fittings are not covered by Delaware Medicaid.

Eyeglass Lens Requirement

Fabrication of eyeglasses shall conform to the current American National Standards Institute (ANSI) prescription requirements, and all lenses, frames, and frame parts must be guaranteed against defects in manufacture and assembly. In order to meet purchase criteria, a change in refractive error must exceed +/- 0.5 diopters or a 10-degree change in axis to qualify within the 12-month limitation. Lenses and all lens charges must be billed at the actual cost (including discounts) from the optical laboratory that fabricates the lenses. The provider must document the reasons for the lenses and outline the appropriate indicator on the claim being submitted. Providers may not make arrangements to furnish the member with more costly lenses or provide lenses with non-covered lens features or lab procedures with the balance of the cost being paid by the member.
NOTE: When one lens meets the above criteria, both lenses can be provided to the member unless the prescribing provider specifies otherwise.

Buy-up: Members can choose to purchase a frame directly from the Provider. Payment must be dealt with privately and must include the fitting charge. AmeriHealth Caritas Delaware can only be billed for the fitting charge associated with the services rendered. Under no circumstances may a provider make arrangements to furnish non-covered frames to a member and bill AmeriHealth Caritas Delaware for the difference or balance of the cost paid by the member.

Polycarbonate lenses: CR39 or glass lenses are a covered benefit for all members. Polycarbonate or thermoplastic lens materials may be covered for a recipient's safety or documented medical condition (when necessary).

Variable Asphericity Lenses: Variable asphericity lenses may be covered for prescriptions greater than or equal to 12 diopters.

Contact Lenses

Medically Necessary Contact Lenses

Medically necessary contact lenses are covered for all members; this benefit is in lieu of eyeglasses. Contact lens fittings are not covered by Delaware Medicaid. Contact lens examination services shall include, at a minimum, the following:

- Examination
- Fitting
- Training
- Follow-up visits for a minimum of 60 days after completion of fitting

The following medically necessary conditions considered for medically necessary contact lenses are anisometropia, aphakia, keratoconus, progressive myopia, cornea disorders, etc.

Contact Lens Standards
In lieu of eyeglasses, eligible members can elect to receive contact lenses. Members can receive new contact lenses every 12 months. When the maximum benefit of $120.00 is exhausted, members will not receive additional material benefits until the following benefit period. The fitting is bundled with elective contact lenses (S0500) and not paid separately.

The following standards are recommended for contact lens patients:

- Patient shall receive a diagnostic evaluation prior to the time of dispensing
- A 60-day clinical adaptation period should be used for all patients who are newly fitted for contact lenses
- A thorough evaluation should be made of all contact lens users at each follow-up visit
- All contact lens patients should have written instructions that advise them of proper wear, hygiene, and maintenance of their lenses

Contact lenses must be billed at the provider's actual cost (including discounts) from the provider's lens supplier.

Replacements

Replacements materials are limited to one frame and one pair of eyeglass lenses per year due to irreparable wear or damage, breakage, or loss. Members are eligible to receive one (1) replacement pair per year, when damaged or broken. Replacement materials must be billed with the RA modifier. Prior authorization is not required.

Non-Covered Services

AmeriHealth Caritas Delaware will not cover a frame or lenses that are non-covered and members cannot "buy up" and pay the difference between the AmeriHealth Caritas Delaware reimbursement amount and the retail cost of the frame or lenses. Members can purchase frames and/or lenses on a private pay basis. In this scenario, AmeriHealth Caritas Delaware is not to be billed an eyeglass fitting fee. Additional exclusions:

- Sunglasses and cosmetic lenses;
- Replacement lenses without significant change in refractive error.
- Blended or progressive multi-focal lenses,
- Faceted lenses and
- Replacement warranty.

Laboratory Services

In an effort to provide high quality laboratory services in a managed care environment for our members, AmeriHealth Caritas Delaware members may receive laboratory services from laboratories at our contracted hospital facilities. Also, AmeriHealth Caritas Delaware has made an agreement with the following laboratory:

Laboratory	Type	Phone	Website
LabCorp	General Lab Services	See website for locations and contact information	**www.labcorp.com**

To quickly establish an account with one or more of these labs please call the numbers listed above. For more information about individual labs, please visit their website.

[X Network Physicians are encouraged to perform venipuncture in their office whenever possible.

[X Providers should contact the laboratory provider in question to arrange a pick-up service.

[X AmeriHealth Caritas Delaware highly recommends that pre-admission laboratory testing be completed by the PCP. However, testing can be completed at the hospital where the procedure will take place, and does not require a referral from AmeriHealth Caritas Delaware.

[X **STAT labs must only be utilized for urgent problems.** The ordering physician may give the member a prescription form or AmeriHealth Caritas Delaware procedure confirmation form to present to the participating facility.

Hospice Services

A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill member, including the family or other persons caring for the member regardless of where the member resides. Below are some of the covered services:

- Nursing Care.
- Medical Social Services.
- Physician Services.
- Counseling Services.
- Short-Term Inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards.
- Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the member's terminal illness and related conditions.
- Physical therapy, occupational therapy and speech-language pathology.

Hospice Services in a Nursing Facility

Hospice services can occur in the home or in a nursing facility. When services occur in a nursing facility, the facility can be considered the residence of the member. When the member resides in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the residents' personal physician does not apply if all of the following conditions are met:

- The member is terminally ill.
- The member has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.
- The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

Notification and Coverage for Hospice Benefits

AmeriHealth Caritas Delaware covers hospice services provided to members who are certified as terminally ill when there is no Part A, commercial, or any other coverage. The member must have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and the member must elect hospice care rather than active treatment for the illness.

When a member is in need of hospice services – including home hospice, inpatient hospice, continuous care, and respite – the primary care practitioner, attending physician, or hospice agency must notify the AmeriHealth Caritas Delaware Utilization Management department at 1-855-396-5770. The Plan will coordinate the necessary arrangements between the primary care practitioner

and the hospice provider in order to assure continuity and coordination of care.

It is the responsibility of hospice to obtain certification from the physician that the member is terminally ill.

Interpretation and Translation Services

Interpretation and translation services and services for the hearing and visually impaired are free to AmeriHealth Caritas Delaware members. To access any of these services, members may contact Member Services toll-free at:

DSHP Member Services:
1-844-211-0966 or (TTY) **1-855-349-6281.**

DSHP Plus/LTSS Member Services:
1-855-777-6617 or (TTY) **1-855-362-5769.**

Behavioral Health

The AmeriHealth Caritas Delaware behavioral health benefit includes up to 30 outpatient visits per year for members under age 18; visits above 30 are provided through DSCYF.

For member participating in PROMISE, the following services are the responsibility of the state:

- Substance Use Disorder services other than medically managed intensive inpatient detoxification.
- Licensed Behavioral Health practitioner services.
- Community psychiatric support and treatment, including ACT/ICM.
- Community-based residential supports excluding assisted living.
- Peer support.
- Psychosocial rehabilitation.

For additional information on AmeriHealth Caritas Delaware's behavioral health program, please see the "Behavioral Health" section of this *Provider Manual.*

Long Term Services and Supports (LTSS)

What LTSS is or who is considered an LTSS provider

Delaware's Diamond State Health Plan Plus Long-Term Services and Supports (DSHP Plus LTSS) program provides enhanced benefits to DSHP Plus members who qualify for long-term services and supports. DSHP Plus LTSS promotes quality and cost-effective coordination of care for eligible DSHP Plus LTSS members with chronic, complex, and complicated health care, social service, and custodial needs in a nursing facility or home- and community-based setting. AmeriHealth Caritas Delaware serves as a managed care organization operating the DSHP Plus LTSS Program.

The primary goals of DSHP Plus LTSS are to expand access to and utilization of cost-effective home- and community-based services (HCBS) alternatives to nursing facility care and improve coordination of all Medicaid services (acute, behavioral, and LTSS).

LTSS alternatives service wait times

No more than 60 calendar days for minor home modifications;
No more than ten calendar days for home delivered meals;
No more than ten calendar days for personal care attendant services for new members; and
Immediately upon authorization for personal care attendant services for members currently placed in a nursing facility and transitioning to the community other than to assisted living.

LTSS Coverage and Benefits with details on Self-directed HCBS

LTSS Case Management

- *Role of CMs*
- *Plan of Care*
- *Coordination with external partners*
- *LTSS providers & provider notification process*

SECTION IV
Medical Management Programs

Section IV: Medical Management Programs

The following information is in regard to AmeriHealth Caritas Delaware's Care Coordination and Medical Management programs, which includes an integrated model of Care & Disease Management and Care Coordination for physical and behavioral health services provided to Plan members.

Integrated Health Care Management Overview

The Plan's Care Coordination program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This fully integrated model allows members to move seamlessly from one component to another, depending on their unique needs. From this integrated solution, the Plan delivers and coordinates care across all programs.

The Care Coordination program includes assessment, treatment, education and other care planning, as well as service coordination. The Care Coordination program also incorporates health and wellness self-management education. The program is structured around a member-based decision support system that drives both communication and Member-centered care plan development through a multidisciplinary approach to management. The Care Coordination process also includes reassessing and adjusting the Member Centered Care Plan and its goals as needed. The Care Coordination program uses evidence-based practice guidelines.

AmeriHealth Caritas Delaware's Care Coordination team includes nurses, licensed mental health professionals, Care Connectors, clinical pharmacists, Plan medical directors, primary care providers (PCPs), specialists, members and caregivers, parents or guardians. This team works to meet our members' needs at all levels in a proactive manner that is designed to maximize health outcomes. Our Integrated Health Care Management program applies to all AmeriHealth Caritas Delaware's members. Additional information about AmeriHealth Caritas Delaware's LTSS integrated health care management programs can be found in the LTSS section of this manual.

Care Coordination Components

There are six core components to our Care Coordination Program:

- Pediatric Preventive Health Care.
- Bright Start® (Maternity Management).
- Rapid Response Outreach Team (RROT).
- Transitions of Care.
- Complex Care Management (CCM).
- Community-Based Care Management Team (CCMT).

Pediatric Preventive Health Care – Care for Kids

This program is designed to improve the health of members under the age of 21 years by increasing adherence to Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines. This is accomplished by identifying and coordinating preventive services for these members. Program approach combines scheduled member outreach and point-of-contact notification for Plan staff and providers when a member is due or overdue for an EPSDT service.

Bright Start® (Maternity Management)

This program is designed to assist expectant mothers by promoting healthy behaviors and controlling risk factors during pregnancy. The program is based on the Prenatal Care Guidelines from the American College of Obstetricians and Gynecologists (ACOG). As pregnant members are identified by new member assessments, claims data, routine member outreach and provider reporting, Plan staff work to ensure that each pregnant member is aware of the services and support offered through the Bright Start® program.

Obstetrical Needs Assessment Form and Care Authorization

Members may obtain prenatal care without a referral from their primary care provider. The OB provider is responsible for contacting AmeriHealth Caritas Delaware to obtain an authorization for prenatal care. This prenatal care authorization covers all prenatal and postpartum services (exams, testing, etc.) provided by the OB provider in the OB office setting. Fetal biophysical profiles, non-stress tests and amniocentesis are allowed when medically necessary. Three ultrasounds are allowed without authorization; four or more, while they still do not require authorization, will require a high risk diagnosis. This requirement applies to all OB providers, even Maternal Fetal Medicine.

To obtain the prenatal care authorization, OB providers are asked to fax a completed Obstetrical Needs Assessment Form to **1-855-558-0488**.

ONAF Incentive Billing Guidelines:

Maternity:

- Bill an appropriate office visit code with a pregnancy diagnosis in addition to T1001-U9.
- $100 for the ONAF — T1001-U9.
    - If received within seven calendar days of the prenatal visit.
    - ONAFs not meeting the seven-calendar-day submission requirement will not be reimbursed for T1001-U9.
    - Paid only once during a pregnancy.
- The last menstrual period (LMP) is a required field to be submitted on all claim types.
- The completed ONAF must be faxed to Bright Start at 1-855-558-0488 within seven calendar days of the date of the prenatal visit as indicated on the form.

- The provider is eligible for the prenatal outreach bonus (99429):
    - $50 for the outreach bonus — 99429.
    - Eligible if received within seven calendar days of the prenatal visit for a visit that was within the first trimester and billed in conjunction with a pregnancy diagnosis and an appropriate office visit code.
    - Paid only once during a pregnancy.

Postpartum: Render the postpartum visit within 21 to 56 days after delivery:

- Fax the ONAF again to the Bright Start department **1-855-558-0488** with all postpartum information and any additional visit dates as needed.
    - $50 for the postpartum visit —99429.
- Procedure code 99429, the appropriate postpartum diagnosis codes, and the appropriate postpartum visit code (59430) must be reported and billed together on the same claim form within 21 – 56 days after the delivery date to receive payment.
- Appropriate postpartum diagnosis codes and the appropriate postpartum visit code (59430) within 21 to 56 days after the delivery and form submitted to Bright Start maternity program at 1-855-558-0488.
- Paid only once during a pregnancy.
    - This payment is not made if the visit is less than 21 days after delivery. For example, this is not a payment for a postpartum blood pressure check, staple removal, or incision check.

A Bright Start representative will fax the provider an authorization number once the completed Obstetrical Needs Assessment form is received. Please call our Bright Start staff at **1-833-669-7672** with any questions about this process.

- Additional authorization is required for inpatient hospital care (including the delivery) and other services (including testing) provided outside of the OB provider's office. OB providers may call AmeriHealth Caritas Delaware's Medical Management department to secure any additional authorizations for service at **1-855-396-5770**.
- 17-P or Makena infusion for pregnancy related complications:
    - Contact PerformRx for prior authorization requirements: DSHP and DHCP: **1-855-251-0966**. DSHP-Plus and DSHP-Plus LTSS: **1-888-987-6396**.

It is the provider's responsibility to address identified risk factors upon contact with the member and to develop appropriate action items in collaboration with the member to resolve the identified risks.

Rapid Response and Outreach Team (RROT)

This team is designed to address the needs of members in accessing needed health care by identifying and decreasing barriers to such care. The RROT also gives support to providers and their staff. The team is composed of non-clinical Care Connectors. This team performs four functions on behalf of Plan members and providers:

- Receiving inbound calls from members and providers.
- Conducting outbound outreach activities.
- Providing care coordination support.
- Coordinating value added services.

Members and providers may request RROT support by calling **1-844-623-7090**.

Transitions of Care

This program coordinates services for adult and pediatric members with transitions of care needs. Program staff includes Care Managers who are licensed registered nurses (RN) or licensed mental health professionals. Program staff supports members by providing resolution for issues relating to access, care coordination and follow up care with the provider after discharge. Program staff also provide member-centered plan of care support by performing comprehensive member assessments, addressing member goals and setting priorities. Program staff will monitor a member's condition(s) for a short term period of time, if program staff feels the member's condition requires long term/complex care a referral will be made to program staff in Complex Care Management (CCM).

Complex Care Management (CCM)

This program serves members identified as needing comprehensive and disease-specific assessments, and re-assessments, along with the development of member- centered prioritized goals that are incorporated into the member-centered plan of care, developed in collaboration with the member, the member's caregiver(s) and the member's primary care provider (PCP) and supporting service providers when applicable with appropriate consents. Program staff includes Care Managers who are licensed registered nurses (RN) or licensed mental health professionals.

Members in the Complex Care Management program are screened for the following as part of standard protocol:

- All members receive a comprehensive initial assessment that meets NCQA requirements.
- Adult members ages 18 years and older and adolescents ages 11 through17 receive a depression screening to assess for symptoms of depression. Based on the results, the member receives education and is offered a referral to the appropriate behavioral health services
- Subsequent detailed reassessments are performed for any item that screens positive in the

initial assessment.

Community-Based Care Management Team (CCMT)

Members who have frequent hospital admissions, readmissions and complex needs including both physical and behavior or are difficult to contact via telephone may be targeted for engagement by the Community Care Management Team (CCMT). The CCMT provides a high-touch, face-to-face engagement through a community-based team of nurses, social workers, and community health workers to help members navigate and increase their access to needed medical, behavioral health, and social services. The team also supports the development of member self-management skills through encouragement and coaching for chronic disease management. In addition to improving the care and health outcomes of members, this community-based team provides valuable information for and coordination with other health plan staff and services, as well as other providers in the community.

Program Participation

Participation in the IHCM program is offered to all Plan members, with the ability for members to opt out upon request. Members may also self-refer into a program by contacting the Plan.

Members are initially identified for specific IHCM needs upon joining the Plan through systematic risk stratification. The Plan will systematically re-stratify members on a quarterly basis. Members are also identified through material and telephonic outreach by the Plan. Members are encouraged to let the Plan know if they have a chronic health condition, special health need or if they are receiving on-going care. A new member assessment is included in the members' welcome packet to identify current health conditions and health care services. Based upon their responses to the initial health assessment, members are identified for participation in the appropriate care management program.

"Let Us Know" Program

Providers are encouraged to refer members to the IHCM program as needs arise or are identified through our "Let Us Know" program. If you recognize a member with a special, chronic or complex health condition who may need the support of one of our programs, please contact the Rapid Response Outreach Team **1-844-623-7090**. Providers can also complete a "Let Us Know" intervention form and fax to our Rapid Response Outreach Team fax line for members that have missed appointments, need transportation services, or further education on their treatment plan or chronic condition. This form can be downloaded from our website at **www.amerihealthcaritasde.com.**

Members are also referred to the IHCM program through internal Plan processes. Identified issues and diagnoses that result in a referral to the IHCM program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses).
- Risk score indicating over- or under-utilization of care and services.

- Pediatric members requiring assistance with EPSDT and/or IDEA services.
- Pediatric members in foster care or receiving adoption assistance.
- Infants receiving care in the NICU.
- Members with dual medical and behavioral health needs.
- Members with substance use disorder-related conditions.
- Members who are developmentally or cognitively challenged.
- Members with a special health care need.
- Member with polypharmacy use.
- Pregnant members.
- Members in need of long term services and supports to avoid hospital or institutional admission.

Care Coordination with the PCP

AmeriHealth Caritas Delaware recognizes that the PCP is the cornerstone of the member's care coordination and delivery system. Our care management staff contacts each PCP during a member's initial enrollment into the chronic care management program, as part of the comprehensive assessment and member- centered plan of care development process. Program staff creates the member's member-centered plan of care. Program staff complements the PCP's recommendations in the development of an enhanced and holistic plan of care specific to the members' needs. The Care Manager remains in close communication with the PCP during the implementation of the plan of care, should issues or new concerns arise.

Care Coordination with Other Providers

Program staff also contacts the member's key and/or current providers of care, such as the member's behavioral health care providers, to determine the best process to support the member. This process eliminates redundancies and supports efficiencies for both programs. Program staff may also engages key providers to be part of the development of the member-centered plan of care. As the member is reassessed, a copy of the care plan goals is supplied to both the provider and member.

Integrating Behavioral and Physical Health Care

Members with behavioral health and substance use disorders often experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. AmeriHealth Caritas Delaware understands that coordination of care for these members is imperative. To meet this need, AmeriHealth Caritas Delaware has a fully integrated Medical Management department. Under this collaboration, the Plan's integrated platform will seamlessly coordinate member care across the physical and behavioral health and social service areas.

Plan staff will work with the appropriate primary care and behavioral health providers to develop an

integrated plan of care for members in need of physical and behavioral health care coordination. Care Managers will also assure that communication between the two disciplines, providers and organizations, occurs routinely for all members with physical and behavioral health issues. Care Managers will also work to coordinate with substance use disorder providers and community resources with the appropriate member consent as needed. Care Managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning and provider-to-provider communication to ensure that member needs are continuously reviewed, assessed and updated.

Member-Centered Plan of Care

Through the Integrated Health Care Management program, AmeriHealth Caritas Delaware works with practitioners, members, and outside agencies as appropriate to develop member-centered plan of care for members with special or complex health care needs. AmeriHealth Caritas Delaware's plan of care specifies mutually agreed- upon goals, medically-necessary services, mental health and substance use services (as shared with the member's consent), as well as any support services necessary to carry out or maintain the plan of care, and planned care coordination activities. The member-centered plan of care also takes into account the cultural values and any special communication needs of the member, family and/or the child.

AmeriHealth Caritas Delaware care planning is based upon a comprehensive assessment of each member's condition and needs. Each member's care is appropriately planned with active involvement and informed consent of the member, and his or her family or caregiver, as clinically appropriate and legally permissible, and as determined by the member's practitioner and standards of practice.

AmeriHealth Caritas Delaware also utilizes EPSDT guidelines in the development of Treatment Plans for members under age 21. AmeriHealth Caritas Delaware works with practitioners to coordinate care with other treatment services provided by state agencies.

Through AmeriHealth Caritas Delaware's Integrated Health Care Management program, the member is assisted in accessing any support needed to maintain the plan of care. The Plan and the PCP are expected to ensure that members and their families (as clinically appropriate) are fully informed of all covered and non-covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. In order to make treatment decisions and give informed consent, available treatment for members will include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether AmeriHealth Caritas Delaware provides coverage for those treatments.

Member-centered plan of care for members with special health care needs are to be reviewed and updated every 12 months, at a minimum, or as determined by the member's PCP on the basis of the PCP's assessment of the member's health and developmental needs. The revised plan of care is expected to be incorporated into the member's medical record following each update.

Coordinating Care through Transitions and Discharge Planning

One of the most important functions of a managed care organization is to assist in coordination of care during transitions. This includes, but is not limited to:

- Changes in care settings such as from hospital to home or hospital to rehab.
- Changes in health status due to presentation of a new chronic, sometimes life-threatening condition.
- Temporary or permanent changes in the fulcrum of care when a patient must change from a primary care physician to a specialist due to a surgical need or exacerbation of a chronic condition.
- Changes in a living situation to obtain more independence or because of a need for greater support or caregiver and family changes.

During inpatient transitions, members are supported through the IHCM department. Members receive, at minimum three outreach calls, starting within 24-48 business hours of discharge. These calls are strategically placed to ensure the member has the appropriate resources in place and has a follow up appointment scheduled and kept with their provider.

IDEA & Care Coordination for Children with Special Health Care Needs

The Individuals with Disabilities Education Act (IDEA), a federal law, passed in 1975 and reauthorized in 1990, mandates that all children receive a free, appropriate public education regardless of the level or severity of their disability. IDEA provides funds to enable states to provide a public education to students with disabilities. Under IDEA, students with disabilities are able to receive public education because the law provides for individualized education programs (IEP) that meet the unique needs in the least restrictive environment for each child in the IDEA program. The law also provides guidelines for determining what related services are necessary and outlines a "due process" procedure to make sure these needs are adequately met.

Children ages 3 to 21 who have been assessed as needing special education services because of a disabling condition are eligible for the program. Through the program, comprehensive evaluations are performed by a multidisciplinary professional team and shared with the parent, PCP, teachers and other stakeholders who are involved with the child's learning.

AmeriHealth Caritas Delaware is involved as a participant in the coordination of wrap-around services needed to support the child's educational process. The Plan notifies the PCP when a child receiving IDEA services is identified. However, because school health personnel do not necessarily know AmeriHealth Caritas Delaware as the child's insurance carrier, the Plan is often placed in a position of not being aware of these children or their needs. Therefore, AmeriHealth Caritas Delaware also relies upon the practitioner to inform the Plan of children who are receiving special education services. The

Plan's Care Connectors then work with the practitioner to obtain any services that are needed to support the educational process.

IDEA, Part B, specifically details eligibility criteria and services under the IDEA program that support an appropriate, free public education for this population. Practitioners are advised to contact AmeriHealth Caritas Delaware's Rapid Response and Outreach team for assistance in obtaining support services for children receiving IDEA educational services.

IDEA, Part C, specifically details services for children from birth to three years who either have or are "at risk" for a developmental, educational, or behavioral or physical care delay. These children are likely not receiving special education services. Delaware Child Development Watch (CDW) program and AmeriHealth Caritas Delaware jointly monitor the progress of children who are eligible for IDEA Part C. Plan practitioners are asked to report any child they perceive may be eligible for services under this program.

AmeriHealth Caritas Delaware Care Connectors assist the member/caregiver to speak with the early intervention programs and school professionals who will direct the member to work with practitioners to obtain evaluative services for any child who has a screening procedure that indicates the potential need for services under IDEA. Practitioners are expected to contact the Plan's Rapid Response and Outreach team at **1-844-623-7090** to support coordination of services for children who are eligible or who have been identified as eligible for the IDEA education program.

Identifying Children with Special Health Care Needs

PCPs are required to use a valid and standardized developmental screening tool to screen for developmental delays during well child visits or episodic care visits (stand-alone visits qualify as episodic visits). If a child is identified as having a delay that is significantly different than an expected variation, within the norm of age-appropriate development, the PCP is required to refer the child for a comprehensive developmental evaluation.

As a reminder, practitioners are expected to contact the Plan's Rapid Response team at **1-844-623-7090** to support coordination of services for children who may be eligible or who have been identified as eligible for the IDEA education program.

Once the need for evaluation is established, the evaluation appointment must be sought as soon as possible to meet federal guidelines on the timing of referral, evaluation, treatment planning and the initiation of rehabilitative service for children identified as having special needs.

Once the evaluation is completed, a multidisciplinary case meeting will be arranged, as appropriate, to discuss the findings and treatment recommendations. Upon the recommendations, the Care Connector and/or Care Manager will help to arrange services consistent with the treatment plan and as covered by AmeriHealth Caritas Delaware. For recommended services not covered by the Plan, the Care Connector will assist in locating services and assisting in coordination as needed.

After the initiation of recommended services, the provider and Care Manager should receive progress updates periodically. The Care Manager will work to assist the PCP with receiving regular progress updates. Progress monitoring continues until the child has demonstrated substantial progress and is released from the program.

Examples of children who may require a referral include, but are not limited to, those listed below:

- Children diagnosed with hyperactivity, attention deficit disorders, autism spectrum disorder, severe attachment disorders, or other behavioral health disorders.
- Children with delay or abnormality in achieving emotional milestones, such as attachment, parent-child interaction, pleasurable interest in adults and peers, ability to communicate emotional needs, or ability to tolerate frustration.
- Children with persistent failure to initiate or respond to most social interactions.
- Children with fearfulness or other distress that does not respond to comforting by caregivers.
- Children with indiscriminate sociability, for example, excessive familiarity with relative strangers; or self-injurious or other aggressive behavior.
- Children who have experienced substantiated physical/emotional abuse, sexual abuse, or other
- Environmental situations that raise significant concern regarding the children's emotional being.

Examples of clinical conditions or environmental situations that warrant potential referral for evaluation:

Clinical conditions:

- Chromosomal Abnormality or Genetic Disorder.
- Metabolic Disorder.
- Infectious Disease.
- Neurological Disease.
- Congenital Malformation.
- Sensory Disorder (vision and hearing).
- Toxic Exposure.
- ATOD (alcohol, tobacco, and other).
- Exposure to HIV.

Neonatal conditions:

- Birth weight 2000 grams - Infant's Birth weight less than 2000 grams.
- Premature birth – Gestational age less than or equal to 34 weeks.

- Respiratory Distress - Infant experienced respiratory distress requiring mechanical ventilation for more than 6 hours.
- Asphyxia -Infant experienced Asphyxia using APGAR score as an indicator.
- Hypoglycemia - Newborn has a serum glucose level less than 25 mg/dl.
- Hyperbilirubinemia - Newborn has had a bilirubin blood level of greater than 20 mg/dl
- Intracranial Hemorrhage - Newborn or infant has had a subdural, subarachnoid, intraparenchymal or intraventricular hemorrhage (grade II-IV).
- Neonatal Seizures Newborn or infant has had neonatal seizures.
- Major Congenital Abnormalities - Various genetic dysmorphic, or metabolic disorders; including anatomic malfunctions involving the head or neck (e.g., atypical appearance, including syndrome and non-syndrome abnormalities, overt or submucous cleft palate, morphological abnormalities of the pinna), Spina Bifida, congenital heart defects.
- Central Nervous System (CNS) Infection or trauma - Bacterial or viral infection of the brain, such as encephalitis or meningitis; or clinical evidence of central nervous system abnormality, abnormal muscle tone (persistent hypertonia or hypotonia), multiple apneic episodes inappropriate for gestational age, or inability to feed orally in a full-term infant or sustained in a premature infant.
- Congenital Acquired Infection - Congenital or prenatal acquired infection (i.e. cytomegalo-virus, rubella, herpes, toxoplasmosis, HIV, syphilis).

Post-neonatal conditions:

- Suspected Visual Impairment - Infant is not able to make eye contact or to track visually after the first few weeks of life.
- Suspected Hearing Impairment - Infant 1) fails newborn hearing screen, 2) presents with unresolved otitis media, or 3) presents with physical abnormality of the ear or oral-facial anomalies.

Newborn situations:

- Detailed pregnancy, labor, delivery and infant hospital stay history.
- Delayed first well-care visit and/or delayed first immunization visit.
- Frequently missed well care visits within the first year of life.
- Expression of parental concern.
- Suspicion of abuse/neglect.

Childhood situations:

- Frequently missed well care visits.
- Expression of parental concern.
- Screening failure demonstrated on administration of developmental assessment tool (Ages and Stages is recommended however practitioners may use Denver Developmental Tool).
- Physical and/or laboratory results findings (example lead result >10 ng/dl).
- Inappropriate adaptation to school environment; schoolteacher or counselor expresses concerns about child's ability to adapt to school environment or learning.
- Report/suspicion of abuse/neglect.

Adolescence situations:

- Expression of concern from child, parent, or school authority.
- Behavioral risk assessment indication.
- Failing grades or difficulty learning.
- Demonstration of behavior significantly different from the usual norm.
- Report suspicion of abuse /neglect.

Providers are encouraged to refer for further evaluation when any of the above conditions and/or situations, or other conditions and/or situations are present. Especially when the concern varies significantly from what is expected at the member's age or stage of development. If the provider detects what he or she considers a minor variation, the provider may use discretion in the timing of the referral. If the provider perceives that the area of concern may be due to a normal variation in development, the provider may choose to have the child return within a specified timeframe and re-administer the screening tool. However, when choosing to re-administer the screening, providers are expected to consider factors that may impact the child's return to the office:

- Reliability of the parent to return.
- Transportation.
- Competing priorities of parent that may prohibit return on the scheduled date.
- Eligibility issues.

Health & Lifestyle Education

AmeriHealth Caritas Delaware PCPs are expected to provide Plan members with education and information about lifestyle choices and behaviors that promote and protect good health. AmeriHealth Caritas Delaware will support Plan providers in this effort by developing and distributing state-approved health education materials for Plan members, from time to time and as needed to address specific health education needs.
Additionally, AmeriHealth Caritas Delaware PCPs are expected to help educate Plan members

regarding:

- Appropriate use of Urgent Care and Emergency Services, including how to access such care when necessary.
- How to access services such as vision care, behavioral health care and substance use disorder services.
- Recommendations for self-management of health conditions and self-care strategies relevant to the member's age, culture and conditions.

SECTION V
Utilization Management

Section V: Utilization Management

The AmeriHealth Caritas Delaware Utilization Management (UM) program establishes processes for an effective, efficient utilization management system. Utilization Management decision-making is based only on appropriateness of care and services and existence of coverage. AmeriHealth Caritas Delaware does not reward health care professionals/providers or other individuals conducting utilization review for issuing denials of coverage or services. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Per the provider agreement with AmeriHealth Caritas Delaware, providers are required to comply fully with the Plan's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service;
- Providing clinical information to support medical necessity when requested;
- Permitting access to the member's medical information;
- Involving the Plan's medical management nurse and/or licensed clinician in discharge planning discussions and meetings;
- Providing the Plan with copies of plan of treatment, progress notes and other clinical documentation, as required.

Utilization Management Prior Authorization Policy

Applies to all services and providers except pharmacy. Pharmacy providers must follow prior authorization processes with the member's managed care organization regardless of network status.

1. Prior authorizations with AmeriHealth Caritas Delaware are required for certain services. Please refer to the list of services that require prior authorization in this manual.
2. AmeriHealth Caritas Delaware has a Prior Authorization call center available for prior authorization requests and education. Our Prior Authorization call center is open Monday – Friday, 8:00 am to 5:00 pm EST. Please call **1-855-396-5770** to reach our Utilization Management department. To request prior authorization for Behavioral Health services, call: **1-855-301-5512**.

After hours and on weekends and holidays, please call the AmeriHealth Caritas Delaware Member Services department at:

DSHP/DHCP Member Services: **1-844-211-0966**
DSHP Plus/DSHP Plus LTSS Member Services: **1-855-777-6617**

Behavioral Health UM: **1-855-301-5512**

to be connected with the on-call prior authorization nurse or licensed clinician. Our staff will be able to answer questions and help assist you with your prior authorization request, including requests for inpatient hospitalizations.

1. For members new to AmeriHealth Caritas Delaware, we will cover a member's medical or behavioral health condition or diagnosis that is currently being treated or a prior authorization has been issued for providers located within 30 miles of the member's primary residence for 90 calendar days or until the provider has completed treatment of the member's current condition, whichever is lesser. If the treating provider is greater than 30 miles of the member's primary residence, the service will be covered for 30 calendar days and may require the member to transfer to a qualified provider within 30 miles of the member's home address. If the member is pregnant, her primary residence is within 30 miles of the treating provider, and in her second or third trimester, prenatal services will be covered through 60 calendar day's post-partum.
2. For members new to ACDE, AmeriHealth Caritas Delaware will receive a list of existing prior authorizations for its members, and will have a record of those on file.
3. AmeriHealth Caritas Delaware will receive Home and Community Based Services (HCBS) service plans for its HCBS members, and will maintain the service plan on file.
    a. HCBS service plans cannot be altered without an updated assessment.
4. AmeriHealth Caritas Delaware will pay claims according to the following timeframes for both in- network and out-of-network providers:
    a. Pay or deny ninety percent (90%) of all clean claims within thirty (30) calendar days of receipt, ninety-nine percent (99%) of all clean claims within ninety (90) calendar days of receipt.
5. AmeriHealth Caritas Delaware may conduct retrospective reviews of claims for services that did not receive prior authorization to ensure medical necessity but will not suspend payments for review prior to payment. If a retrospective review is to be conducted, AmeriHealth Caritas Delaware will complete the review within 90 days of the date the claim is paid.
6. AmeriHealth Caritas Delaware will document the information that is being requested to complete the retrospective review, the reason the request is being made, and the timeframe for the provider to submit the requested information. Providers must submit information to AmeriHealth Caritas Delaware within the designated timeframes to ensure a timely review.
7. AmeriHealth Caritas Delaware will offer and provide education to providers on its prior authorization process as part of retrospective review determination.
8. AmeriHealth Caritas Delaware may recover payments from providers for reimbursed services determined not to be medically necessary.
9. AmeriHealth Caritas Delaware offers information on its prior authorization policies to reduce

the risk of recovery for claims paid when the service is determined to not be medically necessary. Prior Authorization requirements are listed in detail in this section of the *Provider Manual*, and in the new provider orientation program.

10. Determination of lack of medical necessity is considered an adverse action and maybe appealed.
11. AmeriHealth Caritas Delaware will provide comprehensive, ongoing provider training and outreach to in-network and out-of-network providers. Training will include prior authorization and billing processes to help providers treating our members to avoid delays in payment or member service delivery.
12. AmeriHealth Caritas Delaware offers additional training materials on its website and these materials are accessible for both in-network and out-of-network providers.

Prior Authorization Contact Information

The most up-to-date list of services requiring prior authorization will be maintained in the provider area of our website at **www.amerihealthcaritasde.com**. The Plan's UM department hours of operation are 8:00 a.m. to 5:00 p.m. EST, Monday through Friday except for State of Delaware holidays. The UM departments can be reached at:

- UM Telephone: **1-855-396-5770**
- UM Fax: **1-866-423-0946**
- UM Prior Authorization Fax:**1-866-497-1384**
- UM Concurrent Review Fax:**1-866-773-7892**
- BH UM Telephone: **1-855-301-5512**
- BH UM Fax: **1-877-234-4273**
- Bright Start (NICU and OB related) Telephone: **1-833-669-7672**
- Bright Start (NICU and OB related) Fax: **1-855-558-0488**

For prior authorizations after hours, weekends and holidays, call Member Services at: DSHP: **1-844-211-0966** or DSHP Plus: **1-855-777-6617.**

For prior authorization requests regarding behavioral health inpatient admissions after hours, please call Behavioral Health Utilization Management at **1-855-301-5512.**

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas Delaware reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided.

Physical Health Services Requiring Prior Authorization

- All out of network services excluding emergency services.
- All services that may be considered Experimental and/or Investigational.
- All miscellaneous/unlisted or not otherwise specified codes.
- All services not listed on the AmeriHealth Caritas Delaware Fee Schedule.
- Out of Network Specialty Visits.
- Elective Air Ambulance.
- In-patient services:
    - All inpatient hospital admissions, including medical, surgical and rehabilitation
    - Obstetrical Admissions/Newborn Deliveries exceeding 48 hours after vaginal delivery and 96 hours after caesarean section
    - In-patient Medical Detoxification
    - Elective transfers for inpatient and/or outpatient services between acute care facilities
    - Long Term Acute Care, Skilled Nursing Facility (SNF), and rehabilitation placement
- Gastroenterology services - (codes 91110 and 91111 only).
- Gender reassignment services.
- Genetic Testing.
- Home-Based Services:
    - Multiple members serviced in the same home must have services authorized under modifier U3 for the second member, and modifier U4 for the third member.
        - Home Health Care
        - Private duty nursing if covered under benefit category
        - Skilled Nursing Visits
        - Speech, Physical and Occupational Therapy
- Multiple members serviced in the same home must have services authorized under U3 modifier for second member, and U4 for third member.
- Enteral Feedings.
- Hospice Inpatient Services.
- 17-P or Makena infusion for pregnancy related complications. Contact PerformRx for prior authorization requirements: DSHP and DHCP: **1-855-251-0966**. DSHP-Plus and DSHP-Plus LTSS: **1-888-987-6396.**
- Termination of Pregnancy:
    - First and second trimester terminations of pregnancy require prior authorization and are covered in the following two circumstances:
    - The member's life is endangered if she were to carry the pregnancy to term; or
    - The pregnancy is the result of an act of rape or incest.
    - Submit the physician's certification on the **Abortion Justification Form** and the

complete medical record. The form must be completed in accordance with the instructions and must accompany the claims for reimbursement. All claims and certification forms will be retained by the Plan.

- Submit the Abortion Justification Form with the claim for reimbursement. The Physician's Abortion Justification Form must be submitted in accordance with the instructions on the certification/form. The claim form, medical records and Abortion Justification form will be retained by the Plan.
    - Submit claims and all appropriate forms to:

      Claim Processing Department
      AmeriHealth Caritas Delaware
      P.O. Box 80100
      London, KY 40742-0100

- Speech, Occupational, and Physical Therapy (after 24 visits for each modality).
- Cardiac Rehabilitation and Pulmonary Rehabilitation.
- Transplants, including transplant evaluations.
- DME:
    - All Durable Medical Equipment (DME) rentals.
    - Repairs for purchased DME items or equipment.
    - For billed charges over $500.00, including prosthetics and orthotics.
    - Incontinence products (diapers, pull-ups, etc.).
        - Authorization is required for quantity limits exceeding 8 products per day (240 per 30-day month supply).
    - The purchase of all motorized wheelchairs and all wheelchair components.
    - Use of standard or non-customized DME during a facility stay would be considered part of the per diem payment for the facility (such as a standard wheelchair). Any DME that requires customization would not be regularly owned by a facility or is for use by a member on discharge from a facility would be subject to evaluation for medical necessity similar to DME in any other setting.
- Hearing Services and Devices (may include but not limited to FM Systems, and Cochlear Implants/Devices) with a purchase price that exceeds the limits as noted below:
    - Monaural hearing aids costing more than $500.00.
    - Binaural hearing ads which exceed $500.00.
- Replacement of Hearing Aides that are less than 4 years old, except for children under 21
- Vision services: For prior authorization, contact AmeriHealth Caritas Delaware Provider Service at 1-**855-707-5818.**
- Hyperbaric Oxygen.
- Gastric Restrictive Procedure/Surgeries.
- Surgical services that may be considered cosmetic, including:

    - Blepharoplasty.
    - Mastectomy for Gynecomastia.
    - Mastopexy.
    - Maxillofacial.
    - Panniculectomy.
    - Penile Prosthesis.
    - Plastic Surgery/Cosmetic Dermatology.
    - Reduction Mammoplasty.
    - Septoplasty.
- Inpatient Hysterectomies.
- Cochlear Implantation.
- Pain Management.
- The following Radiology Services, when performed as an outpatient service, require prior authorization by AmeriHealth Caritas Delaware's radiology benefits vendor, National Imaging Associates Inc. (NIA):
    - CT Scan
    - PET Scan
    - MRI
    - MRA
    - Nuclear Cardiac Imaging

To request prior authorization contact AmeriHealth Caritas Delaware's radiology benefits vendor (NIA) via their provider web-portal at **www.radmd.com** or by calling **1-800-424-4791** Monday through Friday 8 a.m. –8 p.m. (EST).

The ordering physician is responsible for obtaining a prior authorization number for the requested radiology service. Patient symptoms, past clinical history and prior treatment information will be requested by NIA and the ordering physician should have this information available at the time of the call.

Weekend, Holidays and After-Hours Requests:

- Requests can be submitted online – The NIA web site is available 24 hours a day to providers.
- Weekend, holiday and after-hours requests for preauthorization of outpatient elective imaging studies may be called in to NIA and a message may be left (1-800-424-4791), which will be retrieved the following business day.

Requests left on voice mail:

- NIA will contact the requesting Provider's office within one business day of retrieval of the

voice mail request to obtain necessary demographic and clinical information to process the request.

- NIA's hours are 8:00 a.m. – 8:00 p.m. Eastern Time, Monday through Friday, excluding holidays.

Emergency room, Observation Care and inpatient imaging procedures do not require prior authorization.

All Long Term Services and Supports (LTSS) Services

All LTSS services should be requested through the waiver case managers. Only those services covered by the respective waivers can be requested.

- All unlisted and miscellaneous codes.
- All HCBS Habilitation program services.
- All services not listed on AmeriHealth Caritas Delaware Fee Schedule.

Physical Health Services that do not Require Prior Authorization

The following services will not require prior authorization from AmeriHealth Caritas Delaware:

- Emergency Room Services (in-network and out-of-network).
- Up to 48-Hour Observations (except for Maternity – notification required).
- Does not include treatment for any condition not related to a diagnosis of subluxation or neck, back, pelvic/sacral or extra spinal pain and/or dysfunction.
- Low-level plain films - X-rays, EKG's.
- Family Planning Services.
- Post Stabilization Services (in-network and out-of-network).
- EPDST Screening Services.
- Women's Healthcare by In-Network Providers (OB-GYN Services).
- Routine Vision Services.
- Dialysis.

Physical Health Services that Require Notification

Providers will be asked to notify AmeriHealth Caritas Delaware when the following services are delivered:

- Maternity Obstetrical Services (after the first visit) and outpatient care (includes 48-hour observations).
- All newborn deliveries.
- Beyond 48-Hours.

Behavioral Health Services Requiring Prior Authorization

- All out of network services (with the exceptions noted above).
- Psychiatric in-patient hospitalization for members aged 18 and older (Inpatient Behavioral Health Services for members under age 18 is managed by Department of Services for Children, Youth and Family DSCYF).
- Behavioral Health Partial Hospitalization.
- Behavioral Health Intensive Outpatient Program.
- Behavioral Health Residential Treatment Facility including Institution for Mental Disease (IMD).
- Transcranial Magnetic Stimulation (TMS).
- Vagus Nerve Stimulation (VNS).
- Substance Use Disorder (SUD) Programs for all members age 18 and older not enrolled in PROMISE.
- Partial Hospitalization Program (Level 2.5).
- Clinically Managed Low Intensity Residential Treatment (Level 3.1).
- Clinically Managed Population Specific High Intensity Residential Treatment (Level 3.3).
- Clinically Managed High Intensity Residential Treatment (Level 3.5).
- SUD treatment: Providers may choose to obtain prior authorization for the following services. If you do not, a retrospective medical necessity review will occur. See details below:
    - SUD residential intensive inpatient treatment: Prior authorization is required if more than 14 days are needed.
    - SUD intensive outpatient (Level 2.1): Prior authorization is required if more than 30 days are needed.
    - SUD withdrawal management: Prior authorization is required if more than five days are needed.
- Electroconvulsive Therapy (ECT).
- Psychological and Neuropsychological Testing.

Behavioral Health Services that do not Require Authorization/Notification

- Medication Assisted Treatment (MAT)
- Licensed Opioid Treatment Programs
- Behavioral Health and Substance Use Disorder Outpatient and Medication Management Services for members aged 18 and older (non-PROMSIE members).

Includes all SUD services:

- Ambulatory withdrawal management (Level 2WM).
- Clinically managed residential withdrawal management (Level 3.2 WM).
- Medically monitored inpatient withdrawal management (Level 3.7 WM).
    - First 14 days of SUD inpatient rehabilitation require notification within 48 hours of admission and upon discharge. If more than 30 days are needed, prior authorization is required. Providers may choose to obtain prior authorization for the following services. If you do not, a retrospective medical necessity review will occur.
- Substance use disorder (SUD) medically managed intensive inpatient withdrawal management (Level 3.7 WM) for all members ages 18 and older, including those members enrolled in PROMISE.
    - First five days require notification within 48 hours of admission and upon discharge. If more than five days are needed, prior authorization is required. Providers may choose to obtain prior authorization for the following services. If you do not, a retrospective medical necessity review will occur.
- Mental health and substance use disorder (SUD) crisis intervention, crisis stabilization, and mobile crisis services for members ages 18 and older: Notification is required within two business days after the service for an authorization number to generate claims.
- First 30 days of SUD intensive outpatient program require notification within 48 hours of admission and upon discharge. If more than 14 days are needed, prior authorization is required. Providers may choose to obtain prior authorization for the following services. If you

do not, a retrospective medical necessity review will occur.

LTSS Services Requiring Prior Authorization

- For enrollees residing in their own home or in an LTSS facility (NF, NFMI, ICF/ID, SNF, MHID), LTSS will be authorized/re-authorized during the face-to-face on-going care management intervention.
- Adult Day Health Care Services and Homemaker Services– Authorization required after first visit and re-evaluated as needed based on authorizations provided or based upon medical necessity.
- Personal Emergency Response System and Home Delivery Meals – Prior authorization required. Care coordinator will re-evaluate and provide further authorization as needed.
- Home Modifications or Non-ambulation Assistive Devices – Clinical evaluation of the home or vehicle is required initially by Care Coordinator or Occupational Therapist or Physical Therapist. Prior authorization for equipment is required.
- Minor home modifications are limited to up to $6,000 per project; $10,000 per benefit year and $20,000 per lifetime.
- A prescription for home modification equipment that will be provided by a DME supplier will need to be written by the PCP to supply to the DME provider. This includes:
    - Kitchen counters, sink space, cabinets, and special adaptations to refrigerators, stoves, and ovens.
    - Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
    - Grab bars and handrails.
    - Turnaround space adaptations.
    - Ramps, lifts, and door, hall and window widening.
    - Fire safety alarm equipment specific for disability.
    - Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
    - Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
    - Keyless entry systems.
    - Automatic opening device for home or vehicle door.
    - Special door and window locks.
    - Specialized doorknobs and handles.
    - Plexiglas replacement for glass windows.
    - Modification of existing stairs to widen, lower, raise or enclose open stairs.
    - Motion detectors.

- Low-pile carpeting or slip-resistant flooring.
- Telecommunications device for the deaf.
- Exterior hard-surface pathways.
- New door opening.
- Pocket doors.
- Installation or relocation of controls, outlets, switches.
- Air conditioning and air filtering if medically necessary.
- Heightening of existing garage door opening to accommodate modified van.
- Bath chairs.

Installation

If the enrollee needs a DME item that requires installation; the care coordinator will pursue with the enrollee their various options and only using qualified providers.

Enrollees who are able to have their equipment installed will do so. The care coordinator will follow up with the enrollee to ensure the installation has occurred consideration to include; timely installation; quality installation; excellent customer service provided.

For enrollees who are unable to have the equipment installed, the care coordinator will select the provider and following consultation with the enrollee will schedule the installation at a time convenient for the enrollee. The care coordinator will follow up with the enrollee to ensure the installation has occurred consideration to include; timely installation; quality installation; excellent customer service provided.

NOTE: A decision will be made once ALL requested/necessary materials have been received. All waiver services should be requested through the waiver care managers. Only those services covered by the respective waivers can be requested.

Organization Determinations

An organization determination is any determination (i.e. approval or denial) by AmeriHealth Caritas Delaware regarding the benefits a member is entitled to receive from the Plan. Examples include:

- Payment for emergency services, post-stabilization care or urgently needed services;
- Payment for any other health service furnished by a non-contracted provider and the member believes:
    - The services are covered under Medicaid program; or,
    - If not covered under the Medicaid program, should have been furnished, arranged for or reimbursed by AmeriHealth Caritas Delaware.
- Refusal to authorize, provide or pay for services – in whole or in part – including the type or

level of services, which the member believes should be furnished, arranged for or reimbursed by the Plan.

- Reduction or premature discontinuation of a previously authorized on-going course of treatment; or,
- Failure of the Plan to approve, furnish, arrange for or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, if the delay adversely affects the health of the member.

The procedures for appealing an organization determination are described in the "Grievances, Appeals and Fair Hearings" section of this Provider Manual.

Standard

AmeriHealth Caritas Delaware must notify the member of its determination as expeditiously as the member's health condition requires, or no later than 10 calendar days after AmeriHealth Caritas Delaware receives the request.

The timeframe may be extended up to 14 additional calendar days if:

- The provider or the member requests an extension; and,
- The Plan justifies the need for additional information and the extension is in the member's best interest.

Expedited

The member's physician may request an expedited determination, including authorizations, from AmeriHealth Caritas Delaware when the member or physician believes waiting for a decision under the standard timeframe could seriously jeopardize the member's life, health or ability to regain maximum function.

In situations where a provider indicates or AmeriHealth Caritas Delaware determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, AmeriHealth Caritas Delaware will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.

AmeriHealth Caritas Delaware may extend the 72 hours by up to fourteen (14) calendar days if the member or the provider requests an extension or the Plan justifies a need (to the State agency, upon request) for additional information and how the extension is in the best interest of the member. AmeriHealth Caritas Delaware will provide its justification to the DHSS upon request.

Unless otherwise provided by law, if the AmeriHealth Caritas Delaware fails to respond to a member's prior authorization request within three (3) business days of receiving all necessary documentation, the authorization is deemed to be granted and notice shall be given. In accordance with 42 C.F.R. § 438.404(c)(1), if the Plan intends to take an action to terminate, suspend, or reduce previously authorized Medicaid-covered services, AmeriHealth Caritas Delaware shall give notice of the adverse action at least 10 days before the date of action.

Medical Necessity of Services

"Medically Necessary" or "Medical Necessity" is defined as services or supplies that are needed for the diagnosis or treatment of the member's medical condition according to accepted standards of medical practice. The need for the item or service must be clearly documented in the member's medical record.

AmeriHealth Caritas Delaware uses the following medical necessity criteria as guidelines for determinations related to medical necessity:

- InterQual Level of Care Acute Adult Criteria.
- InterQual Level of Care Acute Pediatric Criteria.
- InterQual Level of Care Outpatient Rehabilitation and Chiropractic Criteria.
- InterQual Home Care Criteria.
- InterQual Care Planning Procedures Adult Criteria.
- InterQual Care Planning Procedures Pediatric Criteria.
- InterQual DME Criteria.
- InterQual Imaging Criteria.
- InterQual Level of Care Rehabilitation Criteria.
- InterQual Level of Care Subacute and Skilled Nursing Facility Criteria.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Adult and Geriatric.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Child and Adolescent.
- InterQual Level of Care Criteria Behavioral Health Residential & Community Based Treatment.
- Delaware American Society of Addiction Medicine (DE-ASAM) Criteria.
- AmeriHealth Caritas Corporate Clinical Policies.
- Other program-specific criteria are based upon program requirements.

When applying these criteria, Plan staff also considers the individual member factors and the characteristics of the local health delivery system, including:

Member Considerations:

- Age, comorbidities, complications, progress of treatment, psychosocial situation, home environment.

Local Delivery System

- Availability of sub-acute care facilities or home care in the AmeriHealth Caritas Delaware service area for post-discharge support.
- AmeriHealth Caritas Delaware benefits for sub-acute care facilities or home care where needed.
- Ability of local hospitals to provide all recommended services within the estimated length of stay.

Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by the Plan's Medical Director or other designated practitioner under the clinical direction of the Regional Medical Director.

Medical Necessity decisions made by the Plan's Medical Director or designee are based on the above definition of medical necessity, in conjunction with the member's benefits, medical expertise, AmeriHealth Caritas Delaware medical necessity guidelines (as listed above), and/or published peer-review literature. At the discretion of the Plan's Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting practitioner/provider may provide input to the decision. The Plan's Medical Director or designee makes the final decision.

Upon request by a member or practitioner/provider, the criteria used for medical necessity decision-making in general, or for a particular decision, is provided in writing by the Plan's Medical Director or designee. AmeriHealth Caritas Delaware will not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the diagnosis, type of illness or condition of the member.

The Utilization Management staff involved in medical necessity decisions is assessed quarterly, and physicians involved in medical necessity decisions are assessed semi-annually for consistent application of review criteria. An action plan is created and implemented for any variances among staff outside of the specified range. Both clinical and non-clinical staff members are audited for adherence to policies and procedures.

SECTION VI
Grievances, Appeals and Fair Hearings

Section VI: Grievances, Appeals and State Fair Hearings

Grievance Process

If a member has a concern or question regarding the health care services he/she has received under AmeriHealth Caritas Delaware, he/she should contact Member Services at the toll-free number on the back of the member ID card. A Member Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Member Service representative does not resolve the problem to the member's satisfaction, the member has the right to file a grievance.

A *grievance* expresses dissatisfaction about any matter other than an *action* by AmeriHealth Caritas Delaware. The member may file a grievance in writing or by telephone at the information below. It may be filed at any time either orally or in writing. It may be filed by the treating provider or primary care provider (or another authorized representative) on behalf of the member.

A grievance may be filed about issues such as the quality of the care the member receives from AmeriHealth Caritas Delaware or a provider, rudeness from a Plan employee or a provider's employee, a lack of respect for their rights by AmeriHealth Caritas Delaware or any service or item that did not meet accepted standards for health care during a course of treatment.

To file a grievance:

Telephone to:
DSHP Member Services: **1-844-211-0966**; TTY: **1-855-349-6281.**
DSHP Plus Member Services: **1-855-777-6617**; TTY: **1-855-362-5769.**

Member services hours of operation: 24 hours per day, 7 days per week.

Write to:
AmeriHealth Caritas Delaware
Attn: Complaints and Grievances
PO Box 80102
London, KY 40742-0102

If the member needs assistance in filing his/her grievance or needs the help of an interpreter, the member may call Member Services and, if needed, interpretation services will be made available to the member free of charge.

AmeriHealth Caritas Delaware will send the member an acknowledgement letter within five business days of receiving the grievance. The Plan will send a decision letter within 30 calendar days of receiving the request. In some cases, the Plan may need additional time to obtain more information. Reasonable efforts will be made to give the member prompt verbal notice of the delay and a written notice is sent to the member within two (2) calendar days explaining why an extension is needed.

Appeals Process

Adverse Benefit Determination

If AmeriHealth Caritas Delaware decides to deny, reduce, limit, suspend, or terminate a service the member is receiving, or if the Plan fails to act in a timely manner, the member will receive a written "Adverse Benefit Determination." In most cases, the Adverse Benefit Determination will be sent within 10 calendar days from receipt of the request.

If the member does not agree with AmeriHealth Caritas Delaware's determination as outlined in the Adverse Benefit Determination, he/she may file an appeal. The member may ask an "authorized representative" (e.g. his/her physician (with the written consent of the member), a family member or friend) to file the appeal for them. The provider may also file the appeal, with the member's written consent.

The member, or an authorized representative with the written consent of the member, may ask for a Fair Hearing after the appeals process has been exhausted. Additional information on requesting a Fair Hearing is available in this section of the *Provider Manual*.

Standard Appeal

A standard appeal asks AmeriHealth Caritas Delaware to review a decision about the member's care. The timeframe for filing an appeal shall not exceed 60 calendar days from the date on the Notice of Adverse Benefit Determination.

To file an appeal, the member or authorized representative may:

By phone: call AmeriHealth Caritas Delaware Member Services, 24 hours a day, seven days a week, at:

Diamond State Health Plan: 1-844-211-0966 (TTY 1-855-349-6281).

Diamond State Health Plan-Plus: 1-855-777-6617 (TTY 1-855-362-5769).

If your provider or authorized representative files your appeal by phone, they must have proof of your written authorization of consent in order to be involved and/or act on your behalf.

By Fax at 1-855-843-0636

In writing: You or your authorized representative can send the letter to:

AmeriHealth Caritas Delaware

Christiana Executive Campus

220 Continental Drive, Suite 300

Newark, DE 19713

Through the AmeriHealth Caritas Delaware Member Portal

Login to the Member Portal at: https://q1-memberportal.amerihealthcaritasde.com

Once logged in, click on Message Center

In the Message Center, click on Secure Contact Form

On the Secure Contact Form, fill out all necessary fields and select "Appeals" from the subject dropdown

Once all information has been entered, click "Submit"

Provider Appeals (on behalf of a member and with written consent): call **1-855-396-5770** and follow the prompts.

The Plan will send a written acknowledgement to the member within five business days of receipt of the appeal. The Plan has 30 calendar days after receiving the appeal, whether oral or written, to make a decision regarding the matter.

Before the Plan makes a decision, the member and/or the person helping the member with the appeal may give information in writing or in person to AmeriHealth Caritas Delaware. Also, the member may attend the appeal in person or participate telephonically.

In some cases, the Plan, or the member may need additional time to obtain more information. The timeframe for a standard resolution of an appeal may be extended by fourteen (14 calendar) days if:

a) The member requests the extension; or
b) The Plan needs additional information and the delay is in the enrollees' best interest. Reasonable efforts will be made to give the member prompt verbal notice of the delay and a written notice is sent to the member within two (2) calendar days explaining why an extension is needed.

The member may review his/her file any time while AmeriHealth Caritas Delaware is reviewing the appeal. The member and his/her authorized representative may look at the case file. The member's estate representative may review the file after the member's death. The file may have medical records and/or other papers.

AmeriHealth Caritas Delaware will send the member or his/her authorized representative a letter with the decision, explaining how AmeriHealth Caritas Delaware made its decision and the date the decision was made.

Expedited Appeal

If the time for a standard resolution could jeopardize the member's life, health or ability to attain, maintain or regain function, a member, or his/her authorized representative may request an expedited appeal orally or in writing.

Note: Expedited appeals are for health care services only – not denied claims.

To request an expedited appeal, the member or his/her authorized representative may call Member Services. The Plan will not take punitive action against a provider who either requests an expedited resolution or supports a member's appeal. AmeriHealth Caritas Delaware will send a written decision for an expedited appeal within 72 hours and will make a reasonable effort to provide oral notice of the resolution. If the request for an expedited appeal is denied, the appeal will immediately be moved into the standard appeal timeframe of no longer than 30 calendar days and the member will be notified in writing within two business days of the denial for an expedited appeal request. The

member may file a grievance if they do not agree with the decision to change the appeal timeframe to a standard appeal.

For appeals not resolved wholly in favor of the member, the written notice shall include the right to request a State Fair Hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The written notice shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the plan's action.

State Fair Hearing

The member or his/her authorized representative may seek a State Fair Hearing after the appeals process has been exhausted, but the Fair Hearing must be requested within 120 calendar days from the date on the notice of resolution upholding the Adverse Benefit Determination. A provider may also request a State Fair Hearing on behalf of a member with the member's consent by written notice.

Members have the right to self-representation or to be represented by a family caregiver, legal counsel or other representative during a State Fair Hearing. Parties to the State Fair Hearing are the Plan and the member or his/her authorized representative.

A State Fair Hearing can be requested by calling or writing to the State's Division of Medicaid and Medical Assistance (DMMA) office at:

Division of Medicaid & Medical Assistance
DMMA Fair Hearing Officer
1901 North DuPont Highway
P.O. Box 906, Lewis Building
New Castle, DE 19720

Phone: **1-302-255-9500**; or **1-800-372-2022** (toll free)

Continuation of Benefits

A member may continue to receive services while waiting for the AmeriHealth Caritas Delaware appeal or the Fair Hearing decision if all of the following apply:

- The appeal is filed within ten calendar days of the date on AmeriHealth Caritas Delaware's decision, or before the intended effective date of the proposed action, whichever is later.
- The appeal is related to reduction, suspension or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not ended.

- The member requested the services to continue.

The member's services continue to be covered until one of the following occurs:

- The member decides not to continue the appeal or request for State Fair Hearing.
- Ten calendar days have passed, from the date of the notice of resolution of the appeal, unless the member has requested a Fair Hearing within that timeframe.
- The time covered by the authorization is ended or the limitations on the services are met.
- The Fair Hearing office issues a hearing decision adverse to the member.

The member may have to pay for the continued services if the final decision from the Fair Hearing is adverse to them. If the Fair Hearing officer agrees with the member, AmeriHealth Caritas Delaware will pay for the covered services that were rendered to the member while waiting for the decision. If the Fair Hearing officer agrees with the member and the member did not continue to receive covered services while waiting for the decision, AmeriHealth Caritas Delaware will issue an authorization for the covered services no later than 72 hours from the date it receives notice of reversal to restart services as soon as possible and AmeriHealth Caritas Delaware will pay for the covered services.

Peer to Peer Telephone Line

Providers may reach the Peer-to-Peer telephone line by following the prompts at **1-855-396-5770** to discuss a medical determination with a physician in the AmeriHealth Caritas Delaware Medical Management department. A peer to peer review can be requested by your physician within five (5) business days of the member's discharge from an inpatient facility or within five (5) days after a determination for a prior authorization (Pre-Service) request has been rendered.

A physician in the AmeriHealth Caritas Delaware Medical Management department will contact the requesting provider or other authorized agent within three (3) business day of receiving the request. If initial outreach to the provider is unsuccessful, an additional outreach attempt will be made within two (2) business days of the request. If AmeriHealth Caritas Delaware's Medical Management department is unsuccessful in reaching the requesting provider following two (2) attempts, the original determination is upheld and the provider must appeal the determination.

A provider may file an appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call the Provider Appeals telephone line by following the prompts at **1-855-396-5770.**

Note: The purpose of the Peer-to-Peer process is to address ***medical determinations*** regarding health care services. This process is not intended to address denied claims or other issues. For information on filing an informal provider complaint, please refer to the "Provider and Network Information" section of this *Provider Manual*. For information on disputing a claim, please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual.*

SECTION VII
Quality Assessment and Performance Improvement Program

Section VII: Quality Assessment and Performance Improvement Program

AmeriHealth Caritas Delaware's Quality Assessment and Performance Improvement (QAPI) program provides a framework for evaluating the delivery of health care and services provided to members. AmeriHealth Caritas leadership provides strategic direction for the QAPI program and retains ultimate responsibility for ensuring that the QAPI program is incorporated into the Plan's operations. Operational responsibility for the development, implementation, monitoring and evaluation of the QAPI program is delegated by AmeriHealth Caritas leadership through the regional president to the AmeriHealth Caritas Delaware Market President and Quality Assessment Performance Improvement Committee (QAPIC).

The purpose of the QAPI program is to provide a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Caritas Delaware members by providers.

The QAPI program also provides oversight and guidance for the following:

- Determining practice guidelines and standards by which the program's success will be measured.
- Complying with all applicable laws and regulatory requirements, including but not limited to applicable state and federal regulations and NCQA accreditation standards.
- Providing oversight of all delegated services.
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to members through the credentialing/re-credentialing process.
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement.
- Reducing health care disparities by measuring, analyzing and re-designing services and programs to meet the health care needs of our diverse membership.

AmeriHealth Caritas Delaware develops goals and strategies considering applicable state and federal laws and regulations and other regulatory requirements, including Delaware's Quality Strategy (QMS), NCQA standards, evidence-based guidelines established by medical specialty boards and societies, public health goals and national medical criteria. The Plan also uses performance measures such as HEDIS®, CAHPS®, Consumer and Provider surveys, and available results of the External Quality Review Organization (EQRO), as part of the QAPI program.

Quality Assessment Performance Improvement Committee

The QAPIC oversees AmeriHealth Caritas Delaware's efforts to measure, manage and improve quality of care and services delivered to Plan members, and evaluates the effectiveness of the QAPI program. Additional committees and council support the QAPI program and report into the QAPIC:

Member Advisory Committee – Provides a forum for member participation and input on Plan programs and policies to council, promote collaboration, maintain a member focus and enhance the delivery of services to AmeriHealth Caritas Delaware communities.

Quality of Service Committee – Monitors performance and quality improvement activities related to the Plan services; reviews, approves and monitors action plans created in response to identified variances. Drug Utilization Review Committees tracks and reviews operational service performance levels for multiple departments and ensure compliance with state contractual requirements.

Credentialing Committee – Reviews practitioner and provider applications, credentials and profiling data (as available) to determine appropriateness for participation in the AmeriHealth Caritas Delaware network.

Healthy Equity and Culturally Linguistically Appropriate Service (HECLAS) Workgroup – The Health Equity and Culturally and Linguistically Appropriate Services (HECLAS) Committee is a cross-departmental workgroup responsible for providing direction to AmeriHealth Caritas Delaware (ACDE) HECLAS initiatives. The HECLAS Committee directs activities that are relevant to the 15 National CLAS standards and to NCQA's Health Equity Accreditation standards that ensure that ACDE Members are served in a way that is responsive to their cultural and linguistic needs and focused on addressing health disparities for our racially, linguistically, and ethnically diverse members.

Practitioner Involvement

We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Services at 1-855-707-5818 or their Provider Network Account Executive.

QAPI Activities

The QAPI program is designed to monitor and evaluate the quality of care and service provided to members. Practitioners and providers agree to allow AmeriHealth Caritas Delaware to use their performance data as needed for the organization's QI activities to improve the quality of care and

services, and the overall member experience.

Performance Improvement Projects

The Plan develops and implements Performance Improvement Projects (PIPs) focusing on areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations.

Ensuring Appropriate Utilization of Resources

The Plan will perform baseline utilization measurements to calculate inpatient admission rates and length of stay, emergency room utilization rates and clinical guideline adherence for preventive health and chronic illness management services to identify those areas that fall outside the expected range to assess for over- or under-utilization.

Disease Management Programs

The Plan's Disease Management Programs were selected to address the expected high-incidence conditions for which there are evidence-based protocols that have been shown to improve health outcomes.

Measuring Member and Practitioner Satisfaction

The Plan uses the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member satisfaction. The Plan also conducts Practitioner Satisfaction studies annually. Survey results, along with analysis and trends on dissatisfaction and member opt-outs are reported to the QAPIC for review and identification/prioritization of opportunities for improvement.

Member and Practitioner Dissatisfaction

Dissatisfactions or complaints/grievances from members and providers are investigated, responded to and trended. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.

Member Safety Programs

The QAPI department is responsible for coordinating activities to promote member safety. Initiatives focus on promoting member knowledge about medications, home safety and hospital safety. Members are screened for potential safety issues during the initial assessment.

Preventive Health and Clinical Practice Guidelines

The QAPIC is responsible for approving all preventive health and clinical practice guidelines. Guidelines are developed using criteria established by nationally recognized professional organizations and with input from the QCCC. Guidelines are distributed via the Plan's website, with hard copies available upon request. As mandated by the State, participating providers will utilize clinical practice guidelines, including but not limited to those addressing:

- Adult and child preventive care, including Early Periodic Screening, Diagnosis and Treatment (EPSDT) services.
- Chronic conditions (i.e., diabetes and asthma).
- Behavioral health services.
- Obstetrical care.
- AIDS/HIV.
- Palliative care.

Availability and Accessibility Audits

Compliance with the Plan's availability standards is monitored at least quarterly to ensure sufficient numbers of network providers are available to meet member needs. An assessment is conducted to compare the type, number and location of network practitioners and providers to approved standards. The Plan also conducts monthly assessments of network providers' compliance with appointment standards for routine, urgent and sick office visits. Results of the survey are reported to the QCCC for review and recommendations.

Medical Record Requirements

Medical records of network providers are to be maintained in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates access, availability, confidentiality and organization of records at all times. Provider agrees to retain all medical records, whether electronic or paper, for a period of no less than seven (7) years after the last payment was made for the services of the member.

Providers are required by contract to make medical records accessible to all appropriate government agencies, including but not limited to the Delaware DHSS, the Delaware Division of Medicaid and Medical Assistance (DMMA), the United States Department of Health and Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), and their respective designee's in order to conduct fraud, abuse, waste and/or quality improvement activities.

Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate:

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient's first and last name and identification number is on each page of record.
- All entries specify location, date, times of service provision and are legible.
- Identification of the type of service being provided.
- All entries are initialed or signed by the author including professional credentials, if any.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations and illnesses.
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA."
- Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each member under the age of 65.
- Patient's chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Specific interventions, including name, dosage, and route of medications administered.
- Any supplies dispensed as part of the service.
- Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the Plan's Preventive Health Guidelines.
- Member's response to staff interventions.
- An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).

- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.
- Identification of the timeframe for documentation completion.
- Process to ensure units of service billed for payment are based on services provided with substantiating documentation.
- A provider may correct a medical record before submitting a claim for reimbursement; however, the correction must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

Medical Record Audits and Requests

AmeriHealth Caritas Delaware conducts medical record audits to capture HEDIS® data not obtained through claims submission. Medical records may be audited year-round. A fax request may be submitted to a provider office requesting specific medical records be sent to the Plan. At least five (5) business days' notice will be provided for a scheduled onsite audit. If requested, a member list will be provided with Medicaid ID, date of birth, and HEDIS® measure missing prior to the audit. The names of the reviewers performing the audits will also be provided, if requested.

The Quality Management Department shall conduct random quality reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality reviews shall be forwarded to the certifying or accrediting entity.

A quality review could include, but is not limited to, interviews with the consumer and the consumer's parents or legal guardian, designated case manager, and/or provider staff.

Adverse Event Reporting

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas Delaware sends information on reportable events, (as outlined in the NPDB Reporting Manual instructions) to the respective entity and to the State Board of Medicine, as appropriate, in Delaware.

All review outcomes, including actionable information, are incorporated in the provider credentialing

file and database.

Mandatory Reporting Requirements

AmeriHealth Caritas Delaware providers are required to comply with the reporting of specific conditions, diseases, and major incidents in accordance with state regulations and guidelines. Participating providers are also required to report suspected abuse, neglect and financial exploitation of adults and suspected abuse or neglect of children in accordance with State law.

Additionally, AmeriHealth Caritas Delaware providers are required to comply with the reporting requirements of Delaware Division of Public Health (DPH) registries and programs, including but not limited to the Delaware Cancer Registry and DPH Immunization Registry.

Potential Quality of Care Concerns

Potential quality of care concerns are fully investigated by AmeriHealth Caritas Delaware. Quality of care (QOC) concerns will be thoroughly investigated by clinical reviewers in accordance with company policy. Summaries and situational reviews are presented to the Credentialing Committee on a monthly basis. Serious QOC concerns may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from the Plan's network, sanctions or corrective action. Referral to the QAPIC is the discretion of the plan Medical or QM Director.

If the QAPIC investigation involves an action reportable to a national or state entity or database, the appropriate practitioner/provider's case information will be reported to the National Practitioner Data Bank (NPDB) and state regulatory agencies.

The QM Department reserves the right to impose any of the following actions, based on its discretion:

- Submission of medical records.
- Requiring the practitioner/provider to submit of a written description and explanation of the quality of care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record review audit.
- Requiring that the practitioner/provider conform to a corrective action plan which may include continued monitoring by AmeriHealth Caritas Delaware to ensure that adverse events do not continue.
    - This requirement will be documented in writing. A corrective action plan may also include provisions that the practitioner/provider maintain an acceptable pass/fail

score with regard to a particular performance metric.

In addition, the Credentialing Committee or QAPIC may recommend the following:

- Implementing formal sanctions, including termination from the AmeriHealth Caritas Delaware network if the offense is deemed an immediate threat to the well-being of Plan members.

AmeriHealth Caritas Delaware reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the corrective actions listed above.

At the conclusion of the investigation, the practitioner/provider will be notified by letter of the concern of the actions recommended by the QAPIC, including an appropriate time period within which the practitioner/provider must conform to the recommended action.

Provider Sanctioning Policy

It is the goal of AmeriHealth Caritas Delaware to assure members receive quality health care services. In the event that medical, behavioral health, or LTSS care services rendered to a member by a network provider represent a serious deviation from, or repeated non-compliance with, the Plan's quality standards, recognized treatment patterns of the organized medical community, and/or standards established by the State, the network provider may be subject to AmeriHealth Caritas Delaware's formal sanctioning process.

Except for any applicable state licensure board reporting requirements, all sanctioning activity is strictly confidential.

Formal Sanctioning Process

Following a determination to initiate the formal sanctioning process, AmeriHealth Caritas Delaware will send the practitioner/provider written notification of the following by certified mail or via another means providing for evidence of receipt. The notice will include:

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with AmeriHealth Caritas Delaware on the proposed action.
- Reminder that the practitioner/provider has 30 days following receipt of notification within which to submit a written request for a hearing. Otherwise, the right to a hearing will be forfeited. The practitioner/provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action he/she wishes to contest.
- Notification that the practitioner/provider may waive his/her right to a hearing and that the right will be considered waived if no written request for a hearing is submitted.

Notice of Hearing

If the provider requests a hearing in a timely manner the provider will be notified of the following in writing:

- The place, date and time of the hearing, which will not be less than 30 days after the date of the notice.
- That the provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the AmeriHealth Caritas Delaware Medical Director and/or upon advice of the AmeriHealth Caritas Legal Affairs department.
- A list of witnesses (if any) expected to testify at the hearing on behalf of AmeriHealth Caritas Delaware.

Conduct of the Hearing and Notice

The hearing will be held before a panel of individuals appointed by AmeriHealth Caritas Delaware (the Hearing Panel), as follows:

- Individuals on the Hearing Panel will not be in direct economic competition with the practitioner/provider involved, nor will they have participated in the initial decision to propose sanctions.
- The Hearing Panel will be composed of physician members of AmeriHealth Caritas Delaware's quality-related committees, AmeriHealth Caritas Delaware's Medical Director and/or designee, and other physicians and administrative persons affiliated with AmeriHealth Caritas Delaware as deemed appropriate by the Plan's Medical Director, such as legal counsel.
- AmeriHealth Caritas Delaware's Medical Director or his/her designee serves as the Hearing Officer.
- The right to the hearing will be forfeited if the practitioner/provider fails, without good cause, to appear.

Provider Hearing Rights

The provider has the right to:

- Representation by an attorney or other person of the provider's choice;
- Have a record made of the proceedings (copies of which may be obtained by the provider upon payment of reasonable charges associated with the preparation);
- Call, examine and cross-examine witnesses;
- Present evidence determined to be relevant by the hearing officer, regardless of its

admissibility in a court of law;

- Submit a written statement at the close of the hearing;
- Receive the written recommendation(s) of the Hearing Panel within 15 working days of completion of the hearing, including statement of the basis for the Hearing Panel's recommendation(s), which will be provided by certified mail or via another means providing for evidence of receipt; and,
- Receive AmeriHealth Caritas Delaware's written decision within 60 days of completion of the hearing, including the basis for AmeriHealth Caritas Delaware's decision(s), which will be provided by certified mail or via another means providing for evidence of receipt.

Appeal of AmeriHealth Caritas Delaware Decision

The provider may request an appeal after the final decision of AmeriHealth Caritas Delaware. The practitioner/provider must submit a written appeal by certified mail or via another means providing evidence of receipt, within 30 days of the receipt of the Plan's decision; otherwise the right to appeal is forfeited. Written appeal will be reviewed and a decision rendered by the Plan's QAPIC within 30 days of receipt of the notice of the appeal.

Summary Actions Permitted

The following summary actions can be taken, without the need to conduct a hearing, by the Regional President or Market President of AmeriHealth Caritas Delaware or by the Plan's Medical Director:

- Suspension or restriction of the practitioner or provider's participation status for up to 14 days, pending an investigation to determine the need for formal sanctioning process; or,
- Immediate suspension or revocation, in whole or in part, of panel membership or participating practitioner/provider status, subject to subsequent notice and hearing, when it is determined that failure to take such action may result in immediate danger to the health and/or safety of any individual. A hearing will be held within 30 days of the summary action to review the basis for continuation or termination of this action.

Critical Incidents and Provider Preventable Conditions

All critical incidents require notification to the Plan immediately or as reasonably possible following the incident. A critical incident includes but is not limited to the following incidents:

- Abuse
- Neglect
- Mistreatment
- Exploitation
- Injury/Fall or Unexpected medical Issue
- Medication Diversion
- Medication Administration Error
- Elopement
- Unsafe Behavior
- Death
- Theft/Missing Items
- Environmental

- Complaint
- Other/Unsure

Critical incidents should be reported to the appropriate agency, including Division of Medicaid and Medical Assistance (DMMA), Division of Developmental Disabilities Services (DDDS), Division of Substance Abuse and Mental Health (DSAMH), Division of Health Care Quality- Acute and Long Term Care through the WellSky portal. Portal link: https://hssdedhssprod.wellsky.com/assessments/?WebIntake=9A2787C9-BDCF-449A-BFD7-59B32DD77BE7
Portal information can be found here: https://training.wellsky.com/delaware/
Should you have questions, please contact AmeriHealth Caritas Delaware's Quality Management Department at 1-302-286-5896

In addition to the list above, critical incidents include Sentinel and Never events as defined below:

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as "sentinel" because they signal the need for immediate investigation and response. Please note, the terms "sentinel event" and "medical error" as not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.
  - Examples of a sentinel event include:
    - Maternal death after delivery.
    - Suicide while inpatient.
- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above.
  - Examples of Never Events include:
    - Surgery performed on the wrong patient.
    - Surgery on the wrong body part.
    - Unintended retention of a foreign object after surgery.

See **www.CMS.gov** for a complete list.

Provider Preventable Conditions

AmeriHealth Caritas Delaware will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Hospital Acquired Conditions and Other Provider-Preventable Conditions. Providers must also report Critical Incidents to the health plan.

Health Care Acquired Conditions

The category of Hospital Acquired Condition (HAC) applies to Medicaid inpatient hospital settings only. Under this category, the Plan does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Catheter Associated Urinary Tract Infection.
- Stage III and IV Pressure Ulcers (Decubitus Ulcers).
- Falls and trauma (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes).
- Vascular Catheter Associated Infection.
- Surgical Site Infection following:
- Coronary Artery Bypass Graft (CABG).
- Certain Orthopedic Procedures
- Bariatric Surgery for Obesity.
- Cardiac Implantable Electronic Device (CIED)
- Manifestations of Poor Glycemic Control.
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
- Latrogenic Pneumothorax with Venous Catheterization
  https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac

Reporting of critical incidents is required for all health plan members.

AmeriHealth Caritas Delaware monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of the Plan.

AmeriHealth Caritas Delaware's goals are to:

- Have a positive impact on improving patient care, treatment and services and prevent unusual occurrences;
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future; and,
- Increase general knowledge about unusual occurrences, their causes and strategies for prevention.

Reporting Critical Incidents

Providers are expected to report critical incidents, as described above, to the Plan in real-time. The Plan recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore, allowance is made for the stabilization of the member prior to reporting. All critical incidents must be reported to the Plan within 24 hours of occurrence through the identified critical

incident reporting process noted earlier.

AmeriHealth Caritas Delaware will not take punitive action or retaliate against any person for reporting occurrence critical incident. The practitioners involved will be offered the opportunity to present factors leading to the event and to respond to any questions arising from the review of the critical incident.

Once an AmeriHealth Caritas Delaware staff member identifies or is notified of a critical incident, as defined above, the following procedures will take place to investigate and address the occurrence:

1. The Quality Management department is notified of the event via an incident report, telephone, or email as soon as reasonably possible after identification of the occurrence.
2. The Quality Management Director will collaborate with the Market Chief Medical Officer and investigate as appropriate. Certain occurrences may require review of medical records to assist in the investigation.
3. The Quality Management department leads the investigation; analysis and reporting of all identified unusual occurrences.
4. All critical incidents require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance.
5. As appropriate, issues are identified for correction and corrective action plans are developed by the provider to prevent reoccurrence of the event. The corrective action plan will identify strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The corrective action plan by the provider will address responsibility for implementation, oversight, time lines and strategies for measuring the effectiveness of the actions.
6. Critical incidents will be reported to the Delaware Division of Medicaid and Medical Assistance (DMMA) and other appropriate investigative agencies by the Plan within contractual reporting requirements.
7. As appropriate, other state and federal agencies will also be notified of critical incidents.
8. As appropriate, information from the investigation of critical incidents will be provided to the Credentialing Committee to support the re-credentialing process.

Reporting Provider Preventable Conditions or Critical Incidents

Please contact the AmeriHealth Caritas Delaware UM Department at **1-855-396-5770** to report a provider preventable condition. Please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual* for more information regarding AmeriHealth Caritas Delaware's policy on provider preventable conditions and how to report such conditions via the

claims process.

SECTION VIII
Cultural Competency Program and Requirements

Section VIII: Cultural Competency Program and Requirements

Introduction

Embedded in all AmeriHealth Caritas Delaware efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our provider community, by leveraging ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network.

AmeriHealth Caritas Delaware routinely examines the access to care standards for both the general population and the population who speaks a threshold language. A threshold language is a language spoken by at least five percent or 1,000 members of AmeriHealth Caritas Delaware's member population.

In addition, every edition of the provider newsletter includes a pertinent article on addressing cultural or language issues.

Our Cultural Competency Program, led by a cross-departmental workgroup, has been built upon the following 15 national standards for Culturally and Linguistically Appropriate Services (CLAS) as set forth by the U.S. Department of Health and Human Services:

Principal Standard

1. Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

1. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
2. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
3. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication of Language Assistance

1. Offer language assistance to individuals who have limited English proficiency and/or other

communication needs, at no cost to them, to facilitate timely access to all health care and services.

2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

1. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
2. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
3. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
4. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
5. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
6. Create conflict and grievance-resolution process that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
7. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

Providers may request more information on the Cultural Competency Program by contacting Provider Services **1-855-707-5818.**

Cultural and Linguistic Requirements

Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply

with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Section 4302 of the Affordable Care Act supports the self-reported collection of race, ethnicity, sex, primary language and disability status according to the Office of Management and Budget (OMB categories). This provision allows the Plan to comply with federal and national provisions established to reduce health disparities and deliver culturally competent care.

As a provider of health care services who receives federal financial payment through the Medicaid program, you are responsible to make arrangements for language services for members, upon request, who are either Limited English Proficient (LEP) or Low Literacy Proficient (LLP) to facilitate the provision of health care services to such members.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/health care provider relationship. The key to ensuring equal access to benefits and services for LEP, LLP and sensory impaired members is to ensure that you, our Network Provider, can effectively communicate with these members**.** Plan providers are obligated to offer translation services to LEP and LLP members upon request and to make reasonable efforts to accommodate members with other sensory impairments.

Providers are required to:

- Offer written and verbal language access at no cost to Plan members with limited- English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent interpreters, as necessary.
- Offer members verbal or written notice (in their preferred language or format) about their right to receive free language services assistance.
- Post and offer easy-to-read member signage and materials in the languages of the common cultural groups in the Provider's service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.
- Discourage members from using family or friends as oral translators.*
- Advise members that language services are available through AmeriHealth Caritas Delaware, if the Provider is not able to obtain necessary language services for a member.

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation services and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

AmeriHealth Caritas Delaware contracts with a competent telephonic interpreter service provider. We

have an arrangement to make our corporate rate available to participating plan providers. If you need more information on using this telephonic interpreter service, please contact Provider Services at **1-855-707-5818.**

Health care providers who are unable to arrange for interpretation services for an LEP, LLP or sensory impaired member should contact Member Services at:

DSHP Member Services: **1-844-211-0966**; TTY: **1-855-349-6281**
DSHP Plus Member Services: **1-855-777-6617**; TTY: **1-855-362-5769**

A representative will help locate a professional interpreter to communicate in the member's primary language.

When a member uses the Plan's interpretation services, the provider must sign, date and complete documentation in the medical record in a timely manner to reflect the use of services.

AmeriHealth Caritas Delaware contracts with Language Services Associates (LSA) to provide American Sign Language (ASL) services. Securing ASL interpretation services requires two weeks' notice prior to the date of service. If you need additional information on using this service, please contact Provider Services at **1-855-707-5818.**

In addition to the requirements listed above, under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all members in a manner compatible with the member's cultural health beliefs and practices of preferred language/format;
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area;
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services;
- Establish written policies to provide interpretive services for plan members upon request; and,
- Routinely document preferred language or format, such as Braille, audio, or large type, in all member medical records.

Enhancing Cultural Competency in Health Care Settings

AmeriHealth Caritas Delaware encourages providers and their staff to report their race and ethnicity and the languages they speak. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare, or CAQH.

Provider and member information is analyzed to identify opportunities for improvement so the Plan can provide the best possible service to its providers and members.

The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.

Additional Resources

The following additional resources are available upon request:

- HHS Health Resources and Services Administration: Culture, Language Health Literacy
- National Institutes of Health: Clear Communication / Cultural Competency
- Health Literacy Innovations™
- The Health Literacy & Plain Language Resource Guide

Cultural Sensitivity Training the Cultural Competency Training Landing Page

In an effort to deliver culturally sensitive and appropriate care to members who have limited English proficiency, represent diverse cultural and ethnic backgrounds, special health needs, who are poor, homeless, and or from a minority population group, AmeriHealth Caritas Delaware offers providers an annual cultural competency training that will address:

- Delivering services and care that honors members' beliefs.
- Understanding and providing services in a manner that is sensitive to cultural diversity.
- Fostering attitudes and interpersonal communication styles that respect diverse cultural backgrounds.
- Addressing health disparities, the social determinants of health, and health literacy.

Providers are also encouraged to complete the free e-learning cultural competency training offered by HHS Office of Minority Health titled, "A Physician's Practical Guide to Culturally Competent Care." This training offers up to 6 CEU's can be accessed at: **https://cccm.thinkculturalhealth.hhs.gov/.**

Cultural Competency Terms and Definitions

Providers should be aware of the following terms and their definitions:

Cultural Competence

The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

"Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social

groups.

"Competence" implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities.

Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location.

Individuals with Limited English Proficiency (LEP)

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

Low Literacy Proficiency

In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve his or her goals and develop his or her knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.

Sensory Impaired

A person who is deaf or visually impaired.

SECTION IX
Claims Submission Protocols and Standards

Section IX: Claims Submission Protocols and Standards

Claims Submission

All claims for services rendered by in-network providers must be submitted to AmeriHealth Caritas Delaware within 120 days from the date of service (or the date of discharge for inpatient admissions). Claims submitted by practitioners must be billed on the CMS-1500 or UB-04 or via the electronic equivalent (EDI) of these standard forms. The following mandatory information is required on all claims:

- Member's (patient's) name.
- Member's Plan ID number.
- Member's date of birth and address.
- Other insurance information: company name, address, policy and/or group number.
- Amounts paid by other insurance (with copies of matching EOBs).
- Information advising if member's condition is related to employment, auto accident or liability suit.
- Date(s) of service, admission, discharge.
- Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the full specificity available, which may be 3, 4, 5, 6, or 7 digits.
- Name of referring physician, if appropriate.
- HCPCS procedures, services or supplies codes.
- CPT procedure codes with appropriate modifiers.
- CMS place of service code.
- Charges (per line and total).
- Days and units.
- Physician/supplier Federal Tax Identification Number or Social Security Number.
- National Practitioner Identifier (NPI) and Taxonomy.
- Physician/supplier billing name, address, zip code, and telephone number.
- Name and address of the facility where services were rendered.
- NDC's required for physician administered injectable that are eligible for rebate.
- Invoice date.
- Provider Signature.

Note: AmeriHealth Caritas Delaware also encourages providers to submit claims using:

- Plan-assigned individual practitioner ID numbers.
- Plan-assigned member ID numbers.

Out-of-network providers are required to submit claims **within 120 days** from the date of service.

General Procedures for Claim Submission

AmeriHealth Caritas Delaware is required by state and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

When required data elements are missing or invalid, claims will be **rejected** by the Plan for correction and re-submission. Claims for billable services provided to AmeriHealth Caritas Delaware members must be submitted by the provider who performed the services.

Claims filed with AmeriHealth Caritas Delaware are subject to the following procedures:

- Verification that all required fields are completed and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an out-of-network provider has received authorization to provide services to the eligible member.
- Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas Delaware.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to AmeriHealth Caritas Delaware.

AmeriHealth Caritas Delaware accepts paper and electronic claims. Plan providers and practitioners are encouraged to submit claims electronically for faster turn-around.

For more detailed billing information and line-by-line instructions, please refer to the *Claims Filing Instructions*, available in the provider area of our website at: **www.amerihealthcaritasde.com.**

Electronic Claims Submission (EDI)

AmeriHealth Caritas Delaware encourages all providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or Change Healthcare's (formerly Emdeon) Provider Support Line at **1-877-363-3666** for more information.

There are many different products that may be used to bill electronically. As long as you have the capability to send EDI claims to Change Healthcare (formerly Emdeon), whether through direct

submission or through another clearinghouse/vendor, you may submit claims electronically.

- Be prepared to inform the vendor of the Plan's electronic payer identification number.

AmeriHealth Caritas Delaware's EDI Payer ID#: **77799**

Paper Claim Mailing Instructions

Please submit paper claims to the address below:

AmeriHealth Caritas Delaware
Attn: Claims Processing Department
P.O. Box P.O. Box 80100
London, KY 40742-0100

Claim Filing Deadlines

All original paper and electronic claims must be submitted to AmeriHealth Caritas Delaware **within 120 calendar days** from the date services were rendered (or the date of discharge for inpatient admissions). This applies to capitated and fee-for-service claims. Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.

Rejected claims are those returned to provider or EDI source without being processed or adjudicated, due to a billing issue and defined as claims with missing or invalid data elements, such as the provider tax identification number or member ID number. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim. Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data **within 120 calendar** days from the date services were rendered (or the date of discharge for inpatient admissions).

Rejected claims

- Rejected paper claims have a letter attached with a document control number (DCN).
- A DCN is **not** an ACDE claim number. Rebilling of a rejected claim should be done as an original claim.
- Since rejected claims are considered original claims the timely filing limits should be followed.

Denied Claims are those that were processed in the claims system. They may have a payment attached or may have been denied. A corrected claim (see below) may be submitted to have the claim reprocessed.

Corrected claim is defined as a claim that ACDE paid based on the information submitted but the provider submits a claim correcting the original data. A corrected claim must be submitted **within 365 days** of the original date of service. The original claim number must be submitted as indicated below as well as the correct frequency code.

- You can find the original claim number from the 835 ERA, the paper Remittance Advice or from the claim status search in NaviNet®.
- If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet® to get the claim number.
- Corrected/replacement and voided claims may be sent electronically or on paper.
    - If sent electronically, the ***claim frequency code*** (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '**7**' for the Replacement (correction) of a prior claim and '**8**' for the void of a prior claim. The value '**6**' should no longer be sent.
    - In addition, the submitter must also provide the original claim number in ***Payer Claim Control Number*** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).

Claims with Explanation of Benefits (EOBs) from primary insurers, including Medicare, must be submitted **within 60 days** of the date on the primary insurer's EOB.

Important Billing Reminders

Claim Reporting

Visit Reporting

CMS defines an encounter as "an interaction between an individual and the health care system." Encounters occur whenever an AmeriHealth Caritas Delaware member is seen in a provider's office or facility, whether the visit is for preventive health care services or for treatment due to illness or injury.

An encounter is any health care service provided to a Plan member. Encounters must result in the creation and submission of an encounter record or claim (CMS-1500 or UB-04; paper form or electronic submission) to AmeriHealth Caritas Delaware. The information provided on these claims represents the encounter data the Plan reports to the state, according to mandatory reporting requirements.

Completion of Encounter (Claims) Data

PCPs must complete and submit a CMS-1500 or UB-04 paper form or file an electronic claim every time an AmeriHealth Caritas Delaware member receives services from the provider. Completion of the CMS-1500 or UB-04 form or electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services.
- It allows the Plan to gather statistical information regarding the medical services provided to members, which better support our statutory reporting requirements.
- It allows the Plan to identify the severity of illnesses of our members.

AmeriHealth Caritas Delaware accepts claim submissions via paper or electronically (EDI). For more information on electronic claim submission and how to become an electronic biller, please refer to the billing information available on our Plan website at **www.amerihealthcaritasde.com**.

In order to support timely statutory reporting requirements, PCPs must submit encounters (claims) within 120 days of the visit.

AmeriHealth Caritas Delaware monitors claim data submissions for accuracy, timeliness, and completeness through claims processing edits and through network provider profiling activities. Claims can be rejected or denied for inaccurate, untimely, and incomplete information. Network providers will be notified of the rejection via a remittance advice and are expected to re-submit corrected information to the Plan. Network providers may also be subject to sanctioning by the Plan for failure to submit accurate claim data in a timely manner.

Claims Inquiry

If a provider does not receive payment for a claim within 45 days or has concerns regarding any claim issue, claims status information is available by:

- Visiting the NaviNet provider website, our secure provider portal. Log on to www.navinet.navimedix.com for web-based solutions for electronic transactions and information.
- You may open a claims investigation via NaviNet with the claims adjustment inquiry function.
- Calling Provider Services at **855-707-5818** and following the prompts.

- Calling your Account Executive for assistance.

Balance Billing Members

Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas Delaware to participating Plan providers must be accepted as payment in full for services rendered. Members may not be balanced billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims provider complaint processes to resolve any outstanding claims payment issues.

Requests for Adjustments

You may open a claims investigation via NaviNet with the claims adjustment inquiry function. Requests for adjustments may also be submitted to Provider Claims Services at:

Phone:
Provider Services: **1-855-707-5818** (Select the prompts for the correct department and then select the prompt for claim issues.)

Mail:
Please address your request to:
AmeriHealth Caritas Delaware
Attn: Claims Processing Department
P. O. Box P.O. Box 80100
London, KY 40742-0100

Provider Complaints about Claims

If a claim or a portion of a claim is denied for any reason or underpaid, the provider may file a complaint about the claim within 365 days from the date of service. A telephone inquiry regarding payment or denial of a claim does not constitute a complaint of the claim. Provider Complaints must be submitted in writing, along with supporting documentation, to:

AmeriHealth Caritas Delaware
Attn: Provider Complaints
P. O. Box P.O. Box 80101
London, KY 40742-0101

Refunds for Improper Payment or Overpayment of Claims

If a Plan provider identifies improper payment or overpayment of claims from AmeriHealth Caritas Delaware the improperly paid or overpaid funds must be returned to the Plan within 60 days of

identification. Providers are required to return the identified funds to the Plan by submitting a refund check directly to the claims processing team:

AmeriHealth Caritas Delaware
Attn: Claims Processing Department
P. O. Box 80100
London, KY 40742-0100

Note: Please include the member's name and ID, date of service and claim ID.

Third Party Liability/Subrogation

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than AmeriHealth Caritas Delaware. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as AmeriHealth Caritas Delaware, are always the payer of last resort. This means that all other insurance carriers (the "Primary Insurers") must consider the health care provider's charges before a claim is submitted to AmeriHealth Caritas Delaware.

Therefore, before billing AmeriHealth Caritas Delaware when there is a Primary Insurer, health care providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Providers may then bill AmeriHealth Caritas Delaware for the remaining balance on a claim by submitting the claim along with a copy of the Primary Insurer's EOB.

Claims with Explanation of Benefits (EOBs) from primary insurers, including Medicare, must be submitted **within 60 days** of the date on the primary insurer's EOB.

In the event of an accidental injury (personal or automobile) where a third party payer is deemed to have liability and makes payment for services that have been considered and paid under the AmeriHealth Caritas Delaware contract, the Plan will be entitled to recover any funds up to the amount owed by the third party payer.

While this is a requirement in most cases, there are exceptions when providers are not required to bill the third party prior to AmeriHealth Caritas Delaware. The exceptions are:

- The claim is for prenatal care for a pregnant woman.
- The claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program.

Following reimbursement to the provider in these cost avoidance exception cases, AmeriHealth

Caritas Delaware shall actively seek reimbursement from responsible third parties and will adjust claims accordingly.

Additional Information for Electronic Billing

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass Change Healthcare (formerly Emdeon) HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted with all necessary and valid data elements within the required filing deadline of 120 days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Change Healthcare (formerly Emdeon) or your EDI software vendor in order to identify and re-submit these claims accurately.

Monitoring Reports for Electronic Claims

Change Healthcare (formerly Emdeon) will produce an Acceptance Report* and a R059 Plan Claim Status Report** for its trading partner whether that is the EDI vendor or provider. Providers using Change Healthcare (formerly Emdeon) or other clearinghouses and vendors are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments. In order to verify satisfactory receipt and acceptance of submitted records, please review both the Change Healthcare (formerly Emdeon) Acceptance Report and the R059 Plan Claim Status Report.

*Acceptance Report verifies acceptance of each claim at Change Healthcare (formerly Emdeon).

**R059 Plan Claim Status Report is a list of claims that passed Change Healthcare's (formerly Emdeon) validation edits. However, when the claims were submitted to the Plan, they encountered provider or member eligibility edits.

Plan Specific Electronic Edit Requirements

AmeriHealth Caritas Delaware currently has two specific edits for professional and institutional claims sent electronically:

- **837P –005010X222A1–** Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
- **837I – 005010X223A2 –** Provider ID Payer Edit states the ID must be less than 13alphanumeric digits.

Note: Statement date must be not be earlier than the date of service and Plan-assigned individual practitioner ID number is strongly encouraged.

Electronic Billing Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups and apply to inpatient and outpatient claim types.

Excluded Claim Categories. At this time, these claim records must be submitted on paper.
Claim records for medical, administrative, or claim appeals.

Excluded Provider Categories. Claims issued on behalf of the following providers must be submitted on paper.
Providers not transmitting through Change Healthcare or providers sending to Vendors that are not transmitting (through Change Healthcare) NCPDP Claims.
Pharmacy (through Change Healthcare).

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Change Healthcare
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
Claims without provider numbers
Claims without member numbers
Claims in which the date of birth submitted does not match the member ID.

Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims received with invalid provider numbers
Claims received with invalid member numbers
Claims received with invalid member date of birth

Re-submitted Corrected Claims

Providers using electronic data interchange (EDI) can submit "institutional" and "professional" corrected claims* electronically or via paper claim to AmeriHealth Caritas Delaware. This *Provider Manual* offers basic instructions for the submission of corrected claims via EDI or paper; for more detailed guidance, please refer to the *Claims Filing Instructions* available online at **www.amerihealthcaritasde.com.**

Note: A "corrected claim" is defined as a re-submission of a claim with a specific change you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review

the processing of a claim.

Your EDI clearinghouse or vendor needs to remember the following:

- Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- Include the original claim number in Loop 2300, segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- Corrected claims for which the original claim number cannot be validated will be rejected.
- **Do** use the indicator for claims that were previously processed (approved or denied).
- **Do Not** use the indicator if the corrected claim is for a different member ID or Provider TaxID. The original claim must be voided and a new claim submitted for these situations.
- **Do not** use the indicator for claims that contained errors and were not previously processed (those that were rejected upfront).
- **Do not** submit corrected claims electronically and via paper at the same time.

For more information, please contact EDI Technical Support by email at **edi.acde@amerihealthcaritas.com.**

Providers can also open a claims investigation via NaviNet with the claims adjustment inquiry function at: **www.navinet.net**.

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically…	**Contact Change Healthcare (formerly Emdeon):** 1-877-363-3666.
If you have general EDI questions …	**Contact EDI Technical Support:** **edi.acde@amerihealthcaritas.com**
If you have questions about specific claims transmissions or Acceptance and R059 - Claim Status reports…	**Contact your EDI software vendor or call the Change Healthcare (formerly Emdeon) Provider Support Line:** 1-800-845-6592**.**
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)…	**Contact Provider Services:** 1-855-707-5818
If you have questions about claims that are reported on the remittance advice…	**Contact Provider Services:** 1-855-707-5818
If you need to know your provider NPI number…	**Contact Provider Services:** 1-855-707-5818
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information… **OR** **For questions about changing or verifying provider information…**	**Please contact Provider Services:** **By Fax:** 1-855-396-5790 **By Telephone:** 1-855-707-5818
If you would like information on the 835 remittance advice…	**Contact your EDI vendor or call Change Healthcare (formerly Emdeon):** 1-877-363-3666**.**
Check the status of your claim…	Review the status of your submitted claims by logging in to NaviNet at **https://navinet.navimedix.com/.**

Sign-up for the Provider Portal…	**Go to http://www.navinet.net/ or contact NaviNet Customer Service (via Nant Health Support):** 1-888-482-8057**.**
Sign-up for Electronic Funds Transfer…	**Contact Change Healthcare (formerly Emdeon):** 1-877-363-3666**.**

Provider Preventable Conditions (PPC)

AmeriHealth Caritas Delaware will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions.

The category of Health Care Acquired Conditions (HCAC) applies to Medicaid inpatient hospital settings only. Under this category, the Plan does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign object retained after surgery.
- Air embolism.
- Blood incompatibility.
- Catheter associated urinary tract infection.
- Pressure ulcers (Decubitus ulcers).
- Vascular catheter associated infection.
- Mediastinitis after coronary artery bypass graft (CABG).
- Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes).
- Manifestations of poor glycemic control.
- Surgical site infection following certain orthopedic procedures.
- Surgical site infection following bariatric surgery for obesity.
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.
- Except for pediatric and obstetric populations.

The category of Other Provider-Preventable Conditions (OPPC) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs. Under this category, the Plan will not reimburse providers for any of the following never events in any inpatient or outpatient setting:

- Surgery performed on the wrong body part.
- Surgery performed on the wrong patient.
- Wrong surgical procedure performed on a patient.

Mandatory Reporting of Provider Preventable Conditions

In addition to broadening the definition of PPCs, the ACA requires payers to make pre-payment adjustments. **Therefore, a PPC must be reported by the provider at the time a claim is submitted.** Note that this requirement applies even if the provider does not intend to submit a claim for

reimbursement for the service(s) rendered.

Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a "Present on Admission" indicator.
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; the Plan will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the E diagnosis codes, such as E876.5, E876.6 or E876.7 in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 (or successor) diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q. Examples of ICD-10 and "E" diagnosis codes include:

- Wrong surgery on correct patient E876.5;
- Surgery on the wrong patient, E876.6;
- Surgery on wrong site E876.7
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired".

Inpatient Claims

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired**.**

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted via the paper claims process with the member's medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment

will be adjusted based on exclusion of the PPC from the DRG. Facilities do not need to submit copies of medical records for PPCs associated with this payment type.

Indicating Present on Admission (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the "Present on Admission" (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG-based facilities may submit POA via 837I in loop 2300; segment NTE, data element NTE02.

Valid POA Indicators Include:

- "Y" = Yes = present at the time of inpatient admission.
- "N" = No = not present at the time of inpatient admission.
- "U" = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission.
- "W" = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not "null" = Exempt from POA reporting.

Reimbursement Policy

Prospective Claims Editing Policy

AmeriHealth Caritas Delaware's claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include, but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

Pre-Operative Test Requirements

It is the surgeon's responsibility to provide information to the member on the hospital's requirements for pre-operative physical examination, laboratory and radiology tests. Lab specimens may be drawn by the surgeon or PCP and sent to the appropriate participating lab for work-up.

SECTION X
Behavioral Health Care

Section X: Behavioral Health Care

Introduction

Behavioral Health Services are a critical part of the overall package of care provided to members of AmeriHealth Caritas Delaware. Please note that, in general, the responsibilities, expectations and processes outlined in this *Provider Manual* pertain to all providers, including behavioral health providers, unless otherwise indicated in this section or specified via subsequent communications.

Credentialing of Behavioral Health Providers

AmeriHealth Caritas Delaware works to maintain access to the full scope of care and service resources within established state standards of access and choice for all Plan members. AmeriHealth Caritas Delaware strives to offer a provider network that provides the highest level of quality, as well as adequate choices and convenience to members. All behavioral health network providers are credentialed and re-credentialed to provide clinical care and services.

The following types of individual providers, facilities and provider organizations that provide only behavioral health and/or HCBS services fall under the authority of the behavioral health credentialing/re-credentialing process:

- Independently Practicing Licensed Physicians (Psychiatrist / Addictive Medicine).
- Independently Practicing Licensed Psychologists.
- Independently Practicing Licensed Behavioral Health Clinicians (LPC, LMFT, LCISW, and LMFT).
- Behavioral Analysts.
- Hospital/Inpatient Facilities.
- Community Mental Health Centers.
- Psychiatric Residential Treatment Facilities.
- Institutes of Mental Disease (IMD).
- Nursing Facility - Mentally Ill.
- Home and Community Based Service (HCBS).
- Psychiatric Residential Treatment Facility (PRTF).

Other provider types that offer both medical and behavioral health services are covered by credentialing for the physical health provider network:

- FQHC.
- HCBS Habilitation.
- Crisis Intervention/Stabilization Providers.
- Screening Center.

- Patient Centered Medical Homes.
- Community Based ICF/ID.
- School based wellness centers.

Behavioral Health Provider Application Process

Individual Practitioner Application

The application process for individual behavioral health practitioners requires submission of a completed application. The application must include evidence, such as copies of diplomas, licenses, insurance riders, documentation of privileges, etc.

You must participant with Council for Affordable Quality Healthcare (CAQH), and you must approve AmeriHealth Caritas Delaware to pull the application from CAQH. Through CAQH, each practitioner determines what entity is eligible to receive his or her credentialing information. Providers who have elected "universal" status need not do anything in order for AmeriHealth Caritas Delaware to receive their information. If you do not have broad distribution permissions, please select AmeriHealth Caritas Family of Companies or AmeriHealth Caritas Delaware for us to receive your application.

Professional Provider Organization and Facility Application Process

Facility and professional provider organizations must complete a facility application. The following types of organizations are considered facilities:

- Hospitals.
- Free Standing Psychiatric Facilities.
- Chemical Dependency Treatment Centers.
- Partial Hospitalization Programs.
- Accredited Outpatient Facilities.
- Community Mental Health Centers.
- Other Facility-Based Services/Programs.

Please download your application at: **www.amerihealthcaritasde.com**, complete, and fax to **215-863-6369** or contact your Account Executive for assistance. Beginning January 1, 2018, please send applications to **behavioralhealthde@amerihealthcaritas.com**.

Please refer to the "Provider and Network Information" section of this *Provider Manual* for information regarding credentialing and re-credentialing of practitioners and facilities.

Behavioral Health Practitioner/Provider Credentialing Rights

Right to Review Information Submitted

Behavioral health providers have the right to review information submitted to support the credentialing application process with the exception of peer references and National Practitioner Data Bank (NPDB) reports. Currently peer references are not required as part of the credentialing process. In addition, behavioral health providers have the right to be notified of information received by the plan that is substantially different than was reported by the provider. Practitioners will be sent a letter notifying them of the information that varies substantially from what was received.

Right to Correct Erroneous Information

Behavioral health providers have the right to correct erroneous information submitted in support of their credentialing application. Corrections must be submitted in writing to the Credentialing Department within ten (10) business days of notification of the erroneous information. Corrections or information received will be reviewed and documented in the practitioner's file.

Right to be Informed of Application Status

Behavioral health providers may request information about the status of the application they submitted at any time during the credentialing process. Such requests must be made to the Credentialing Coordinator, who will provide information about the status of the application, including whether or not it was received, whether or not it is complete, and/or whether or not it is scheduled to be presented to the Credentialing Committee, etc.

Right to be Notified of Credentialing Decisions

Behavioral health providers have the right to be notified within 45 calendar days of the Credentialing Committee or Medical Director review decision.

Right to Appeal

Behavioral health providers have the right to appeal any credentialing/re-credentialing denial within 30 calendar days of receiving written notification of the decision.

Credentialing Committee/Medical Director Decision

AmeriHealth Caritas Delaware does not make credentialing/re-credentialing decisions based on the applicants' race, ethnic/national identity, gender, age, sexual orientation, the types of procedures in which the practitioner specializes or the patients for which the practitioner provides care. In developing its network, AmeriHealth Caritas Delaware strives to meet the cultural and special needs of members.

Once all information is received and primary source verifications are completed, the behavioral health providers file is presented to either the Medical Director or Credentialing Committee for review and determination as described below:

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All non-routine (i.e., malpractice cases, sanctions, CMS State Survey discrepancies, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

All behavioral health providers are required to be re-credentialed or recertified at a minimum of every 36 months. All items collected in the Credentialing process are required at the time of re-credentialing or recertification, with the exception of work history and education for practitioners. All primary source verifications are conducted at the time of re-credentialing and recertification.

Applicants are notified of their initial credentialing approval within 45 calendar days of the

Credentialing Committee's or Medical Director's recommendation. Should the Credentialing Committee or Medical Director elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

Re-credentialing

Re-credentialing involves periodic review and re-verification of clinical credentials of network practitioners and providers. The re-credentialing process occurs a minimum of every 36 months. The re- credentialing process includes an up-to-date re-examination of all the submitted materials and a review of the following:

- Member complaints and grievances.
- Results of quality indicators monitoring and evaluating activities.
- Re-verification of licensure standing.
- Re-verification of hospital privileges.
- Accreditation of facilities.
- Sanction history.

Please refer to the "Provider and Network Information" section of this *Provider Manual* for information regarding re-credentialing.

Adding a New Service or Site

Facility Providers who are adding a new service must complete Part II of the initial credentialing application and submit it with required attachments to the attention of their designated Account Executive. The Account Executive will notify you if a site visit is necessary. Facility providers, who are adding a new site, must submit an application and supporting documentation to Credential for that new site to be credentialed.

Address Changes

As a reminder, providers are contractually bound to report changes that affect referrals, such as the relocation of an office site. If your office is considered high volume, relocation of your office site will require a site visit from AmeriHealth Caritas Delaware.

Contracting and Rate Notices

Contracts

AmeriHealth Caritas Delaware uses an Ancillary Provider Agreement that has been approved by all the

appropriate local authorities. Provider Agreements automatically renew each year. An amendment to the agreement is generated only if new services are added due to a change in the state Medicaid program. Rate Notices are used to document rate or per diem changes to existing services.

Rate Notices and Fee Schedules

The AmeriHealth Caritas Delaware fee schedule is reviewed regularly and rates are adjusted as necessary. As a network provider, you will occasionally receive a "Rate Notice" which is an official amendment to your Provider Agreement. Providers will receive 30 days' notice of rate changes. Providers who do not accept the terms of the Rate Notice may terminate their Provider Agreement with 30 days' written notice.

Please review EOB's closely to assure that you begin receiving the new rates for services delivered on or after the date indicated in the Rate Notice. You are responsible to monitor payment received from the Plan. In the event of a discrepancy, please contact your Account Executive immediately. AmeriHealth Caritas Delaware strongly suggests provider's bill the usual and customary charges rather than the rate indicated on the Rate Notice. In the event of a system or data entry error, this practice helps you avoid the need to resubmit corrected claims when the issue is resolved.

Behavioral Health Covered Services

Behavioral Health Services are included under **Basic Covered Services** in the "Provision of Services" section of this *Provider Manual.*

Access to Behavioral Health Care

AmeriHealth Caritas Delaware providers must meet standard guidelines as outlined in this publication to help ensure that Plan members have timely access to behavioral health care.

The Plan endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. AmeriHealth Caritas Delaware has mechanisms for measuring compliance with existing standards and identifying opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Access to care and office wait times for members should comply with the standards defined below.

The standards below apply to behavioral health care services and behavioral health providers; please refer to the "Provider and Network Information" section of this *Provider Manual* for the standards that apply to physical health care services and medical providers.

AmeriHealth Caritas Delaware Behavioral Health Access Standards

Access Standards	
Emergency Behavioral Health Services	Within 24 hours of request.
Treatment for Potentially Suicidal Individuals (Including Mobile Team Response)	Immediate – within one hour.
Routine Outpatient Services With non-prescribing clinician for: • Requests for an initial assessment; • Follow-up after discharge from an inpatient or residential setting for a community placement. • Follow-up after being seen in the Emergency Room or by a Behavioral Health Crisis Provider for a behavioral health condition.	Within seven calendar days of request.
Non-Emergency Outpatient Services	Within three weeks of request for prescribing clinician services.
Office Waiting Time	- Not to exceed one hour. - Exceptions occur when a provider "works in" urgent cases, when a serious problem is found, or when a patient has an unknown need that requires more services or education than anticipated at the time the appointment was made. - When wait times must be extended due to the circumstances described above, waiting patients must be notified of the delay as soon as possible. If the delay will result in more than a 90 minute wait, the patient must be offered a new appointment.

Behavioral Health Services Requiring Prior Authorization

For a list of services requiring prior authorization or notification, please refer to the "Utilization Management" section of this *Provider Manual*.

The Plan's Utilization Management (UM) department hours of operation are 8:00 a.m. to 5:00 p.m. EST, Monday through Friday except for State of Delaware holidays. For prior authorization requests for behavioral health inpatient admissions, the UM department is available 24/7/365. The UM department can be reached at:

- BH UM Telephone: **1-855-301-5512**
- BH UM Fax: **1-877-234-4273**
- UM Telephone using BH prompt: **1-855-396-5770**

For additional information on how to submit requests for prior authorization, please refer to the provider area of our website at **www.amerihealthcaritasde.com.**

Billing for Behavioral Health Care Services

Behavioral health providers follow the same billing procedures as medical health care providers with some exceptions. Please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual* for more information on how to submit claims for services covered by the Plan.

For more detailed billing information and line-by-line instructions, please refer to the *Claims Filing Instructions*, available in the provider area of our website at: **www.amerihealthcaritasde.com.**

SECTION XI
LTSS Providers

Section XI: LTSS Providers

Introduction

The information contained in this section of the *Provider Manual* applies to providers who are contracted with AmeriHealth Caritas Delaware to provide long term services and support (LTSS) to enrollees of the Diamond State Health Plan Plus LTSS program. Please note that, in general, the responsibilities, expectations and processes outlined in this *Provider Manual* pertain to all providers, including LTSS providers, unless otherwise indicated in this section or specified via subsequent communications. For more information, please contact Provider Services at **1-855-707-5818.**

AmeriHealth Caritas Delaware, in providing LTSS for Diamond State Health Plan Plus enrollees, strives to offer quality, cost-effective, and coordinated care for those with chronic, complex, and complicated health care, social, and support services needs in a Nursing Facility or Home and Community-Based setting. Case management for program enrollees includes assessment, planning, coordinating, implementation and evaluating care through a fully integrated physical health, behavioral health, and LTSS program.

The Plan provides all services in a manner that facilitates maximum community integration and participation for members that require LTSS. The Delaware Department of Health and Social Services (DHSS) and the Plan are dedicated to serving individuals in the communities of their choice with the resources available and to implementing the United States Supreme Court's mandate in Olmsted v. L.C. Our mutual goal is to educate members about the LTSS community options available to them and support them in the choices they make.

AmeriHealth Caritas Delaware supports and enhances member-centered care, regardless of the setting in which our members receive services.
When members with long-term care needs live in their own homes or other community-based residential settings, AmeriHealth Caritas Delaware develops a care plan to address their care and treatment needs, to provide assurances for health and safety, and to proactively address the risks that may face a member desiring to live as independently as possible. For members residing in nursing facilities or Intermediate Care Facilities/Intellectual Disabilities (ICF/DD), AmeriHealth Caritas Delaware provides care management and quality oversight.

AmeriHealth Caritas Delaware LTSS providers who offer non-institutional services must offer LTSS services in settings that comport with the CMS home and community-based setting requirements as defined in regulations at 42 C.F.R. § 441.301(c)(4) and 42 C.F.R. § 441.710(a).

LTSS Continuity of Care

Transition of New Members

- All new members (either as a new DSHP/DSHP Plus member or transferring from another MCO) are assessed to identify needed services and are provided Medically Necessary Covered Services in a timely manner.
- If a member is transferring from AmeriHealth Caritas Delaware to another MCO, the Plan will share the completed member transfer coordination of care form (specified by the State) and transfer of relevant information and data in order to facilitate continuity of care (e.g., the member's treatment plan or plan of care and identification of the member's providers).
- If a new member transferring from another MCO is hospitalized at the time of enrollment, the originating MCO shall be responsible for inpatient facility payment until discharge, but the Plan will be responsible for payments for professional services as of the member's enrollment date, and will participate in discharge planning, and will be responsible for all services upon discharge.
- AmeriHealth Caritas Delaware will implement a continuity of care transition plan to provide continuity of care for new members.
- For members transferring from another MCO, the Plan will immediately contact the transferring MCO and request the completed member transfer coordination of care form (specified by the State) and transfer of relevant information and data in order to facilitate continuity of care (e.g., the member's treatment plan or plan of care and identification of the member's providers).
- For members transferring from another MCO who also participate in PROMISE, the Plan will contact DSAMH, in accordance with DSAMH's processes, within two business days in order to provide the name and contact information of the Plan's point of contact to facilitate seamless transition, care coordination, integrated physical and behavioral health care, and continuity of care.
- For treatment (other than prenatal services to a pregnant member in the second or third trimester and the provision of services in the DSHP Plus LTSS benefit package) of a medical or behavioral health condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, the Plan will cover the service from the treating provider if located within the distance standards for a lesser of:
    - A period of 90 calendar days or until the treating provider releases the patient from care. If the member is a pregnant woman in her second or third trimester, the Plan will cover prenatal services from the treating provider if located within the distance standard through 60 calendar day's post-partum.
    - If the treating provider is not located within the distance standards, the Plan will cover

the service but after a period of 30 calendar days may require the member to transfer to a qualified provider that is located within the distance standards.

Enrollment in the LTSS Program

An individual must qualify financially and medically in order to enroll in the Diamond State Health Plan Plus Long Term Services and Support (DSHP Plus LTSS) program. The State of Delaware delegates to the Health Benefits Manager (HBM) to perform functions related to outreach, education, enrollment, transfer, and disenrollment of members. As part of the enrollment process, the State performs the initial and annual Level of Care assessments for those seeking LTSS Level of Care benefits; the State also performs the financial assessment for those being considered for the program.

Once the State determines that an enrollee is medically and financially eligible, AmeriHealth Caritas Delaware receives notice of the new member. In most cases, a member's effective date of enrollment is the first day of the month. Effective dates are not retroactive except in the case of DSHP Plus LTSS members residing in a Nursing Facility who may be retroactive up to ninety (90) calendar days prior to the member's date of application for Medicaid.

LTSS benefits:

For services in the DSHP Plus LTSS benefit package, the Contractor shall continue the services authorized by the Transferring MCO, in accordance

with the approved nursing facility level of service/plan of care, regardless of whether the treating providers are participating or non-participating providers, for a minimum of 30 calendar days after the member's Enrollment date and thereafter shall not reduce these services unless a case manager has conducted a comprehensive needs assessment and developed

a plan of care, and the Contractor has authorized and initiated services in the DSHP Plus LTSS benefit package in accordance with the member's new plan of care, which may include transition from non-participating to participating providers.

The following populations are eligible for coverage through the DSHP Plus LTSS program:

- Institutionalized individuals in Nursing Facilities who meet the Nursing Facility (NF) Level of Care (LOC);
- Aged and/or disabled individuals over age 18 who do not meet the NF LOC, but who, in the absence of Home and Community-Based Services (HCBS), are "at risk" of institutionalization and meet the "At-Risk" for NF LOC criteria; and
- Individuals with a diagnosis of AIDS or HIV, over age one (1), who meet the Hospital LOC criteria and who receive HCBS as an alternative.

LTSS Covered Services

The following services are covered through the AmeriHealth Caritas Delaware LTSS program:

Service	Definition/Limitation
Nursing facility services	The services provided by a nursing facility to residents of the facility, including skilled nursing care and related services, rehabilitation services, and health-related care and services.
Community-based residential alternatives that include assisted living facilities	Community-based residential services offer a cost-effective, community based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes assisted care living facilities. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to participants who reside in a homelike, non-institutional setting. Assisted living includes a 24-hour onsite response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors. Services that are provided by third parties must be coordinated with the assisted living provider. Personal care services are provided in assisted living facilities as part of the community-based residential service. To avoid duplication, personal care (as a separate service) is not available to persons residing in assisted living facilities.
Attendant care services	• Attendant care services include assistance with ADLs (bathing, dressing, personal hygiene, transferring, and toileting, skin care, eating and assisting with mobility). Not available to persons residing in assisted living or nursing facilities. • In those instances where an unforeseeable gap in in-home services occurs, the Contractor shall ensure that in-home services are provided within three hours of the report of the gap. If the provider agency or case manager is able to contact the member or member representative before the scheduled service to advise him/her that the regular provider/employee will be unavailable, the member or member representative may choose to receive the service from a back-up substitute provider/employee, at an alternative time from the regular provider/employee or from an alternate provider/employee from the member's informal support system. The member or member representative has the final say in how (informal versus paid) and when care to replace a scheduled provider/employee who is unavailable will be delivered. • When the provider or the Contractor is notified of a gap in in-home services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to the reason for the gap, and the alternative plan being created to resolve the particular

	gap and any possible future gaps.
Respite care (provided at home and in nursing and assisted living facilities)	• Respite care includes services provided to members unable to care for themselves furnished on a short-term basis because of the absence or need for relief for the member's caregiver. • Limited to no more than 14 calendar days per year. The Plan's case manager may authorize service request exceptions above this limit when it determines that: (1) no other service options are available to the member, including services provided through an informal support network; (2) the absence of the service would present a significant health and welfare risk to the member; or (3) respite service provided in a nursing facility or assisted living facility is not utilized to replace or relocate an individual's primary residence.
Adult day services	• Services furnished in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service. The service is reimbursed at two levels: the basic rate and the enhanced rate. The enhanced rate is authorized only when staff time is needed to care for members who demonstrate ongoing behavioral patterns that require additional prompting and/or intervention. Such behaviors include those which might result from an acquired brain injury (ABI). The behavior and need for intervention must occur at least weekly. • Not available to persons residing in assisted living and nursing facilities. • Meals provided as part of this service are only provided when the member is at the adult day care center. The cost of such meal is rolled into the adult day care provider's reimbursement rate. The provider does not bill separately for the meal.
Day habilitation	• Day habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place ina non-residential setting, separate from the member's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Day habilitation services focus on enabling the member to attain or maintain his/her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. This service is provided to members who demonstrate a need based on cognitive, social, and/or behavioral deficits such as those that may result from an ABI. • Not available to persons residing in non-ABI assisted living and nursing facilities.
Cognitive services	• Cognitive services are necessary for the assessment and treatment of individuals who exhibit cognitive deficits or interpersonal conflict, such as

	those that are exhibited as a result of a brain injury. • Cognitive services include two key components: • Multidisciplinary assessment and consultation to determine the member's level of functioning and service needs. This cognitive services component includes neuropsychological consultation and assessments, functional assessment and the development and implementation of a structured behavioral intervention plan; and • Behavioral therapies include remediation, programming, counseling and therapeutic services for members and their families which have the goal of decreasing or modifying the member's significant maladaptive behaviors or cognitive disorders that are not covered under the Medicaid State Plan. These services consist of the following elements: individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law), services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily recreational or diversionary, family counseling (the primary purpose of which treatment of the member's condition) and diagnostic services. • Not available to persons residing in assisted living and nursing facilities. Limited to 20 visits per year plus an assessment.
Personal emergency response system (PERS)	• A PERS is an electronic device that enables a member to secure help in an emergency. As part of the PERS service, a member may be provided with a portable help button to allow for mobility. The PERS device is connected to the member's phone and programmed to signal a response center and/or other forms of assistance once the help button is activated. • Not available to persons residing in assisted living and nursing facilities.
Support for self-directed attendant care services	• Support for Self-Directed Attendant Care Services combines two functions: financial management services (FMS) and information and assistance in support of consumer direction (support brokerage). Providers of support for Self-Directed Attendant Care Services carry out activities associated with both components. The support for self-directed attendant care services provides assistance to members who elect to self-direct their attendant care services.
Independent activities of daily living (chore) service	• Chore services constitute housekeeping services that include assistance with shopping, meal preparation, light housekeeping, and laundry. This is an in-home service for frail older persons or adults with physical disabilities. The service assists them to live in their own homes as long as possible. The service must be provided through licensed providers or self-directed care services. • Not available to persons residing in assisted living or nursing facilities. • In those instances where an unforeseeable gap in in-home services occurs, the Contractor shall ensure that in-home services are provided within three hours of the report of the gap. If the provider agency or case manager is able to contact the member or member representative before the scheduled service to advise him/her that the regular provider/employee will be unavailable, the member or member representative may choose to receive the service from a

	back-up substitute provider/employee, at an alternative time from the regular provider/employee or from an alternate provider/employee from the member's informal support system. The member or member representative has the final say in how (informal versus paid) and when care to replace a scheduled provider/employee who is unavailable will be delivered. • When the provider or the Contractor is notified of a gap in in-home services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to the reason for the gap, and the alternative plan being created to resolve the particular gap and any possible future gaps.
Nutritional supplements for individuals diagnosed with HIV/AIDS that are not covered under the State Plan	• This service is for individuals diagnosed with HIV/AIDS to ensure proper treatment in those experiencing weight loss, wasting, malabsorption and malnutrition. Such oral nutritional supplements are offered as a service to those identified at nutritional risk. This service covers supplements not otherwise covered under State Plan service. The service does not duplicate a service provided under the State Plan as an EPSDT service. The service must be prior authorized by a case manager in conjunction with the consultation of a medical professional's recommendation for service. The standards for assessing nutritional risk factors: - Weight less than 90% of usual bodyweight; - Experiencing weight loss over a one to six month period; - Losing more than five pounds within a preceding month; - Serum albumin is less than 3.2 or very high indicating dehydration, difficulty swallowing or chewing, or persistent diarrhea; or - Wasting syndrome affected by a number of factors including intake, nutrient malabsorption and physiological and metabolic changes. Not available to persons residing in assisted living or nursing facilities.
Specialized medical equipment and supplies not covered under the Medicaid State Plan	• This service includes: - Devices, controls, or appliances specified in the plan of care that enable the member to increase his/her ability to perform ADLs; - Devices, controls, or appliances that enable the member to perceive, control, or communicate with the environment in which he/she lives; - Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; - Such other DME and non-DME not available under the State Plan that is necessary to address participant functional limitations; and - Necessary medical supplies not available under the State Plan. Items reimbursed under the DSHP Plus LTSS benefit package are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the member. • Does not duplicate a service provided under the State Plan as an expanded

	EPSDT service.
Minor home modifications	• Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the member, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement of heating or cooling units or systems, installation or purchase of air or water purifiers or humidifiers and installation or repair of driveways, sidewalks, fences, decks and patios. Adaptations that add to the total square footnote of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. • Up to $6,000 per project; $10,000 per benefit year; and $20,000 per lifetime. The Plan's case manager may authorize service request exceptions above this limit when it determines the expense to be cost-effective. Not available to persons residing in assisted living or nursing facilities.
Home-delivered meals	• Up to one meal per day. Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act or through Social Service Block Grant (SSBG) funds, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the member's home. Special diets shall be provided in accordance with the member's plan of care when ordered by the member's physician. These meals are delivered to the member's community residence and not to other settings such as adult day programs or senior centers. • The Plan must coordinate the delivery of these meals with staff within DSAAPD that authorize home-bound meals utilizing Title III (Older Americans Act) and SSBG funds. • Not available to persons residing in assisted living or nursing facilities.
Transition services for those moving from a nursing facility to the community	Can include security deposit, telephoneconnection fee, groceries, furniture, linens, etc., up to $2,500 per transition. The Plan's case manager may authorize service request exceptions above this limit.

Workshops for those moving from a nursing facility to the community	These workshops prepare the individual and their families and other Caregivers for community living.
In-home supports and services to help qualified participants avoid nursing home stays	This benefit offers waiver-like services for non-waiver members as a bridge until they get onto the waiver or in short term instances to help avoid a hospital or institution stay.

Members have the option to self-direct their Attendant Care Services. This allows members to choose and control the Attendant Care Services that are provided to them.

LTSS Member Services and Member Advocates

A dedicated, 24/7/365 Member Services is available to help LTSS members with any questions about their coverage and services at: **1-855-777-6617**; TTY: **1-855-362-5769.**

The Plan also employs a LTSS Member Advocate who is responsible for working with members, providers, and the member's case managers to assist members in obtaining care. Member Advocates are available to assist with scheduling appointments, navigation of the grievance and appeals process, and identification of resources necessary to help members with limited English proficiency or communication barriers. LTSS members may call the LTSS Member Services to be connected to a Member Advocate.

- Apartment;
- Community-based residence with no more than four (4) unrelated residents.

For a complete list of services requiring prior authorization or notification, please refer to the "Utilization Management" section of this *Provider Manual*.

Requesting Long Term Services and Supports (LTSS) Services

All LTSS services should be requested through the LTSS case managers. Only those services covered by the respective waivers can be requested.

- All unlisted and miscellaneous codes.
- All HCBS Habilitation program services.
- All services not listed on the AmeriHealth Caritas Delaware Fee Schedule.

The Plan's LTSS Personal Care Connector Team's department hours of operation are 8:00 a.m. to 5:00 p.m. EST, Monday through Friday. The Care Connectors can be reached at:

- LTSS Case Manager Telephone: **1-855-260-9544.**
- LTSS Fax: **1-855-843-1177.**

For prior authorizations after hours, weekends and holidays, call Member Services at 855-349-6281.

Background Checks Required for Attendant Care Staff

Self-Directed HCBS

The Plan or its Self-Directed (HCBS) Support Broker verifies that potential Attendant Care employees meet all applicable qualifications prior to delivering services including the following minimum qualifications:

- Potential employee is 18 years of age or older;
- Possesses skills necessary to perform the required services;
- Possesses a valid Social Security number; and,
- Submits to a criminal record check.

For all potential Attendant Care employees, the Plan or it's SDAC Support Broker conducts criminal history checks pursuant to 16 DE Admin Code 3110, checks of the Delaware's Adult Abuse Registry (see 11 DE Admin Code 8564; registry is available on the Delaware Department of Health and Social Services' (DHHS) website), checks of the national and Delaware sex offender registries, and checks of the excluded provider list.

Reporting Abuse and Critical Incidents

AmeriHealth Caritas Delaware monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies and other providers of services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of the Plan. This includes critical incidents, sentinel events and never events, as well as abuse, neglect, and exploitation, which are considered critical incidents.

For more information on the AmeriHealth Caritas Delaware policies and procedures around these incidents, please refer to the "Quality" section of this *Provider Manual*.

For all LTSS Plan members, Case Managers will review abuse, neglect, and exploitation identification materials upon intake and at each face-to-face interaction. Components of member education include descriptions of abuse, neglect, and exploitation, such as:

- Abuse includes inflicting pain, injury, mental anguish, unreasonable or other cruel treatment. Abuse can be:
    - Physical abuse.
    - Emotional abuse; or,
    - Sexual abuse.
- Neglect can occur:
    - When an adult is unable to care for him/herself or to obtain needed care, placing their health or life at risk;
    - The neglect may be unintended, resulting from the caregiver's lack of ability to provide or arrange for the care the person requires;
    - Neglect may be due to the intentional failure of the caregiver to meet the person's needs.
- Financial exploitation occurs when a caregiver improperly uses funds intended for the care or use of an adult. These funds are paid to the adult or caregiver by a government agency. Exploitation can include:
    - Fraud or coercion;
    - Forgery; or,
    - Unauthorized use of banking accounts, cash or government cards.

As part of its Critical Incident reporting protocols, the Plan shares reportable information with the following investigative agencies, as appropriate:

- **Adult Protective Service (APS)** for suspected abuse, neglect, disruptive behavior, and exploitation. Inadequate self-care cases are handled by the Community Services Program within Division of Services for Aging and Adults with Disabilities (DSAAPD).

- **Delaware Health and Social Services (DHSS) Long Term Care Office of the State Ombudsman (OSO)** for residents of a long-term care facility that have a complaint about their rights.

- **Division of Health Care Quality (DHCQ) Long term*** for members receiving services in a long-term care facility who are suspected victims of incidents of abuse, neglect, mistreatment, and/or financial exploitation. Reports of suspected abuse, neglect, and exploitation of members who are children residing in pediatric nursing facilities must also be reported to DHCQ.

- **Division of Health Care Quality (DHCQ) Acute*** is the designated agency to regulate hospitals and receives Critical Incidents occurring in these facilities involving abuse, neglect or harassment, hospital, hospice seclusion and restraint deaths.

- **Division of Family Services (DFS)** is the designated agency to receive, investigate, and respond to Critical Incidents of abuse or neglect of children living in the community.

Late and Missed Visits Reporting

Some AmeriHealth Caritas Delaware members, due to their exceptional health care needs and family circumstances, may require shift skilled nursing or home health aide services. The Division of Medicaid and Medical Assistance (DMMA) requires AmeriHealth Caritas Delaware to provide accurate reporting of late and missed visits for authorized shift care services. To meet the DMMA regulatory requirement, AmeriHealth Caritas Delaware encourages all agencies authorized for shift care, to report accurate and timely information on late and missed care services for AmeriHealth Caritas Delaware members.

All agencies authorized for shift care should submit completed and validated missed and late shift visit data to ACDEHHA@amerihealthcaritasde.com. We encourage providers to utilize the Late and Missed Shifts Reporting Form available on our website.

Note: Late and missed shift reporting logs must be tracked every week (Monday to Sunday, seven days a week), and submitted to AmeriHealth Caritas Delaware the following Monday or Tuesday.

LTSS Case Management

AmeriHealth Caritas Delaware LTSS members are supported through intake and ongoing case management by Case Managers who engage the member, caregiver, and family in the planning and decision-making process. Case Managers are the primary point of contact with the member. All Case Managers are licensed Registered Nurses (RNs) and/or Social Workers with Bachelor or Master Degrees with active licensure and appropriate credentials.

Case Managers support the member through initial assessment, plan of care development, care coordination, plan of care implementation, and ongoing evaluation.

The LTSS case managers are responsible to:

- Give the member information about AmeriHealth Caritas Delaware and answer questions.
- Work with the member to make sure they have all the information needed to make informed choices about their health care.
- Coordinate the person-centered planning process to help the member get appropriate long-term services and supports in the right setting.
- Coordinate the member's physical, mental, and long-term services and support needs.
- Help resolve issues the member is having about the care they are receiving.

- Make sure that the member's care plan is carried out and is working for them.
- Conduct face-to-face visits at least every 3 months.
- Be aware of the member's needs as they change and update their care plan to make sure the services they are receiving are appropriate for their changing needs.
- Talk with the member's providers to make sure they are informed about the member's health care and to coordinate the member's services.

If the member receives nursing facility care, the case manager will:

- Be part of the person centered planning process with the nursing facility where the member is living.
- Perform any additional needs assessment that may be helpful in managing the member's health.
- Update the nursing facility's care plan when AmeriHealth Caritas Delaware manages or coordinates physical and mental health care the member needs.
- Coordinate with the nursing facility when the member needs services the nursing facility isn't responsible for providing.
- Check at least 1 time a year to make sure that the member continues to need the level of care provided in a nursing facility.

Credentialing LTSS Providers

The Plan credentials and re-credentials providers in accordance with the National Committee for Quality Assurance (NCQA) credentialing standards and ensures that all providers, facilities and AmeriHealth Caritas Delaware providers who deliver LTSS services meet licensing, certification and qualifications required by: Delaware Medical Assistance Programs (DMAP), and the Centers for Medicaid and Medicare Services,

LTSS Credentialing Requirements

All LTSS providers are required to meet the following state minimum requirements:

- Current, unrestricted state license, if entity is licensed.
- Current, active certifications, where applicable.
- Enrollment in the Medicaid Program.
- If eligible, individual National Provider Identification (NPI) number and group NPI number.
- Current certificate of liability insurance.

Additionally, the AmeriHealth Caritas Delaware credentialing process includes review of the following for each provider:

- Medicaid sanction status through the OIG's List of Excluded Individuals, Entities Database and the General Services Administration.
- Background checks for Attendant Care Employees as required by Delaware DHSS.

Delegated Vendor Credentialing

- In instances where a provider is part of a delegated vendor credentialing LTSS network, AmeriHealth Caritas Delaware will rely on the credentialing methodology adopted by that organization. All LTSS providers must meet at least the minimum requirements listed above.

Individual LTSS Provider Application

The application process for individual LTSS providers requires the submission of a completed application. The application must include the following:

- LTSS Credentialing Application.
- Current, unrestricted State License (if applicable).
- Current State Certification/accreditation (if applicable).
- State Bond (if applicable).
- CV/Resume (if applicable).
- Current Insurance liability policy (showing expiration and times).
- Explanation of affirmative answers on the application.

Self-directed LTSS providers who are not employed by a provider agency or licensed/accredited by an agency/board that conducts background checks will also be subject to:

- Criminal background checks.
- Child and dependent adult abuse background checks.
- Licensing, certification and qualifications as set forth above.

To obtain a LTSS application, please visit the AmeriHealth Caritas Delaware website **www.amerihealthcaritasde.com** or contact your Account Executive.

Non-institutional and institutional LTSS providers covered by this policy will be re-credentialed at least every 36 months, with the exception of Home and Community Based Service Providers (HCBS), who will be re-credentialed at least annually.

LTSS providers are required to accept the contractual terms and conditions, reimbursement terms and meet the state's and the health plan's credentialing and quality standards. AmeriHealth Caritas

Delaware will maintain a network that includes LTSS providers whose physical locations and services accommodate individuals with physical, behavioral and intellectual/ developmental disabilities.

Plan credentialing staff abide by policies and procedures for the collection, use, transmission, storage, access to and disclosure of confidential information to ensure the appropriate and legitimate use of the information and in order to protect the privacy and confidentiality of Plan members, practitioners, and providers.

Home and Community Based Service Providers (HCBS) Final Rule

Delaware HCBS Provider Assessment for Initial Credentialing and Annual Re-Credentialing

The Centers for Medicare and Medicaid Services (CMS) published a final home and community-based services (HCBS) regulation that included new requirements for HCBS settings. Delaware's Division of Medicaid and Medical Assistance (DMMA) requires providers who render adult day services, day habilitation services, or personal care services in an assisted living facility under the Diamond State Health Plan-Plus (DSHP-Plus) program to assess whether the services being provided and the settings in which they are provided are consistent with the new requirements in the HCBS Final Rule.

AmeriHealth Caritas Delaware LTSS providers are required to submit a completed HCBS Provider evaluation assessment form as part of the initial credentialing process and the annual re-credentialing process with the Diamond State Health Plan managed care organizations (MCOs). Providers will then receive an onsite visit from DMMA staff (for initial credentialing) or from the AmeriHealth Caritas Delaware case management staff (as part of annual re-credentialing) to verify the assessment results. Providers that do not complete this process will not be credentialed/re-credentialed by the plan.

Completion of this assessment is required by all HCBS providers who render adult day services, day habilitation services, or personal care services in an assisted living facility. Providers of personal care and supportive services exclusively to members in their homes are not required to complete this assessment.

To obtain an assessment form, please contact your Account Executive.

LTSS Provider Credentialing Rights

Right to Review Information Submitted

LTSS providers have the right to review information submitted to support the credentialing application process with the exception of peer references and National Practitioner Data Bank (NPDB) reports. Currently AmeriHealth Caritas Delaware does not require peer references for LTSS providers. In addition, non-licensed providers have the right to be notified if information received by the Credentialing department is substantially different than was reported by the provider. The Credentialing department will notify the provider of the information that varies substantially from

what was submitted.

Right to Correct Erroneous Information

LTSS providers have the right to correct erroneous information submitted in support of their credentialing application. Corrections must be submitted in writing to the credentialing staff within ten (10) business days of notification to the provider. Corrections or information received will be reviewed and documented in the practitioner's file.

Right to be Informed of Application Status

LTSS providers may request information about the status of the application they submitted at any time during the process. Such requests must be made to the Credentialing Department, who will provide information about the status of the application, including whether or not it was received, whether or not it was complete upon receipt, and/or whether or not it is scheduled to be presented to the Credentialing Committee or Medical Director for review, etc.

Right to be Notified of Credentialing Decision

LTSS providers have the right to be notified within 45 calendar days of the Credentialing Committee or Medical Director review decision.

Right to Appeal

LTSS providers have the right to appeal any credentialing/re-credentialing denial within 30 calendar days of receiving written notification of the decision.

Credentialing Committee/Medical Director Decision

AmeriHealth Caritas Delaware does not make credentialing/re-credentialing decisions based on the applicants' race, ethnic/national identity, gender, age, sexual orientation, the types of procedures in which the practitioner specializes or the patients for which the practitioner provides care. In developing its network, AmeriHealth Caritas Delaware strives to meet the cultural and special needs of members.

Once all information is received and primary source verifications are completed the LTSS provider file is presented to either the Medical Director or Credentialing Committee for review and determination.

- All routine (clean) files are presented daily to the Medical Director for review and determination.
- All non-routine (i.e., malpractice cases, sanctions, criminal history, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

Applicants are notified of their initial credentialing approval within 45 calendar days of the Credentialing Committee's recommendation. Should the Credentialing Committee elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

Re-credentialing

Re-credentialing involves periodic review and re-verification of credentials of network providers. The Credentialing database houses all LTSS provider information and a report is run to ensure each provider organization, facility and individual LTSS provider is re-credentialed at a minimum of every 36 months. HCBS providers are re-credentialed at least annually. As part of this process, AmeriHealth Caritas Delaware periodically reviews provider information from the National Practitioner's Data Bank (NPDB) as well as the Office of Inspector General (OIG) list of individuals who have been excluded from participation in Medicare and Medical Assistance Programs. Providers are required to disclose, at the time of discovery, any criminal convictions of staff members related to the delivery of health care or services under the Medicare, Medicaid, or Title XX Social Service programs. Such information must also be reported at the time of application for or renewal of network participation (Credentialing and Re-Credentialing). Providers are also obligated to provide such information to AmeriHealth Caritas Delaware at any time upon request.

The re-credentialing process includes an up-to-date re-examination of all the materials and a review of the following:

- Member complaints and grievances.
- Results of quality indicators monitoring and evaluating activities.
- Re-verification of licensure standing;
- Re-verification of Certifications; and
- Sanction history.

Address Changes

As a reminder, providers are contractually bound to report changes that affect referrals, such as the relocation of an office site. If your office is considered high volume, relocation of your office site will require a site visit from AmeriHealth Caritas Delaware.

Contracting and Rate Notices

Contracts

AmeriHealth Caritas Delaware uses a Provider Agreement that has been approved by all the appropriate local authorities. Provider Agreements automatically renew each year. An amendment to

the agreement is generated only if new services are added due to a change in the state Medicaid program. Rate Notices are used to document rate or per diem changes to existing services.

Rate Notices and Fee Schedules

The AmeriHealth Caritas Delaware fee schedule is reviewed regularly and rates are adjusted as necessary. As a network provider, you will occasionally receive a "Rate Notice" which is an official amendment to your Provider Agreement. Providers will receive 30 days' notice of rate changes.
Providers who do not accept the terms of the Rate Notice may terminate their Provider Agreement
with 90 days' written notice.

Please review EOB's closely to assure that you begin receiving the new rates for services delivered on or after the date indicated in the Rate Notice. You are responsible to monitor payment received from the Plan. In the event of a discrepancy, please contact your Account Executive immediately.
AmeriHealth Caritas Delaware strongly suggests provider's bill the usual and customary charges rather than the rate indicated on the Rate Notice. In the event of a system or data entry error, this practice helps you avoid the need to resubmit corrected claims when the issue is resolved.

Billing for LTSS Providers

AmeriHealth Caritas Delaware will accept the universal CMS-1500 paper claim form or electronic claims submission. For complete instructions, please refer to the AmeriHealth Caritas Delaware LTSS Provider Claims Filing Instructions at **www.amerihealthcaritasde.com**.

LTSS Provider Standards

AmeriHealth Caritas Delaware's LTSS providers are held to the same as all other AmeriHealth Caritas Delaware providers. All LTSS providers should review all sections of this *Provider Manual* verify that they are compliant with quality standards, cultural competency requirements and more. This LTSS section of the *Provider Manual* covers items that are specific to the LTSS providers but does not preclude LTSS providers from the standards and requirements described throughout this document.

LTSS Patient Liability

There are occasions when a member may have a liability, also referred to as client participation, which must be met before Medicaid reimbursement for services is available. DHSS is responsible for determining the member liability amount. The State will notify AmeriHealth Caritas Delaware of any applicable client liability amounts. This information will be made available to providers. Providers will be required to collect this amount from the

member. Providers must bill gross/full charges and AmeriHealth Caritas Delaware pays the remaining claim, less the client liability. In the event that the client liability is in excess of billed charges, no payment will be made to the provider. If as a result of cancellation, transfer, or termination of services a member pays client liability in excess of charges, the provider shall make arrangements for prompt reimbursement to the member.

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