AmeriHealth Caritas Delaware
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AmeriHealth Caritas Delaware

Date	Section	Page	Change
9/18/2020	Program Integrity Operations Team	43	**Revised:** Verbiage for Program Integrity Operations Team (see - entire section): **PROVIDER MANUAL VERBIAGE** *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.*

3/31/2021	Late and Missed Visit Reporting	179	**Added:** Verbiage for Late and Missed Visit Reporting (see - entire section): **PROVIDER MANUAL VERBIAGE** *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.*
4/6/2021	Peer to Peer Telephone Line	118	**Revised:** Verbiage for Peer to Peer Telephone Line Verbiage noting the medical director or designee would reach out to provider within 1 BD of P2P request was removed and replaced with "within 3 BD of receiving P2P request) (see - highlighted section): ***PROVIDER MANUAL VERBIAGE*** *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. Providers must call within two (2) business days of notification of the determination or within two (2) business days of the member's discharge from an inpatient facility. A*

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<tr><td></td><td></td><td></td><td>physician in the AmeriHealth Caritas Delaware Medical Management department will contact the requesting provider or other authorized agent within three (3) business days 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.</td></tr>
<tr><td>5/13/2021</td><td>Behavioral Health Access Standards</td><td>35</td><td>Revised: Behavioral Health Access Standards/Definitions (see - entire section):

PROVIDER MANUAL VERBIAGE
<table>
<tr><th colspan="2">Behavioral Health Access Standards</th></tr>
<tr><td>Appointment type</td><td>Availability standard</td></tr>
<tr><td>Emergency (life-threatening)</td><td>Immediately</td></tr>
<tr><td>Emergency (non life-thretening)</td><td>Within six hours</td></tr>
<tr><td>Nonemergency access</td><td>Within 21 calendar days</td></tr>
<tr><td>Initial assessment (initial visit for routine care)</td><td>Within seven calendar days</td></tr>
<tr><td>Routine outpatient services (with nonprescribing clinician)</td><td>Within seven calendar days</td></tr>
<tr><td>Follow-up to inpatient care (members seen in an ER or behavioral health crisis provider)</td><td>Within seven calendar days of discharge</td></tr>
<tr><td>Nonemergency outpatient services</td><td>Within three weeks</td></tr>
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5/25/2021	Appeals Process	115	**Removed:** Verbiage for Appeals Process **Verbiage noting the member is required to submit an appeal request in writing after verbally making the request was removed (see - highlighted section):** **PROVIDER MANUAL VERBIAGE** *Provider Appeals (on behalf of a member and with written consent): call 1-855-396-5770 and follow the prompts.* *If the member or authorized representative files an appeal by telephone, he/she must also send the appeal in writing. The written request must be received within 10 calendar days of the oral request unless an expedited resolution is requested. The review begins the day the Plan receives the request.*
7/14/2021	Behavioral Health	85	**Revision:** Language for ABA BH Services **PROVIDER MANUAL VERBIAGE** The AmeriHealth Caritas Delaware behavioral health benefit for members under the age of 18 is limited to thirty (30) units per calendar year. After the member has reached 30 units of behavioral health service for the calendar year, providers should obtain a prior authorization and payment for future applied behavioral analysis (ABA) services from the Delaware Division of Developmental Disabilities Services (DDDS).
7/22/2021	Credentialing and Recredentialing	25	**Removed:** Home Infusion from provider requiring credentialing/recredentialing. Changed language to read: Practitioners are re-credentialed and facility/organizational providers are recertified at least every 36 months. Changed from every 3 years.

7/22/2021	Practitioner Credentialing Rights	26	**Added:** Language to 2nd bullet stating: The practitioner will have 10 business days to correct the erroneous information.
7/22/2021	Credentialing/ Recredentialing for Practitioners	27	**Removed:** Under DEA, 2nd bullet, removed language stating DEA must contain the address where the practitioner is treating AmeriHealth Caritas members.
7/22/2021	Practitioner Recredentialing	27	**Changed:** Updated recredentialing takes place every 3 years to every 36 months.
7/22/2021	Initial and Recredentialing Process	28	**Updated:** Capitalized words in first bullet
7/22/2021	Credentialing/ Recredentialing for Ancillary/Hospital Providers	29	**Updated:** Changed recertification every 3 years to every 36 months.
7/22/2021	Presentation to the Medical Director/ Credentialing Committee	29	**Added:** Added organizational providers to the first paragraph.

7/22/2021	Credentialing Site Visit	165	**Removed:** Removed entire section as this is no longer part of the credentialing process.
7/22/2021	Credentialing Committee/Medical Director Decision	166	**Updated:** Changed recertification every 3 years to every 36 months.
7/22/2021	Recredentialing	167	**Updated:** Changed recertification every 3 years to every 36 months.
7/22/2021	LTSS Credentialing	187	**Updated:** Changed recredentaling every 3 years to every 36 months.