Behavioral Health Staff Workshop

Driscoll Health Plan 2023

Agenda

- Introduction
- Behavioral Health Updates
- Triple P
- CPW
- Member Services
- Cultural Competency
- Administrative Reminders
- Utilization Management
- Billing and Claims

Who are We?

Who is Driscoll Health Plan?

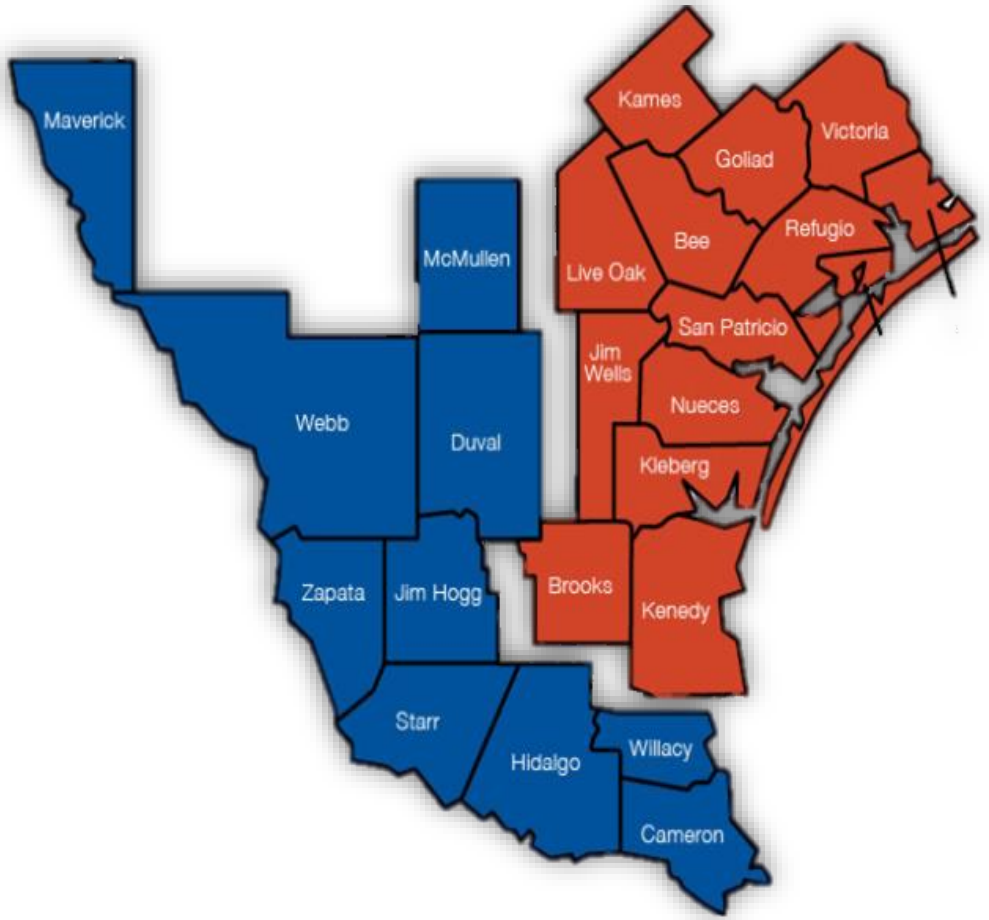
- Driscoll Health Plan is a non-profit, community-based health insurance plan offering health care coverage to the communities of South Texas. Our insurance products include STAR Medicaid, STAR Kids, CHIP and CHIP Perinatal.

- Driscoll Health Plan was originally developed and funded through the Driscoll Foundation and licensed by the Texas Department of Insurance as a Health Maintenance Organization (HMO) in 1998.

DHP Service Delivery Areas

Nueces SDA
- CHIP since 2000
- STAR since 2006
- STAR Kids since 2016

Hidalgo SDA
- STAR since 2012
- STAR Kids since 2016



Driscoll Contact Information

Member and Provider Services

STAR Nueces

877-324-3627

STAR Kids Nueces

844-508-4672

STAR Hidalgo

855-425-3247

STAR Kids Hidalgo

844-508-4674

Behavioral Health Updates

Behavioral Health Crisis Hotline

Available 24-hours/7 days a week

CHIP	1-833-532-0218
STAR Nueces	1-833-532-0216
STAR Hidalgo	1-833-532-0220
STAR Kids Nueces	1-833-532-0209
STAR Kids Hidalgo	1-833-532-0219

Definition of Behavioral Health

Behavioral Health Services are services for any mental and emotional health disorders, any substance abuse diagnosis, or any combination. Substance abuse includes drug and alcohol abuse, and the detoxification and withdrawal treatment that may be required.

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Covered Services

The following services are available to all CHIP (excluding CHIP Perinate Members), STAR and STAR Kids Member:

- Inpatient Substance Use Disorder Treatment Services
- Outpatient Substance Use Disorder Treatment Services
- STAR and STAR Kids Members Only Mental Health Rehabilitative Service and Mental Health Targeted Case Management

The following services are available to all CHIP Members (excluding CHIP Perinate Members), under the age of nineteen STAR and STAR Kids Members under the age of twenty-one:

- Inpatient Mental Health Services (including in Freestanding Psychiatric Facilities)
- Outpatient Mental Health Services (including treatment, medication, and medication management for Attention Deficit Hyperactivity Disorder (ADHD)

Referral Authorization

- PCP Referral is not required for members to access BH services
- DHP Members do not require referral authorizations for initial evaluation or follow-up behavioral health treatment from an in network Behavioral Health provider.
- Authorization is only required for Psychological testing over eight hours, developmental testing, and inpatient admission. Authorization is required for, partial hospitalization, intensive outpatient treatment, and residential treatment only if the benefit is exceeded.

Preauthorization

Preauthorization is required for:

- inpatient mental health hospitalizations
- dual diagnosis inpatient mental hospitalizations with inpatient detoxification
- detoxification
- chemical dependency rehabilitation
- partial hospitalization
- intensive structured outpatient
- residential treatment only if the benefit is exceeded
- psychological testing > 8 hours

Admission and Discharge Notification

Admission and discharge notification is required for Residential Treatment Care; however, no authorization is required.

Case Managers and UR Nurses

CHIP/STAR Case Managers and STAR Kids Support Services Utilization Review (UR) nurses have the authority to:

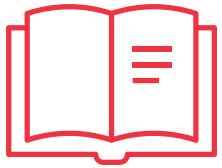
- approve all situations that meet criteria and refer potential denials or questionable cases to the Medical Director for review
- manages all requests for any treatment that is urgent or emergent
- manages all inpatient requests

7-day and 30-day Follow-up

Providers must ensure Members must have scheduled seven-day follow-up appointments at time of discharge from an inpatient Behavioral Health admission. They should also have a 30-day follow-up from date of discharge. These follow-up appointments are monitored by the Executive Quality Committee, as well as through Health and Human Services Commission (HHSC).

Behavioral Health providers need to ensure that these appointments are scheduled and kept. Members who miss appointments are attempted to be contacted to reschedule. STAR Kids Services coordinators communicate with STAR Kids Members who miss appointments and provide follow up to reschedule the missed appointment.

Texas Medicaid Provider Procedures Manual, Volume 2



Behavioral Health and Case Management Services Handbook – Ch. 4: Outpatient Mental Health Services

4.2.2 Psychotherapy (Overview)

Individual Focuses on a single member.

Group Involves one or more therapists working with several members at a time.

Family Focuses on the dynamic of the family where the goal is to strengthen the family's problem-solving and communication skills.

- Psychotherapy (individual, family or group) is limited to 4 hours per member, per day. Psychotherapy is limited to 30 individuals per group

- If the member changes providers during the year, the new provider should try to obtain complete information on the member's previous treatment history.

4.2.2 Psychotherapy (Documentation)

Documentation for individual, family or group psychotherapy must be legible to someone other than the writer, and must include:

- Identifying client information.
- Provider name and identifier.
- Current DSM diagnosis/es.
- Current psychotropic medications.
- Treatment plan, including measurable short term goals, specific therapeutic intervention utilized, and measurable expected outcomes of therapy.

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4.2.2.1 Family Psychotherapy

- May be provided to Medicaid members 20 years of age andyounger using procedure code 90846, or to members of any age using procedure code 90847.
- Only reimbursable for one Medicaid-eligible member per session, regardless of the number of family members present persession.
- For Medicaid members 20 years of age and younger, family psychotherapy may be provided to the child's parent(s), foster parent(s), or legal guardian without the child present, asclinically appropriate, using procedure code 90846.
    - Parent, or guardian-only, sessions may be indicated when addressing sensitive topics such as parenting challenges or related stressors that would be inappropriate to discuss with the child present at the session.

4.4 Medical Necessity

All services require documentation to support the medical necessity of the service rendered, including mental health services.

- The documentation must support the medical necessity of the treatment for its entire duration.

Mental health services are subject to retrospective review to ensure that the documentation in the member's medical record supports the medical necessity of the services provided.

4.5 Twelve-Hour System Limitation

The following provider types are limited to a maximum combined total of 12 hours per provider, per day, regardless of the number of patients seen for outpatient mental health services:

- Psychologist.
- Advanced Practice Registered Nurse (APRN).
- Physician Assistant (PA).
- Licensed Clinical Social Worker (LCSW).
- Licensed Marriage and Family Therapist (LMFT).
- Licensed Professional Counselor (LPC).

Triple P

Positive Parenting Program

What is Triple P?

The Triple P – Positive Parenting Program ® is a parenting and family support system designed to prevent – as well as treat – behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential.

Purpose

Triple P draws on social learning, cognitive behavioral and developmental theory as well as research into risk factors associated with the development of social and behavioral problems in children. It aims to equip parents with the skills and confidence they need to be self-sufficient and to be able to manage family issues without ongoing support.

And while it is almost universally successful in improving behavioral problems, more than half of Triple P's 17 parenting strategies focus on developing positive relationships, attitudes and conduct.

Triple P is delivered with coursework for parents of children up to age 12 year and another framework for parents of teenagers age 13-16.

Goals

The Triple P system aims to:

- Put evidence-based parenting into the hands of parents across the world
- Normalize the concept of parenting programs so parents feel comfortable asking for help
- Deliver the exact amount of support a parent needs – enough but not too much
- Give parents the confidence and skills to be self-sufficient – to manage problems independently
- Provide communities with population-level early intervention to prevent child abuse, mental illness and anti-social behavior.

Flexibility & Delivery of Triple P

Intensity of program

Triple P's distinctive multi-level system is the only one of its kind, offering a suite of programs of increasing intensity, each catering to a different level of family need or dysfunction, from "light-touch" parenting help to highly targeted interventions for at-risk families.

How it's delivered

Just as the type of programs within the Triple P system differ, so do the settings in which the programs are delivered – personal consultations, group courses, larger public seminars and online and other self-help interventions are all available.

Who can be trained to deliver

Practitioners come from a wide range of professions and disciplines and include family support workers, doctors, nurses, psychologists, counselors, teachers, teacher's aides, police officers, social workers, child safety officers and clergy.

Level 2 Seminar

This is a "light touch" intervention providing brief one-time assistance to parents who are generally coping well but have one or two concerns with their child's behavior or development. It is available for parents of children from birth to 12 years and for parents of teenagers.

- **Triple P Selected Seminar Series –** An introduction to the strategies of positive parenting and Triple P. Parents attend any number of three 90-minute seminars (Power of Positive Parenting; Raising Confident, Competent Children; and Raising Resilient Children) or any of the three seminars in the **Teen Triple P Seminar Series** (Raising Responsible Teenagers; Raising Competent Teenagers; and Getting Teenagers Connected). Take-home tip sheets are given to all parents who attend Triple P seminars.

- **Who Can provide?** – DHP has accredited and trained staff that deliver both in person and virtual Level 2 Seminar.

- **How to register -** Caregivers of DHP members can call Member Services at 877-324-7543 to enroll in upcoming Level 2 group classes or visit our website at https://driscollhealthplan.com/triple-p/

Level 3 Primary Care

Targeted counseling for parents of a child with mild to moderate behavioral difficulties. It is available for parents of children from birth to 12 years and for parents of teenagers. Level 3 interventions deal with a specific problem behavior or issue.

- **Primary Care Triple P –** A brief face-to-face or telephone intervention with a provider (from areas such as child and community health, education, allied health, child care etc.). Approximately four individual consultations lasting between 15 and 30 minutes. Uses tip sheets and Positive Parenting Booklet to reinforce strategies. For parents of children birth to 12 years and **Primary Care Teen Triple P** for parents of adolescents to 16 years.

Level 4 Standard

For parents of children with severe behavioral difficulties (or in the case of Group Triple P/Group Teen Triple P, for motivated parents interested in gaining a more in-depth understanding of Positive Parenting). It is available for parents of children from birth to 12 years and 12–16 years and covers Triple P's 17 core positive parenting skills that can be adapted to a wide range of parenting situations.

- **Standard Triple P/Standard Teen Triple P –** For parents who need intensive support. Individual counseling delivered over ten (1 hour) sessions(minimum of 6 total) Uses DVD, workbook.

Accredited Providers

Provider Name	Level	Age Groups	City	Phone Number
Cobos Cruz, LCSW	4	Children & Teens	Edinburg	956-457-2888
Daniel Rodriguez, LPC	3	Children & Teens	Victoria	361-575-0611
Amira Maya-Martinez, LPC	3	Children & Teens	Brownsville	956-592-7889
Demetrio Rosales, LPC	3	Children & Teens	Corpus Christi	361-851-8185
Ramiro Aguilar, LPC	3	Children Only	Laredo	956-568-5857

Children and Pregnant Women (CPW)

What is CPW?

CPW is a Medicaid State Plan benefit that assists a person in gaining access to necessary medical, social, educational, and other service needs related to the person's health condition, health risk, or high-risk condition.

Eligibility

- Children 20 and under with health condition or health risk
- Pregnant women with high-risk condition

Advocacy in Education

CPW agencies provide school advocacy for members that require accommodations due to a wide array of at risk and potentially disruptive behaviors.

CPW agency case managers attend appointments and meetings for (Admissions, Review, and Dismissal (ARD) and 504 in court and/or school.)

Other CPW Benefits

- Assistance with transition to adulthood and guardianship
- Assist with camps, childcare, respite, parenting classes for parents of children with special needs
- Assist with Home Instruction for Parents and Preschool Youngsters (HIPPY)
- Assist with Nurse Family Partnership (NFP)
- Assist with Parents as Teachers (PAT)
- Assist with Prevention Early Interventions (PEI) Programs
- Assist with member or LAR/guardian that have complex language barriers, cognitive impairments, health or mental health issues which make accessing services on their own difficulty.
- Assist with active CPS investigation
- Assist with psychosocial threat to the well-being of the client, such as domestic violence, substance use by caretaker, current or risk of homelessness, or a current traumatic event.

Referral and Authorization Process

Provider Referral

To refer a Medicaid eligible person for Case Management for Children and Pregnant Women services, providers may do one of the following:

- Call DHP Case and Disease Management toll free at 1-877-222-2759 from 8 a.m. to 5 p.m., Central. Time, Monday through Friday.
- Fax a CPW Referral Form to DHP Case and Disease Management at 1-866-704-9824. Referral forms can be found by going to the Driscoll Health Plan website. Click on Providers > Authorization Requirement Portal > Forms and Checklist
- Provider can send CPW referral via physician portal.

Member Services

Member Eligibility

HHSC determines eligibility. Providers should verify the patient's Medicaid eligibility and DHP enrollment for the date of service prior to services being rendered. To confirm member eligibility, providers may use:

- DHP Provider Portal
- DHP Provider Services line
- State Automated Inquiry System at 1-800-925-9126

Member ID Info

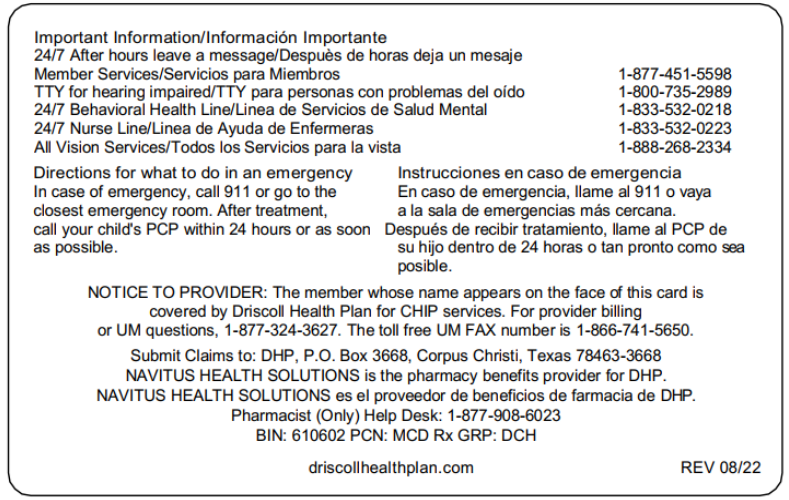
The Member ID Card is your source of verified member information.

Each ID card will display

- Line of Business
- Coverage Dates
- Important Contact Info
- Co-Pays, if applicable

Driscoll Health Plan
NAVITUS TDI
TEXAS Health and Human Services
CHIP

CHIP Nueces Service Area
Member/Miembro: DCCHIP00 A SAMPLE
Member ID/ID del Miembro: 999901101
Effective Date/Fecha de vigencia: 09-01-2018
PCP: PRIMARY CARE PHYSICIAN
PCP Phone #/Numero de telefono: (555) 777-1234
Effective Date of PCP/Fecha de vigencia de PCP: 10-01-2018
Co-payment Amounts/Co-pagos:
OV: $5 *ER: $5 IP: $35 RX Brand: $5 RX Generic: $0
No Co-payment for CHIP Perinate Newborn
No hay Co-pago para los recien Nacidos Perinatal
ER co-pays apply only for non-emergent ER visits/ Los copagos por visitas a la sala de emergencias solo se aplican si la visita no es una emergencia.



Important Information/Información Importante
24/7 After hours leave a message/Después de horas deja un mesaje

Member Services/Servicios para Miembros	1-877-451-5598
TTY for hearing impaired/TTY para personas con problemas del oído	1-800-735-2989
24/7 Behavioral Health Line/Linea de Servicios de Salud Mental	1-833-532-0218
24/7 Nurse Line/Linea de Ayuda de Enfermeras	1-833-532-0223
All Vision Services/Todos los Servicios para la vista	1-888-268-2334

Directions for what to do in an emergency
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

Instrucciones en caso de emergencia
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

NOTICE TO PROVIDER: The member whose name appears on the face of this card is covered by Driscoll Health Plan for CHIP services. For provider billing or UM questions, 1-877-324-3627. The toll free UM FAX number is 1-866-741-5650.

Submit Claims to: DHP, P.O. Box 3668, Corpus Christi, Texas 78463-3668
NAVITUS HEALTH SOLUTIONS is the pharmacy benefits provider for DHP.
NAVITUS HEALTH SOLUTIONS es el proveedor de beneficios de farmacia de DHP.
Pharmacist (Only) Help Desk: 1-877-908-6023
BIN: 610602 PCN: MCD Rx GRP: DCH

driscollhealthplan.com REV 08/22

Additional Services

Dental Services
Driscoll Health Plan covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

- Treatment of dislocated jaw
- Treatment for traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.

Vision Services
To get eye exams or glassed, members will reach out to Envolve to find a provider. Members will not need a referral from the PCP for routine eye checkups from ophthalmologists or optometrists in Envolve's provider network

<u>Members two and older:</u>

- Should receive an exam once every 12 months
- Glasses may be replaced every 12 months

<u>Members 21 and older</u>

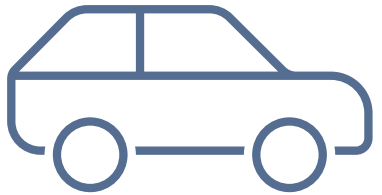
- Should receive an exam once every 2 years
- Glasses may be replaced every 2 years

Non-Emergency Medical Transportation

What is NEMT?

NEMT services provide transportation to covered health care services for Members who have no other means of transportation.

Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services.



SAFERIDE

Cultural Competency

DHP Goal

To ensure sensitivity and understanding of cultural differences, DHP's Cultural Competency Plan guides staff and subcontractors in the effective delivery of services in a culturally competent manner to all Members.

By recognizing individual values, cultural competence affirms the worth of individuals and protects and preserves the dignity of each. This Cultural Competency Plan builds on our experience and relationships with the community, Members, and Network Providers.

Why Cultural Competence?

The increasing diversity of the nation brings opportunities and challenges for health care providers, health care systems, and policy makers to create and deliver culturally competent services.

Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.

A culturally competent health care system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.

How does culture impact healthcare?

Cultural health beliefs affect how people think and feel about their health and health problems, when and from whom they seek health care, and how they respond to recommendations for lifestyle change, health-care interventions, and treatment adherence.

Cultures also differ in their styles of communication, in the meaning of words and gestures, and even in what can be discussed regarding the body, health, and illness.

What are culturally and linguistically appropriate services

Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization (regardless of size) at every point of contact.

Why do culturally and linguistically appropriate services matter?

- Changing demographics
- Strengthening relationships
- Building trust
- Improving communication

Tips to Improve the Health Literacy of our Members

Consider how you present information	Improve your Health Service	Ensure understanding	Know your Members
• Try different formats • Tailor information • Decision making tools	• Education & Training • Improvement Activities	• Encourage questions • Ask patients to repeat information	• Don’t assume understanding • Actively listen • Talk about decisions

DHP Interpreter Services

If you have a DHP Member who needs help with special language services or American Sign Language services, DHP is contracted with Pacific Interpreters, who can assist you with interpretation services in your office.

Call 866-421-3463 and provide the customer service representative with Pacific Interpreters the following:

- Language needed
- Member DHP ID number
- Physician's first and last name
- Access Code# 80006625

Administrative Reminders

Telemedicine, Telehealth and Telemonitoring Access

DHP supports Telemedicine, Telehealth and Telemonitoring services as a critical component of Members' care when face-to-face interactions are not feasible and continues to explore opportunities to enhance our provider network through the use of these services.

Member Balance Billing

Balance billing is defined as billing the Member for the difference between what a provider charges and what DHP or any other insurance company has already paid.

- Providers are not allowed to “balance bill” DHP Members. All covered services are included within the payment made by DHP and the residual balance of covered charges must be written off as a contractual allowance.

Member Billing Situations

For a non-covered benefit, the Member must sign an Advance Beneficiary Notice that documents that the Member was made aware of the responsibility to pay for the service.

SERVICE	PLAN PAYS NOTHING	PLAN PAYS CONTRACTED RATE	PLAN PAYS USUAL & CUSTOMARY	PROVIDER CAN BILL MEMBER if an Advance Beneficiary Notice and Private Pay Form was Executed Prior to Rendering the Services	PROVIDER CANNOT BALANCE BILL MEMBER
IN NETWORK					
Authorized		✓			✓
Not Authorized	✓				✓
OUT OF NETWORK					
Authorized			✓		✓
Not Authorized	✓			✓	
EMERGENCY CARE					
Authorized		✓			✓
Not Authorized			✓		✓
LTSS SERVICES					
Authorized		✓			✓
Not Authorized	✓				✓
NON-COVERED SERVICES					
Non-Covered Services	✓			✓ *(See "STAR – B – STAR and STAR Kids/Medicaid Covered Services" or "CHIP – B – Covered Services" in this manual)*	

Billing CHIP Members for Co-pay Amount

- Some CHIP Members have co-pay amounts for certain services. The Members' DHP identification card will indicate the co-pay amounts for these specific services. Only valid co-pay amounts can be collected from CHIP Members.

- For a list of when a co-pay may apply, refer to CHIP, Section B, of our Provider Manual.

Credentialing and Re-credentialing

- Providers must be enrolled in Texas Medicaid before they can be contracted and credentialed by an MCO or Dental plan
- Re-credentialing notices are sent to providers 180 days before re-credentialing is required
- Providers that fail to complete the credentialing process will be removed from the directory immediately and terminated within 30 days for failure to recredential.
- Providers should submit a completed Standardize Credentialing Application or CAQH application and required attachments at least 90 days before the re-credentialing requirement

Electronic Funds Transfer (EFT)

- All providers are encouraged to enroll in Electronic Funds Transfers by completing the EFT Agreement for the direct deposit of payments.
- EFT Agreements are available on the DHP Website

Driscoll HEALTH PLAN

A friend of the family

Electronic Funds Transfer (EFT) Authorization Agreement

Type of Authorization (check one): ___ NEW ___ CHANGE

Tax Payer ID# (TIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___

Provider Name	9-digit Medicaid ID # (TPI #)	Provider NPI Number
Provider Accounting Address	**Phone Number**	**FAX Number**
Bank Name	**ABA/Transit Number (bank routing number)**	
Bank Street Address	**Account Number**	
Bank City/State/Zip	**Provider e-Mail Address**	
Bank Phone Number	**Type of Account (check only one)**	
	___ Checking ___ Savings	
	PLEASE ATTACH A VOIDED CHECK	

I (we) hereby authorize Driscoll Health Plan (DHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If DCHP erroneously deposits funds into my (our) account, I (we) authorize DHP to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of DHP and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by DHP or its authorized affiliate(s) or subcontractor(s). I (we) understand that payment of claims will be made from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through DHP in accordance with applicable state and federal laws, rules, and regulations.

Authorizing Signature _____ Date Signed _____

Printed Name _____ Title of Signatory _____

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from the www.driscollhealthplan.com website. *No paper copies will be mailed.

RETURN THIS FORM TO:
Driscoll Health Plan
ATTN: EFT Enrollment Department
615 N Upper Broadway; Suite 1621 Corpus Christi, TX 78477
*Forms must be mailed-in or scanned and sent by e-mail. Fax copies WILL NOT be acceptable due to readability.

Complaints

A complaint may be filed orally, in person, in writing or online at www.driscollhealthplan.com. A provider may file a complaint by calling Customer Services

- Nueces SDA: 877-220-6376
- Hidalgo SDA: 855-425-3247

A complaint may also be filed with the HHSC at 800-252-8263.

Abuse, Neglect, and Exploitation

While working with vulnerable members of our communities it is extremely important to remember that each DHP staff and contracted Provider is a mandated reporter.

By reporting suspected child abuse and/or neglect or elder abuse you could save a life, prevent further neglect or abuse, or encourage families to more fully participate in the services offered at DHP.

Reporting abuse plays an important role in realizing our vision that every member live in stable, nurturing environments and safe, supportive communities.

Waste, Abuse and Fraud

If you believe a provider or a member receiving benefits is doing something wrong, it could be fraud, waste or abuse.

To report fraud, waste or abuse choose on of the following:

OIG Hotline	800-436-6184	Email	FraudandAbuseInvestigations@dchstx.org
DHP WAF	844-808-3170	Mail	Driscoll Health Plan Attn: SIU 5001 N. McColl McAllen, TX 78504
Online Submission	https://oig.hhsc.state.tx.us/wafrep		

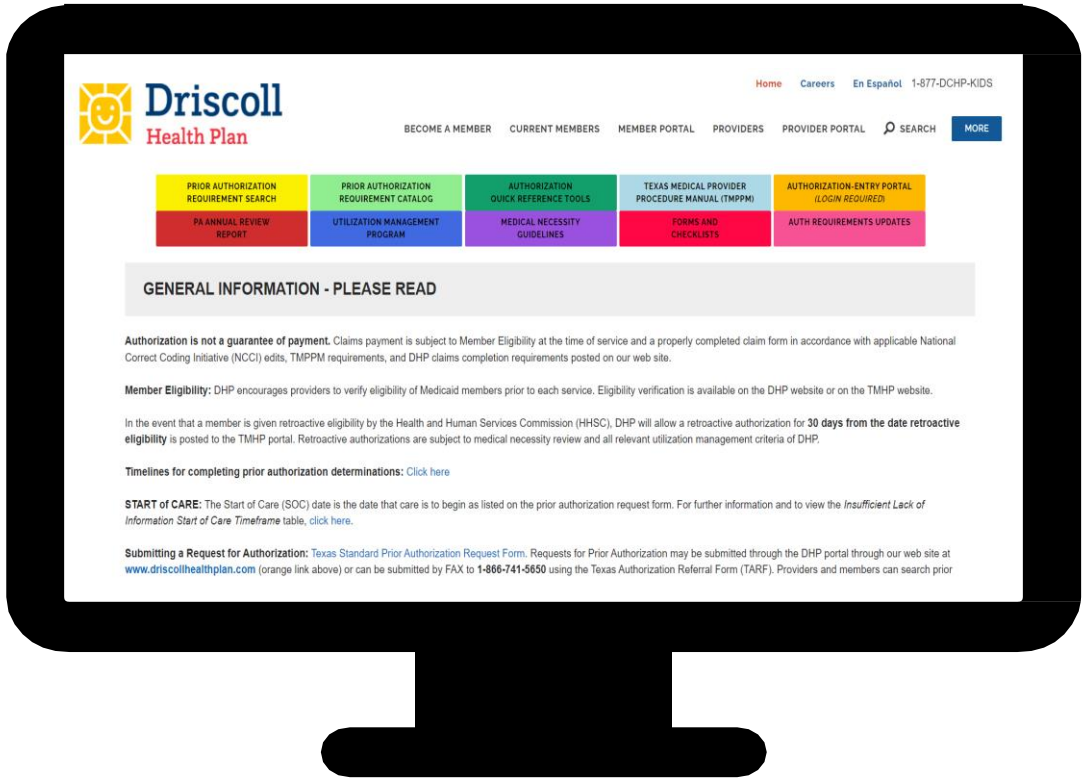
Utilization Management

Utilization Management

- Authorization is not a guarantee of payment. Claims payment is subject to Member Eligibility at the time of service and a properly completed claim form in accordance with applicable National Correct Coding Initiative (NCCI) edits, TMPPM requirements, and DHP claims completion requirements posted on our web site.
- DHP encourages providers to verify eligibility of Medicaid members prior to each service. Eligibility verification is available on the DHP website or on the TMHP website.
- In the event that a member is given retroactive eligibility by the Health and Human Services Commission (HHSC), DHP will allow a retroactive authorization for 30 days from the date retroactive eligibility is posted to the TMHP portal. Retroactive authorizations are subject to medical necessity review and all relevant utilization management criteria of DHP.

Authorization Requirements

Providers can search prior authorization requirements by accessing the look-up tool found on our website at: https://driscollhealthplan.com/priorauthcheck



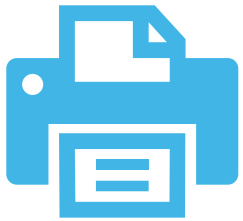
Supporting Information

- To avoid delays in authorization or administrative denials, providers are strongly encouraged to submit sufficient documentation to validate the medical necessity for the services being requested.
- This may include, current progress notes, history and physical, radiology or laboratory results, consult notes/reports, treatment plans showing progress to goals *(e.g. therapy requests*), or similar medical record documentation to illustrate medical necessity.
- Requests for Case-by-Case services beyond the benefit limit or which are not a covered benefit may be considered with submission of supporting clinical documentation.

Authorization Request Submission

Requests for Prior Authorization may be submitted as follows:

DHP website at www.driscollhealthplan.com ***(quickest method and strongly encouraged)*** Your PR Representative will provide you with a User ID and Password



By fax to 1-866-741-5650 using the Texas Authorization Referral Form (TARF).

Authorization Assistance

DHP Member Services
877-324-7543

DHP Utilization Management
Ph: 877-455-1053
Fax: 866-741-5650

DHP STAR Kids LTSS Services
Ph: 844-376-5437
Fax: 844-381-5437

Envolve Vision Services
800-465-6972

Navitus Pharmacy Services
877-908-6023

Coordination of Benefits

- Authorization and/or admission notification is required for inpatient services if DHP is secondary payer.
- No authorization is required for observation services if DHP is secondary payer. Some outpatient services/procedure codes may require prior authorization regardless of DHP as secondary payer.
- Providers should verify authorization requirements on the DHP Prior Authorization Portal at https://driscollhealthplan.com/priorauthcheck.

Coordination of Benefits

- In cases where DHP is secondary payer and no prior authorization is required, as based on directive within the DHP Prior Authorization Portal, providers should verify the services are a covered benefit by the primary payer.

- If the services are known to be a non-covered benefit by the primary payer, prior authorization is required by DHP and proof of non-coverage of benefit must accompany the claim submission.

Billing and Claims

Billing and Claims

Driscoll Health Plan requires providers to bill and code claims in accordance with the TMPPM guidelines and comply with all NCCI billing requirements.

What is a Clean Claim?

- A clean claim is defined as a claim submitted by a physician or provider for medical care or health care services rendered to a Member, with the data necessary for DHP to adjudicate and accurately report the claims.
- Once a clean claim is received DHP is required, within the **30-day claim** payment period, to:
  - Pay the claim in accordance with the provider contract, or
  - Deny the entire claim, or part of the claim, and notify you why the claim or part of the claim was not paid.

Submission of Claims - Paper

Paper claim forms are mailed to:

Driscoll Health Plan
ATTN: CLAIMS
P.O. Box 3668
Corpus Christi, TX 78463-3668

Submitting Corrected Claims

- A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed.
- If you have omitted charges or changed claim information (diagnosis codes, dates of service, member information, etc.), resubmit the entire claim, including all previous information and any corrected or additional information.

Bill and Frequency Codes

Corrected Claims

CMS Form

- Electronic Claim
  - Frequency Type – 7
- Paper Claim
  - Resubmission Code (Field 22) – 7

UB04 Form

- Electronic Claim
  - Third digit of Bill Type – 7
- Paper Claim
  - Third digit of Bill Type – 7

Voided Claims

CMS Form

- Electronic Claim
  - Frequency Type – 8
- Paper Claim
  - Resubmission Code (Field 22) – 8

UB04 Form

- Electronic Claim
  - Third digit of Bill Type – 8
- Paper Claim
  - Third digit of Bill Type – 8

Failure to mark your claim appropriately may result in rejection as a duplicate.

Filing an Appeal for Non-payment of a Claim

Provider & Administrative Claims Appeals are processed by the Claims Department:

Driscoll Health Plan
ATTN: CLAIMS APPEALS DEPARTMENT
P. O. Box 3668
Corpus Christi, TX 78463-3668

Note: Administrative denials for non-timely filing of claims or appeals and failure to obtain an authorization for services rendered as required under the terms of your contract will not be overturned. Administrative reconsideration is available only when DHP has made an error. See the DHP Administrative Claim Denial Form in Appendix A.

Claims Status and Follow-up

- Providers should check claims status and follow-up on claims 30 days after submission.
- Providers may follow-up on their submitted claims by the following methods:
  - Obtain claim status via the DHP Provider Web portal
  - Fax Claims Status Request to 361-808-2079
  - Providers may call Customer Service and ask for the status telephonically for up to eight (8) claims daily
  - Providers are able to check claims statuses through the IVR Call System for dates of service 2/1/19 or later

Coordination of Benefits (COB) Requirements

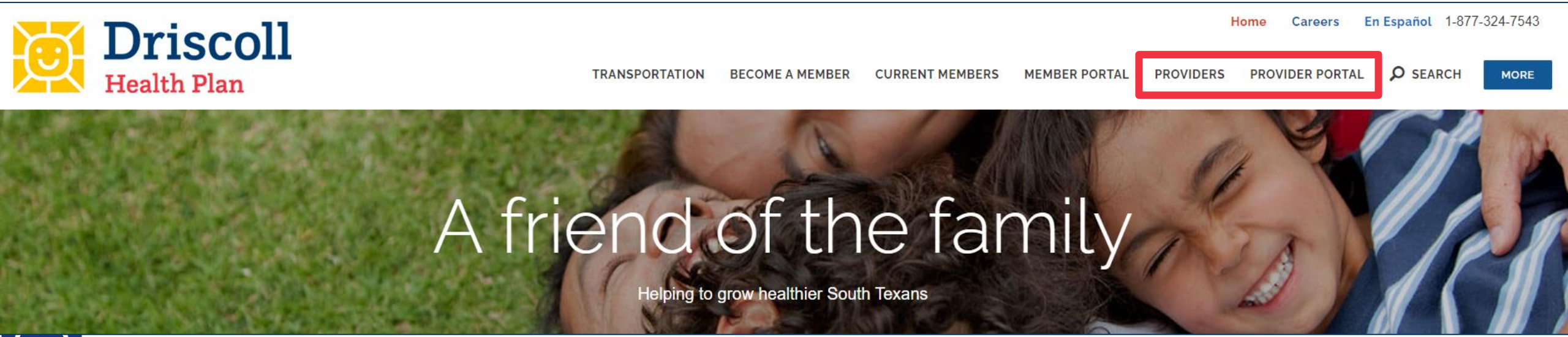
- Driscoll Health Plan (DHP) utilizes a third-party vendor to verify COB status on all DHP Plan Members.
- Verified information obtained through this process will take precedent on all claim processing.
- Providers must bill all other carriers and receive payment or denial prior to billing DHP.

Recoupments

DHP only requests or recoups a refund due to overpayment of a claim or completion of a claim audit after specific criteria is met, in compliance with the Texas Administrative Code. Automatic recoupment would be done on all overpayments totaling less than or equal to $25,000 to facilities, and less than or equal to $1,000 for individual providers. For amounts greater than stated, facilities and providers will be notified of overpayment, including the amount of overpayment and specific information regarding the overpayment. If no appeal is received within the allotted timeframe, facilities and providers will have 45 days to payback the overpaid or audited amount. If payback is not received by the stated timeframe, recoupment will occur.

Additional questions?

The Driscoll Health Plan Provider Manual is the most up-to-date resource for all your questions and concerns. The manual is updated monthly and can be located on the DHP website. Benefit types, descriptions, services, therapies and limitations can be found here.



Thank you!

Driscoll Health Plan appreciates all that you do for our members and values our relationship and your continued services to our members.