Hospital Staff

Driscoll Health Plan 2023

Who are We?

Who is Driscoll Health Plan?

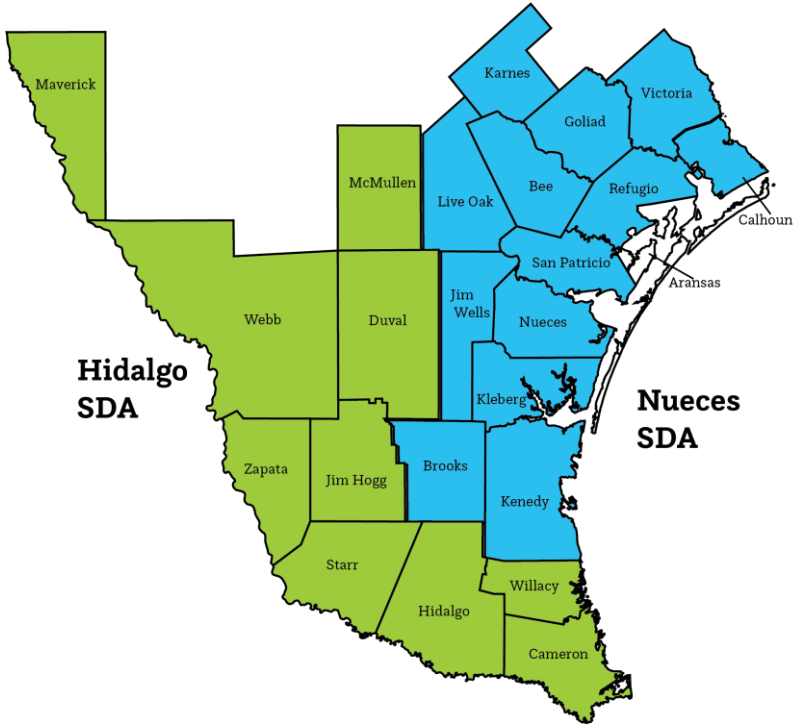
- Driscoll Health Plan is a non-profit, community-based health insurance plan offering health care coverage to the communities of South Texas. Our insurance products include STAR Medicaid, STAR Kids, CHIP and CHIP Perinatal.

- 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

Member Services

Member Eligibility

HHSC determines eligibility. Providers should verify the patient's Medicaid eligibility and DHP enrollment for the service date before services are 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.

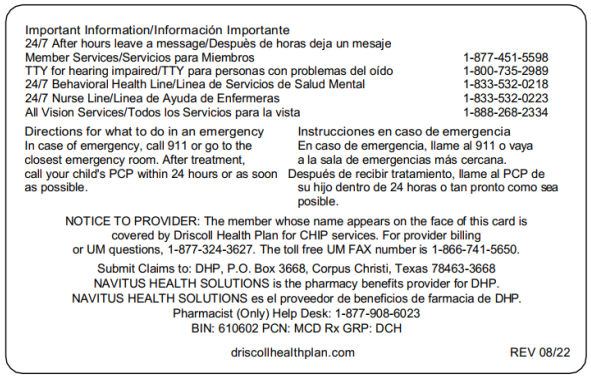
Each ID card will display

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

Driscoll Health Plan

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 glasses, 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

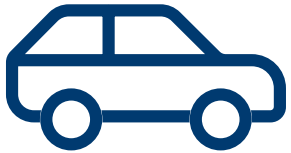
<u>Members 21 and older</u>
- Should receive an exam once every 2 years
- Glasses may be replaced every 2 years

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 "S*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.

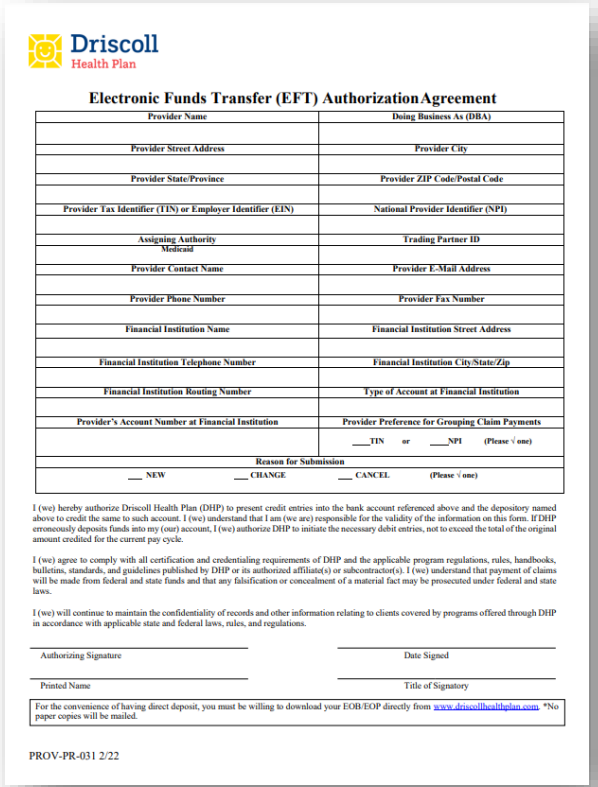
- For a list of when a co-pay may apply, refer to CHIP, Section B, of our Provider Manual.

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

Electronic Funds Transfer (EFT) Authorization Agreement

Provider Name	Doing Business As (DBA)
Provider Street Address	Provider City
Provider State/Province	Provider ZIP Code/Postal Code
Provider Tax Identifier (TIN) or Employer Identifier (EIN)	National Provider Identifier (NPI)
Assigning Authority Medicaid	Trading Partner ID
Provider Contact Name	Provider E-Mail Address
Provider Phone Number	Provider Fax Number
Financial Institution Name	Financial Institution Street Address
Financial Institution Telephone Number	Financial Institution City/State/Zip
Financial Institution Routing Number	Type of Account at Financial Institution
Provider's Account Number at Financial Institution	Provider Preference for Grouping Claim Payments
	___TIN or ___NPI (Please √ one)
Reason for Submission	
___ NEW ___ CHANGE ___ CANCEL (Please √ one)	

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 DHP 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 www.driscollhealthplan.com. *No paper copies will be mailed.

PROV-PR-031 2/22

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 for Hospital Staff

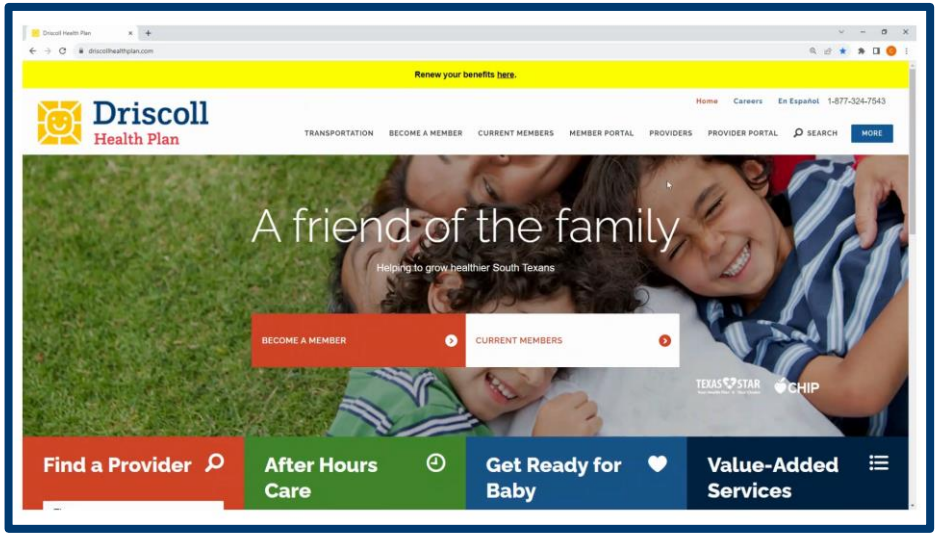
Pre-Authorization Tool

At any time, Providers can visit

https://driscollhealthplan.com/priorauthcheck.

This site contains helpful information to assist Providers in the Pre-Authorization process.

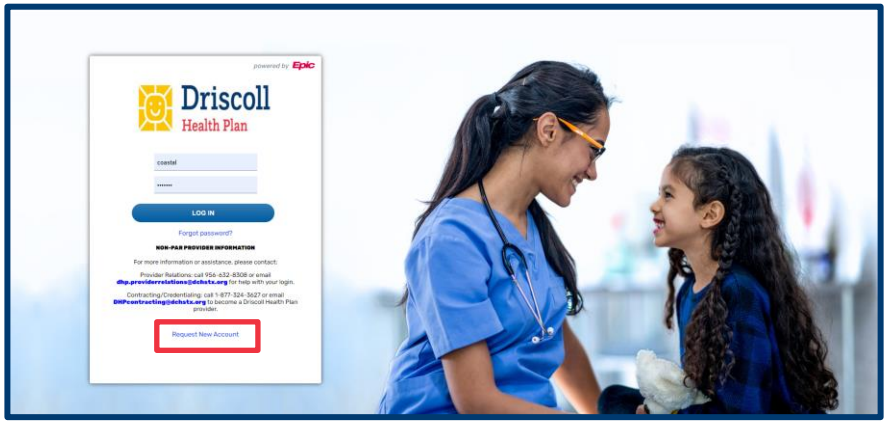
Scroll to the bottom of the screen to perform a search of criteria based on HCPCS/CPT4 Codes.



Request for Prior Authorization

Authorizations may be requested through Driscoll Health Plan's Provider Portal at : https://www.dhpproviderportal.com/

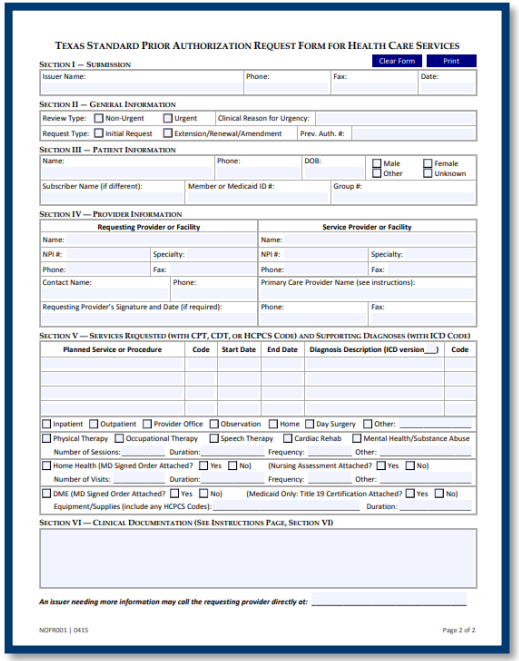
Office staff may request a new account through the Portal or by contacting their friendly PR representative.



Request for Prior Authorization

Alternatively, requests for Prior Authorization may be submitted by fax using the Texas Standard Prior Authorization Request Form (TARF)

1-866-741-5650



TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Clear Form | Print

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

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Authorization Request and Inquiries

To obtain assistance submitting a prior authorization request or to receive clarification on our prior authorization requirements, please contact us:

DHP Utilization Management
Ph: 1-877-455-1053
Fax: 1-866-741-5650

Hours of Operation:
Monday - Friday 8 a.m. - 5 p.m. (CST) (Except state holidays)
Messages will be returned within one business day.

DHP Response Times

3 Business days	Routine request with all supporting documentation
14 Calendar days	Routine request if information is lacking

To learn more about response times for Urgent, Emergent, and Concurrent requests, please view the timeframes located on the Authorization Requirement Portal on driscollhealthplan.com.

Essential Information Required

All Inpatient, Outpatient, and Therapy Requests for services must include:

- Member Name
- Member or Medicaid number
- Member date of birth
- Requesting provider name
- Requesting provider NPI
- Procedure codes requested
- Service start and end dates
- Quantity requested

Clinical Information Required

For Inpatient and Observation requests, DHP may request the following:

- Admission Notification and/or Face Sheet
- Rendering provider/facility name
- Rendering provider National Provider Identifier (NPI)
- Behavioral Health Inpatient Admission Notification Form
- Diagnosis
- History and Physical
- Progress Notes
- Consult Notes and/or Reports from Specialists
- Behavioral Health Inpatient Extended Stay Form
- Physician Orders
- Radiology/Imaging Results
- Laboratory Results
- Blood Glucose Testing
- Vital Sign Reports
- Medication Administration Records
- Discharge Summary
- Behavioral Health Discharge Summary Form

Only applicable documents listed that are related to the requested services need to be submitted. A comprehensive list of required clinical information can be found on the Authorization Portal.

Inpatient Admission and Discharge

Require Prior Authorization

Admission types that require Prior Authorization

- Admissions for Delivery extending beyond 4 days for vaginal and 6 days for C-section
- Elective Admission (non-maternity or delivery related)- Acute or Behavioral Health
- NICU or Infant Stays beyond Mom's Discharge
- OBSERVATION for non-OB Circumstances
- OBSERVATION for diagnoses unrelated to pregnancy

Require Notification within 24 Hours

Admission types that require notification within 24 hours

- Urgent or emergent acute medical or behavioral health conditions
- Admissions for delivery-related circumstances where delivery is not anticipated (e.g. preterm labor)
- Court-ordered admissions

NO Prior Auth Required

Admission types that **no prior authorization** is required:

- Admissions for Delivery- up to 4 days for vaginal or 6 days for C-section
- OBSERVATION for diagnoses related to pregnancy

Discharge Planning

Hospitals must provide DHP with notification of pending discharge as early as practical. This allows DHP case managers to work with the hospital case managers and ensure the patient/member has everything needed to make a successful transition to home

Clinical Criteria

- **InterQual**: Driscoll Health Plan utilizes proprietary InterQual review criteria in the process of managing utilization for prospective, concurrent, and retrospective review.

- **Driscoll Clinical Guidelines:** Driscoll Health Plan peer reviewers utilize proprietary as well as internally developed criteria and evidence-based guidelines.

- **TMPPM**: DHP utilizes the same clinical guidelines for many services as found in the current Texas Medicaid Provider Procedures Manual.

Concurrent Review

Concurrent review is the process of reviewing inpatient/observation health care services while rendered to ensure that:

- Patient safety remains the top priority
- All admission types are medically necessary and at the appropriate level and setting of care

Interdisciplinary Team Meetings (IDT): Cases in which the admission is greater than 21 days are presented at weekly IDT meetings to review medical necessity, ensure patient safety is maintained, and report suspected issues as appropriate.

Retrospective Review

Retrospective Review evaluates the appropriateness and medical necessity of health care services after care has been provided to the member. For retrospective review, DHP bases review determinations solely on the medical information available to the Attending or Ordering Provider when he/she provided the medical care, including inpatient medical necessity reviews when certification is required.

Facility Admissions

An emergency admission usually occurs directly from a hospital emergency facility following evaluation and stabilization of a patient.

The facility should contact the DHP's UM Department within 24 hours or next Business Day for authorization

Observation to Admission

Observation cannot exceed 48 hours.

If the patient requires observation for longer than 48 hours, the facility should notify DHP Utilization Management to perform a review of the medical necessity of the inpatient stay.

Please note: Labor and Delivery Observation Stays do not require authorization

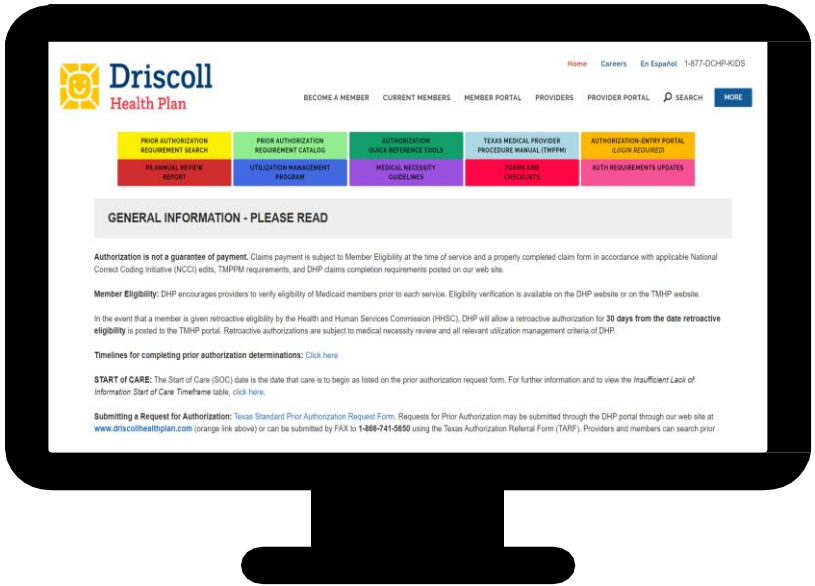
Utilization Management

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 website.

Authorization Requirements

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



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.

Hospital Billing

Billing Observations

Facilities can be reimbursed for approved Observation, which is considered an outpatient claim by DHP.

Please include the **UB Revenue Code** and the number of observation hours in the itemized charges section on the claim form.

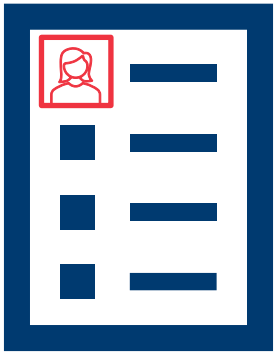
Please note! No authorization is needed for Labor and Delivery Observation Stays.

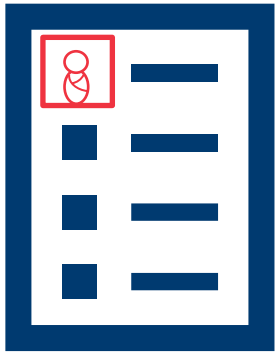
Billing Observation to Admission

Observation is limited to 48 hours.

If it becomes apparent during the Observation period that the patient requires more than 48 hours of hospitalization and care transitions into an inpatient admission, please inform DHP's Utilization Management team. Failure to notify UM may lead to reimbursement delays or denials.

Billing for Deliveries and Newborn Services





DHP requires separate claim forms for mothers and babies.

During the first 90 days, facilities can use a proxy ID for the baby's Medicaid number. This proxy ID consists of the mother's Medicaid number and a letter (A, B, etc.), accompanied by the newborn's name and date of birth. Once DHP receives the actual newborn ID, the records will be merged.

If DHP has already paid the claim using the proxy ID, any new claim with the same information will be denied as a duplicate.

Billing for Outpatient Surgery

Physician claims should be submitted using the standard CMS-1500 form or acceptable ANSI-837 professional electronic formats, clearly indicating the necessary CPT-coded surgical procedure code(s).

Facility claims should use the CMS-1450 (UB04) form or acceptable ANSI-837 institutional electronic format. These submissions should include the relevant ICD9 or ICD10 surgical procedure code(s), the surgery date, itemized charges, and associated CPT/HCPCS procedure codes.

Coding Requirements

For inpatient institutional claims	DHP mandates using ICD10 diagnosis codes and either ICD10 or CPT surgical procedure codes. Line-item charges should use UB04 Revenue Codes.
For outpatient institutional claims	DHP requires ICD10 diagnosis codes, HCPCS codes for applicable line-item charges, the corresponding UB04 Revenue Code, and either ICD10 or CPT surgical procedure codes. This also applies to NDC numbers when medications are administered.

Timely Filing

Type of Claim	Timely Billing Parameter
Professional Claims	95 days from the DATE OF SERVICE
Ancillary Services Claims	95 days from the DATE OF SERVICE
Ancillary Services Claims (for services billed monthly)	95 days from the LAST DAY OF THE MONTH for which services are being billed
Outpatient Hospital Services	95 days from the DATE OF SERVICE
Inpatient Hospital Services	95 days from the DATE OF DISCHARGE
LTSS (including nontraditional LTSS providers)	95 days from the DATE OF SERVICE

Present on Admission

Present on Admission (POA) denotes the conditions present at the time the order for inpatient admission occurs. The POA indicator is intended to differentiate conditions present at the time of admission from those conditions that develop during the inpatient admission.

POA value is mandatory for inpatient hospital claims using prospective payment

For more information on POA, see TMHP manual section 3.7.2 – Inpatient Claims Information

Span of Coverage Scenarios

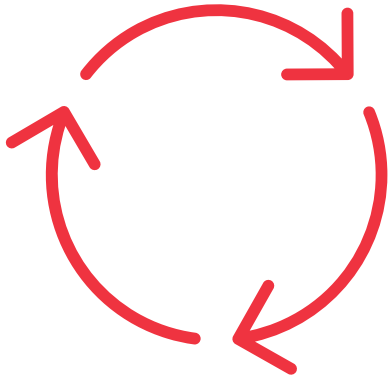
As determined by the TMPPM:

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member moves from FFS to STAR Kids	FFS	New MCO
2	Member movies from STAR, STAR Health or STAR + PLUS to STAR Kids	Former MCO	New MCO
3	Member moves from CHIP to STAR Kids	New MCO	New MCO
4	Adult Member moves from STAR Kids to STAR or STAR + PLUS	Former STAR KIDS MCO	New STAR or STAR + PLUS MCO
5	Member moves from STAR Kids to STAR Health	Former STAR Kids MCO	New STAR Health MCO
6	Member retroactively enrolled in STAR Kids	New MCO	New MCO
7	Member moves between STAR Kids MCOs	Former MCO	New MCO

Replacement Claims

Claims that have been denied may be re-submitted. All diagnoses, charges, and code updates should be billed as a **replacement claim.**

DHP will accept electronic versions of replacement claims.



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

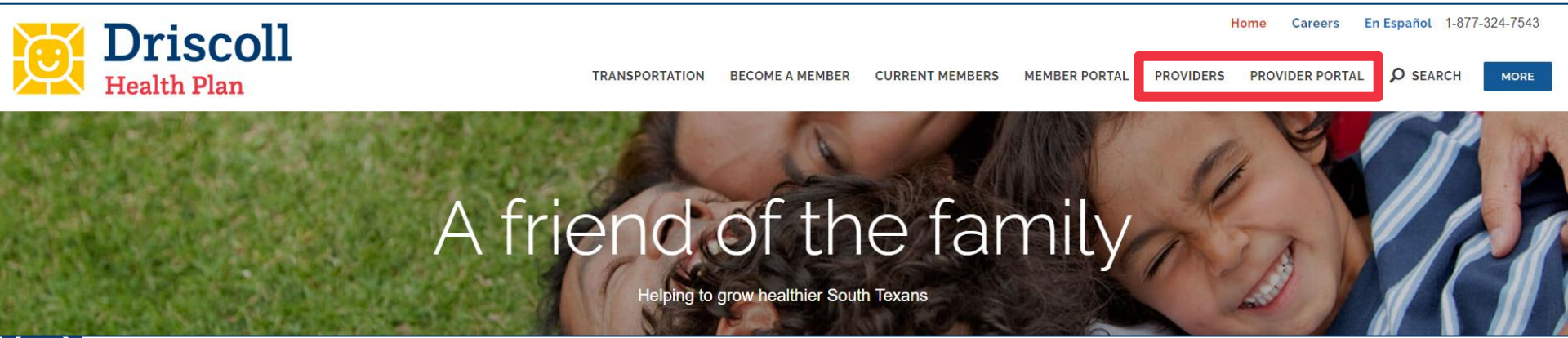
- Driscoll Health Plan (DHP) utilizes a third-party vendor to verify COB status on all DHP Plan Members.
- Verified information obtained through this process will take precedent on all claim processing.
- Providers must bill all other carriers and receive payment or denial prior to billing DHP.

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.