



LTSS Staff Workshop

Driscoll Health Plan 2023



Agenda

- Introduction
- STAR Kids and LTSS Updates
- Member Services
- Cultural Competency
- Administrative Reminders
- Utilization Management
- Billing and Claims





Who are We?

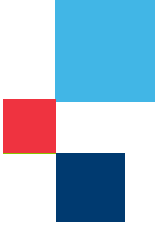




Who is Driscoll Health Plan?

- 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.





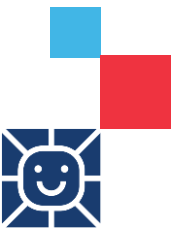
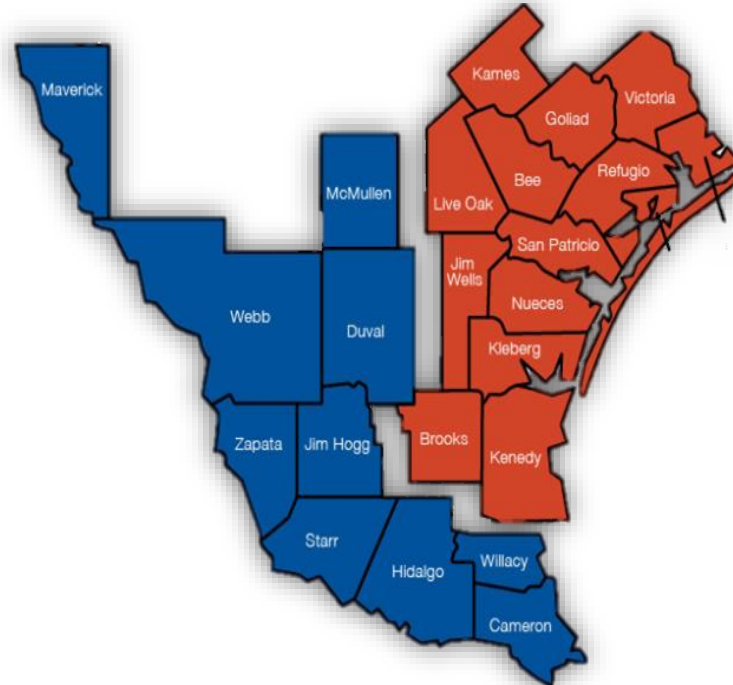
DHP Service Delivery Areas

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





STAR Kids





STAR Kids

STAR Kids is a Medicaid-managed care program for children with a disability, including acute services and long-term support and services.



Eligibility

Eligibility Requirements:

- Children and young adults aged 20 and younger with Medicaid and a Disability Designation.

Examples

- Receiving Social Security Income (SSI)
- Receiving SSI and Medicare (Dual Members)
- Medicaid Buy-in Program (MBIC)



Service Coordination

Through STAR Kids, families receive help with coordinating care. Each health plan provides service coordination, which helps identify needs and connect Members to services and qualified Providers. STAR Kids health plans assess each Member's service needs.



Service Coordination



Service Coordination provides the Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using Covered Services and other supports to enhance the Member's well-being, independence, community integration, and productivity potential.

Service Coordination aims to assist the Member to best lead a healthy and productive life in the least restrictive environment.



Charlie's Story



Services Offered

- Prenatal/Birthing Services
- Cancer diagnosis and treatment
- Chiropractic
- Dialysis
- Pharmacology
- Emergency Services
- Hospitalization inpatient/outpatient
- Lab services
- Podiatry
- Radiology
- Specialist Care
- DME
- Transplants
- Mastectomy procedures and reconstruction
- Early Childhood Intervention
- Family Planning
- Home Health Care Services (Skilled Nursing)
- Preventative Care Texas Health Steps
Periodicity Schedule
- ABA Therapy
- Oral Fluoride Varnish

Acute Care Covered Services
***Non-exhaustive List**





LTSS Programs



Comprehensive Care Program



Comprehensive Care Program (CCP) represents medically necessary services that are offered as a Texas Medicaid Benefit for Medicaid Beneficiaries, ages birth through 20 years of age, as an expansion of the Early Periodic Screening, Diagnosis, Treatment (EPSDT) Services known as Texas Health Steps in the state of Texas

A list of benefits is located in the Texas Medicaid Provider Procedure Manual (TMPPM) handbook

- <https://www.tmhp.com/resources/provider-manuals/tmppm>



Long Term Services and Support



Long Term Services and Supports are a wide range of services provided to a qualified member in his or her home or other community-based setting to allow the member to remain in the most integrated setting possible.

LTSS services are benefits for those meeting criteria through the CCP program



LTSS Services

Types of LTSS Services Include:

- Personal Care Services (PCS)
- Community First Choice (CFC)
- Private Duty Nursing Services (PDN)
- Prescribed Pediatric Extended Care (PPEC)
- Daily Activity Health Service (DAHS)





Personal Care Services (PCS)

- To qualify for PCS, the member's disability or chronic health condition must be substantiated by a practitioner statement of need (PSON).
- PCS includes assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing, including nurse-delegated tasks.



Community First Choice (CFC)

To qualify for CFC, the member's disability or chronic health condition is required to meet the level of care provided in a hospital, nursing facility (NF), an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID), or an institution for mental disease (IMD).

- CFC includes assistance with all the activities normally covered by PCS, and adds teaching and acquisition of tasks (Habilitation), Emergency Response System (ERS), and support Management



Private Duty Nursing Services (PDN)

PDN services are nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, for clients who meet the medical necessity criteria and who require individualized, continuous, skilled care beyond the level of skilled nursing (SN) visits normally authorized under Texas Medicaid Home Health SN and Home Health Aide (HHA) services.



Prescribed Pediatric Extended Care Centers (PPEC)



A PPEC is a facility that provides nonresidential basic services.

- These services include medical, nursing, psychosocial, therapeutic and developmental services to medically dependent or technologically-dependent members under 21 years of age for up to 12 hours per day.



Day Activity Health Services (DAHS)

DAHS are Licensed Day Activity and Health Services facilities that provide daytime services, up to 10 hours per day, Monday through Friday, except for Holidays.

- Services for individuals 18 through 20 years of age with an identified chronic medical condition, one or more functional limitation.
- Includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services and other supportive services.



Medically Dependent Children Program (MDCP)



The MDCP provides services to support families caring for children and young adults aged 20 and younger who are medically dependent and to encourage the deinstitutionalization of children and young adults who reside in nursing facilities.



MDCP provides respite, flexible family support services, minor home modifications, adaptive aids, transition assistance services, employment assistance, supported employment and financial management services through a STAR Kids or STAR Health managed care organization.



Service Coordinators collect member information on a state assessment (SK-SAI) and submit it to Texas Medicaid Health Partnership (TMHP). TMHP makes the determination for medical necessity for MDCP program eligibility



Delivery Options



Service Delivery Options

STAR Kids members may choose from the following three service delivery options for the delivery of certain long-term services and supports (LTSS):

- **Agency option-** Agency does all employer functions and manages the people who provide services. i.e., onboarding, hiring, training, coaching-correction action plans and payroll
- **Consumer Directed Services (CDS)-**The individual who receives services or his or her legally authorized representative (LAR) hires and manages the people paid to provide services with assistance from a financial management services agency (FMSA)
- **Service Responsibility Option (SRO)-**An Agency is the attendant's employer and handles the business details (i.e., paying taxes, doing payroll). The agency also orients the attendants to agency policies and standards. The member/LAR or AR assists with most of the day-to-day management of the attendant's activities, i.e., interviewing, and selecting the person who will be the attendant.



NEW Value-Added Services

Starting on September 1, 2023, there will be two new VAS available for STAR Kids.

- Menstrual Cycle Kit: Female members can receive a menstrual cycle starter kit and educational information. These kits are available upon request; members can receive up to 3 per year.
- Educational Braille Learning Kit: Members 0-5 years of age who are diagnosed as legally blind can receive an educational brail learning kit and materials. Members who meet criteria will fall onto a generated report.



VAS Highlight: In Home Respite

- Available for members currently receiving Personal Care Services (PCS)
- Up to 32 hours available for use each fiscal year (Sept 1 – Aug 31)
- Value Added Respite Procedure Code is S5150

To view all other VAS, please visit our website at driscollhealthplan.com/programs/star-kids/value-added-services-star-kids/



LTSS Billing Matrix Updates

The LTSS Billing Matrix and Crosswalk is a table that provides the billing codes and modifiers for state plan services used in STAR Kids as well as services specific to the Medically Dependent Children Program (MDCP).

MCOs and providers must use the link below for services provided on or after July 1, 2023.

Scan here to access the new
billing matrix from HHSC





LTSS Updates

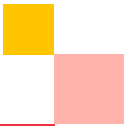




Responsibility to Verify Eligibility

LTSS providers have the responsibility of, but not limited to:

- Contacting DHP for Member Eligibility, ensuring member is eligible to receive LTSS under DHP, and authorization of services.
- Notifying DHP of any change on member's condition or eligibility.
- Providing services based on contract agreement with DHP.
- Providing those services in which they are licensed to deliver.





Prior Authorization

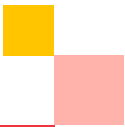


LTSS providers must submit a referral for prior authorization of LTSS services:

- *Respite*
- *Adaptive aids*
- *EA*
- *FMS*
- *FFSS*
- *MHM*
- *Supported Employment*
- *Transition Assistance*

Please submit requests to DHP's Service Coordination Department at 1-844-381-5437.

For all other Prior authorization requests, including but not limited to PCS, PDN, and PPEC send faxes to DHP UM Department at 1-866-741-5650.



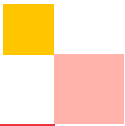


Continuity of Care

To ensure Continuity of Care, when the Member transfers from another MCO, the Service Coordination will attempt to contact the Member's prior MCO and request information regarding the Member's needs, current Medical Necessity determinations, authorized care, and treatment plans.

DHP will ensure that Members receiving services through a Prior Authorization from either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

- 90 Days after the transition to a new MCO,
- until the end of the current authorization period, or
- until the MCO has appropriately evaluated and administered the STAR Kids Screening and Assessment Process and issued or denied a new authorization.





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



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 recién 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 mensaje

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/Línea de Servicios de Salud Mental

1-833-532-0218

24/7 Nurse Line/Línea 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

Instrucciones en caso de emergencia

In case of emergency, call 911 or go to the

En caso de emergencia, llame al 911 o vaya

closest emergency room. After treatment,

a la sala de emergencias más cercana.

call your child's PCP within 24 hours or as soon

Después de recibir tratamiento, llame al PCP de

as possible.

su hijo dentro de 24 horas o tan pronto como sea

possible.

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

Members two and older:

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

Members 21 and older

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

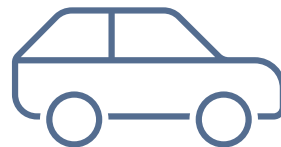


Non-Emergency Medical Transportation

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.





Cultural Competency

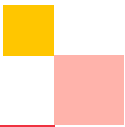




DHP Goal

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

- Try different formats
- Tailor information
- Decision making tools

Improve your Health Service

- Education & Training
- Improvement Activities

Ensure understanding

- Encourage questions
- Ask patients to repeat information

Know your Members

- 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 <small>if an Advance Beneficiary Notice and Private Pay Form was Executed Prior to Rendering the Services</small>	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	✓			✓ <small>(See "S*STAR – B – STAR and STAR Kids/Medicaid Covered Services" or "CHIP – B – Covered Services" in this manual)</small>	

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)	
	<input type="checkbox"/> Checking <input type="checkbox"/> 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 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 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



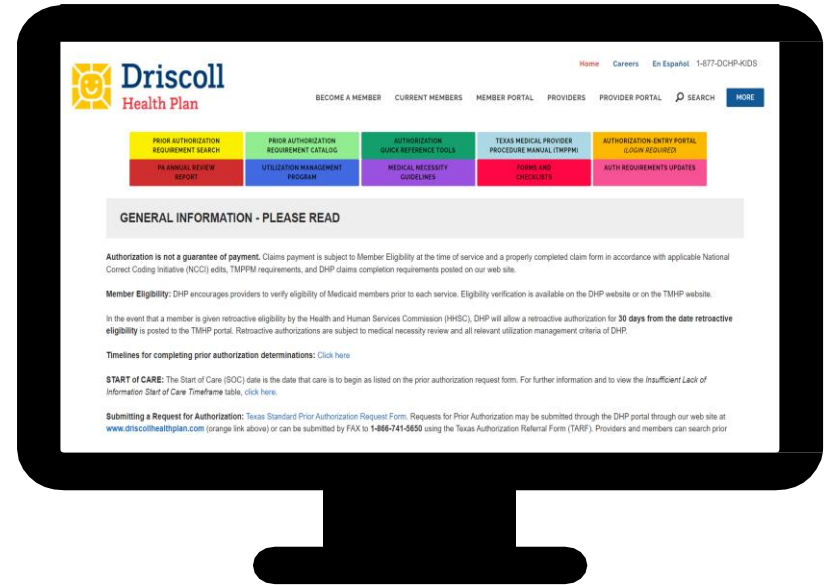
- Authorization is not a guarantee of payment. Claims payment is subject to Member Eligibility at the time of service and a properly completed claim form in accordance with applicable National Correct Coding Initiative (NCCI) edits, TMPPM requirements, and DHP claims completion requirements posted on 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

Involve Vision Services

800-465-6972

DHP Utilization Management

Ph: 877-455-1053

Fax: 866-741-5650

Navitus Pharmacy Services

877-908-6023

DHP STAR Kids LTSS Services

Ph: 844-376-5437

Fax: 844-381-5437



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



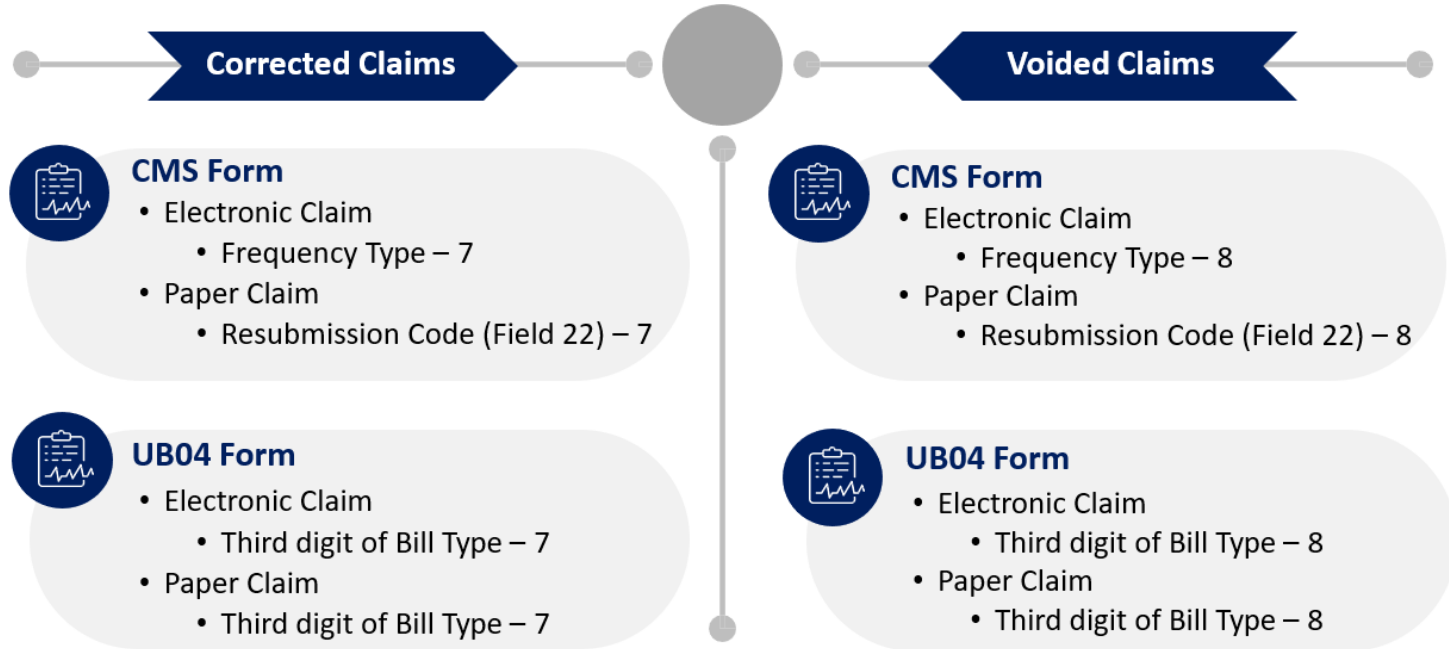
Submitting Corrected Claims



- 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



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.



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Thank you!

Driscoll Health Plan appreciates all that you do for our members and values our relationship.

