OB/GYN Staff Workshop

Driscoll Health Plan 2023

Agenda

- Driscoll Health Plan
- Introduction
- OB/GYN Updates
- Member Services
- Cultural Competency
- Administrative Issues
- Utilization Management
- Claims

Who are We?

Who is Driscoll Health Plan?

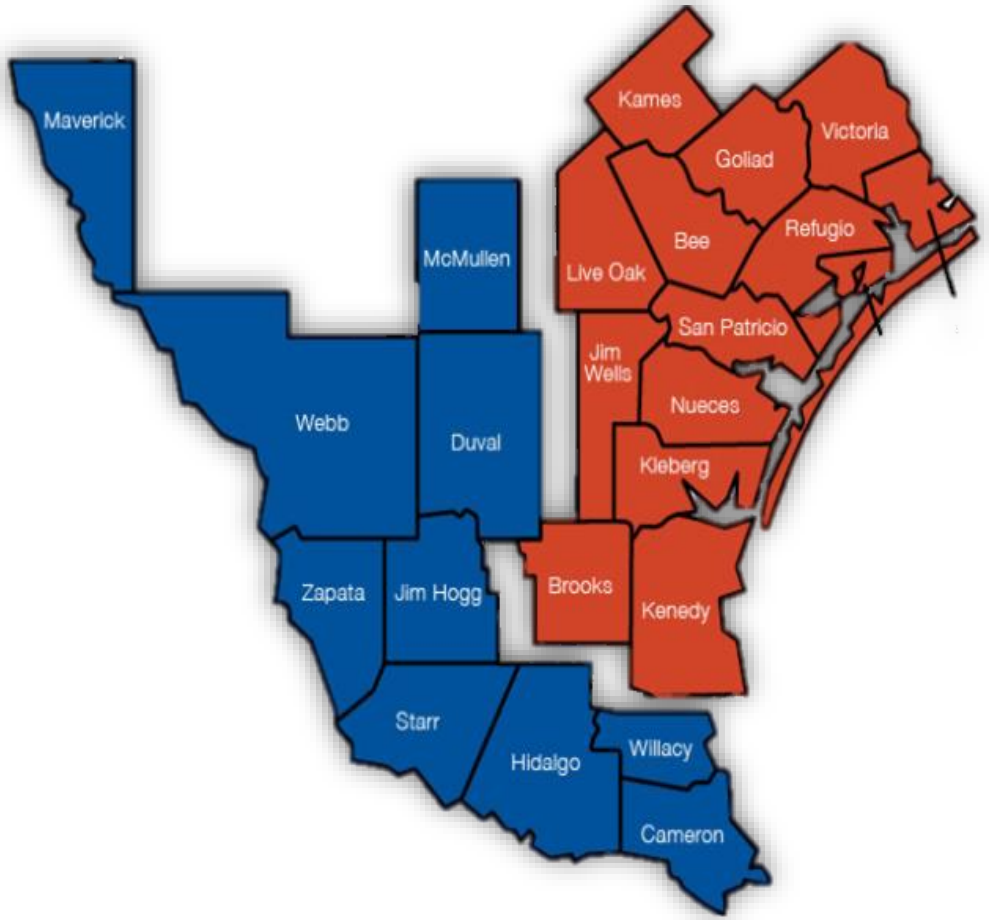
- Driscoll Health Plan is a non-profit, community-based health insurance plan offering health care coverage to the communities of South Texas. Our insurance products include STAR Medicaid, STAR Kids, CHIP and CHIP Perinatal.

- 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

OB/GYN Updates

Makena

Makena is administered intramuscularly at a dose of 250 mg (1ml) once a week (every 7 days) or 275 mg subcutaneous once weekly. **Prior authorization requests** must indicate the total number of doses to be administered during the pregnancy. The maximum prior authorized amount for Makena is 21 doses.

Procedure Code	Name	Auth Required
J1725	Makena	Yes, authorization is required through Navitus

High Risk Pregnancy

Driscoll Health Plan provides case management to high-risk pregnant women of all ages.

Call toll free to 1-877-222-2759 to refer Members.

Disease Management for Moms

Disease Management services are available to help manage a chronic illness, or address a sudden, catastrophic event or medical condition requiring multiple services and intensive management.

DHP's goal is to help members with a chronic disease or disease risk factors better manage their condition. DHP offers eligible members comprehensive educational resources and access to one-on-one nurse coaching and specialty care.

Disease Management programs are available to members with chronic health conditions, including Asthma, Diabetes and Behavioral Health

Ultrasounds

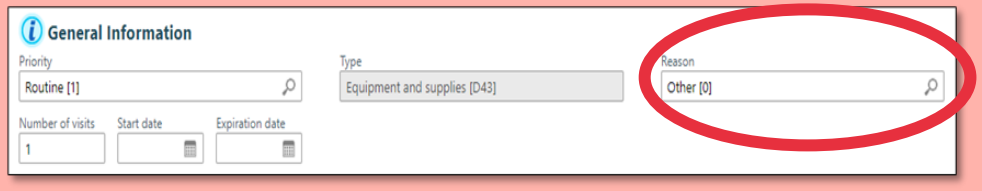
Texas Medicaid allows four obstetric ultrasounds per pregnancy. Any additional ultrasound performed during the same pregnancy is required to have **prior authorization**.

When an OB patient's medical need requires ultrasounds beyond the guidelines, DHP requests a reason code of **OB Ultrasound > 4** when submitting a new authorization request.

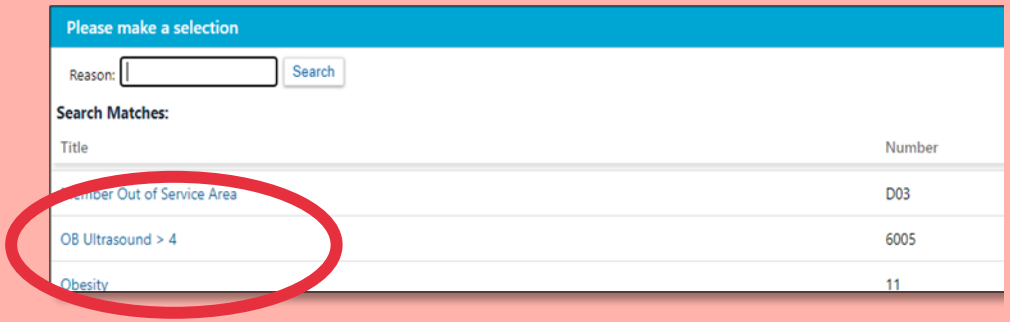
This limitation does not apply to obstetric ultrasound procedures in the emergency room, outpatient observation, or inpatient hospital setting. Obstetric ultrasounds provided in these settings must be submitted with modifier U6.

Entering Referral Reason: Ultrasound >4

Step 1: Begin the process of submitting a new authorization request. On the **General Information** section, navigate to the **Reason** field in the top right and click the Magnifying Glass.



Step 2. Select the reason code **OB Ultrasound >4.**



Ultrasounds Continued

OB Ultrasound Procedure Codes

76801, 76802, 76805, 76811, 76812, 76813, 76814, 76815, 76816, 76817

When billed as an add-on to a primary procedure code for OB US, these do not count toward the limit of 4.

76802, 76810, 76812, 76814

Fetal Echo

These procedure codes are restricted to specific diagnosis codes.

Procedure Codes	Restricted to Diagnosis Codes	Auth Required
76820, 76825, 76827, and 93325	009.811- 009.813, and 009.819	Yes, auth required

Genetic Testing

For the following procedures, please attach the required attestation form to the authorization request.

Procedure	Procedure Codes	Timeframe	Auth Required
Fetal Aneuploidy	81420	Once per pregnancy	Yes, auth required
Cystic Fibrosis	81220	Once per lifetime	Yes, auth required

Reminder: Required forms can be found by utilizing the **Prior Authorization Requirement Search** or searching by the specific code in the tool at the bottom of the Authorization Portal.

Prenatal Care

DHP reimburses prenatal care, deliveries, and postpartum care as **individual services**. No authorization is required.

For prenatal care, itemize each service individually and submit claims as the services are rendered. Claims must be received within 95 days of each service date.

*Note: Prenatal services must be billed with TH modifier

Claims for Delivery and Postpartum Services

DHP covers prenatal care, labor with delivery, and postpartum visits between 7 and 60 days after delivery or end of pregnancy. Obstetrical delivery, including postpartum care may be billed to DHP with one of the following CPT codes:

CPT	Description
59410	Vaginal delivery only; including postpartum care
59515	Cesarean delivery only; including postpartum care
59614	Vaginal delivery only, after previous cesarean delivery; including postpartum care
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Claims for Delivery and Postpartum Services- Continued

Delivery only and postpartum only may be billed to DHP with the following CPT codes:

CPT	Delivery Description
59409	Vaginal delivery only
59514	Cesarean delivery only
59612	Vaginal delivery only, after previous cesarean delivery
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

CPT	Postpartum Visit Description
59430	Postpartum care only (separate procedure)

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

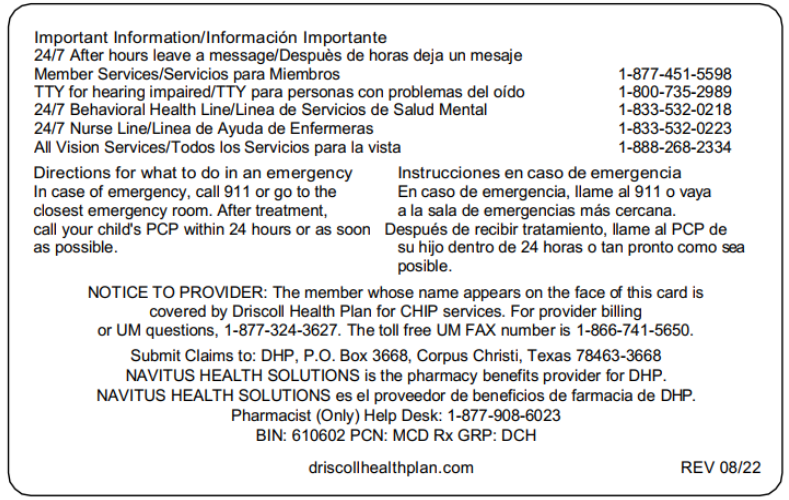
The Member ID Card is your source of verified member information.

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>

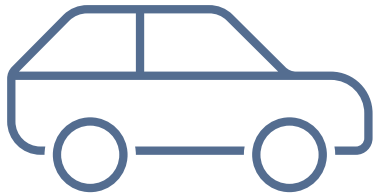
- Should receive an exam once every 2 years
- Glasses may be replaced every 2 years

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		

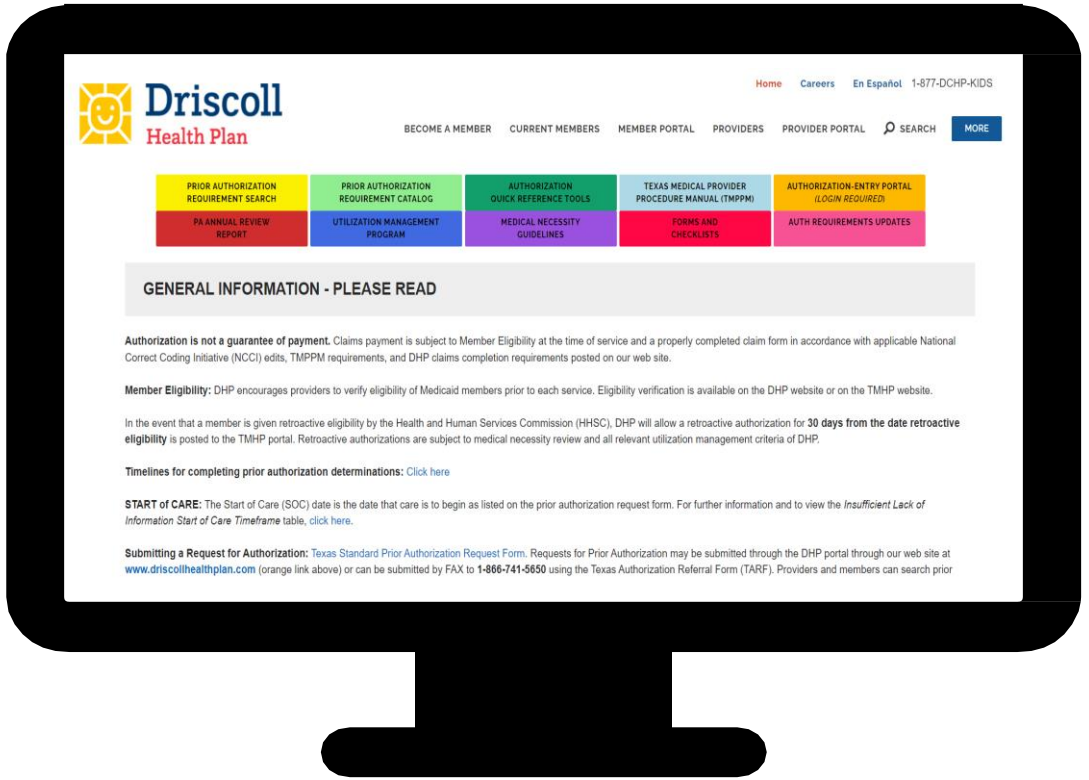
Utilization Management

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



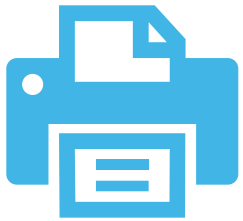
Supporting Information

- 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

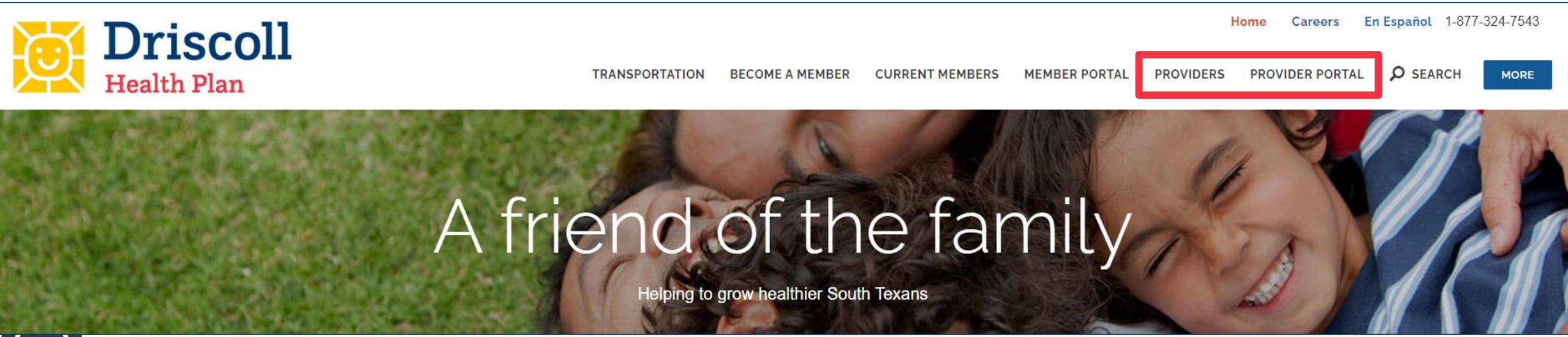
- Driscoll Health Plan (DHP) utilizes a third-party vendor to verify COB status on all DHP Plan Members.
- Verified information obtained through this process will take precedent on all claim processing.
- Providers must bill all other carriers and receive payment or denial prior to billing DHP.

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.