LTSS Staff Workshop

Driscoll Health Plan 2024

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.

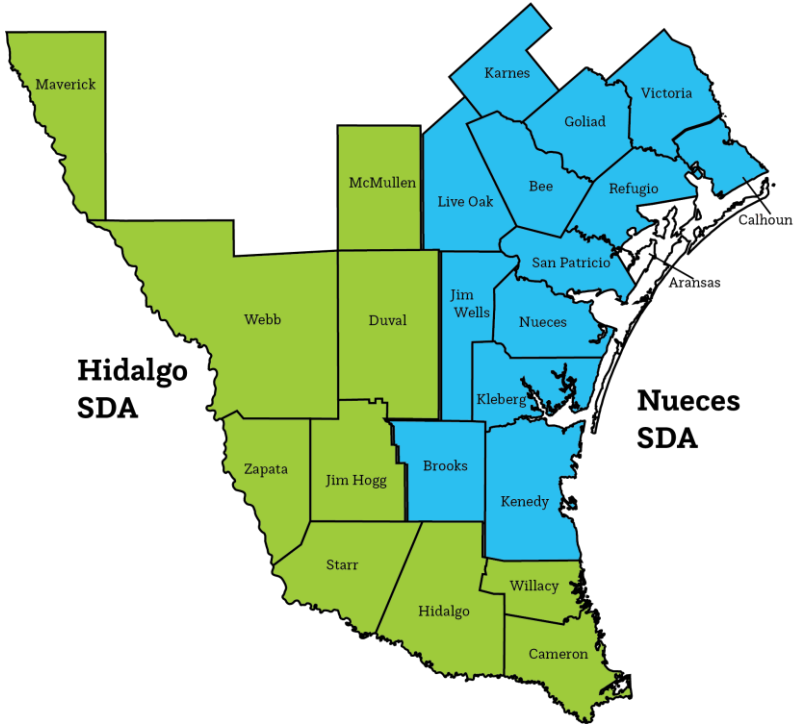
- Driscoll Health Plan was originally developed and funded through the Driscoll Foundation and licensed by the Texas Department of Insurance as a Health Maintenance Organization (HMO) in 1998.

- Driscoll Health Plan is affiliated with Driscoll Children's Hospital which has been taking care of kids and their families in South Texas and the Rio Grande Valley for more than 60 years. We offer health care services at Driscoll Children's specialty centers and clinics in McAllen, Harlingen, Brownsville, Laredo, Rio Grande City, Eagle Pass, Edinburg, Victoria and Weslaco.

DHP Service Delivery Areas

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

Hildago SDA
- STAR since 2012
- STAR Kids since 2016



Driscoll Contact Information

Provider Services:

STAR Nueces

1-877-324-3627 (option 1)

STAR Kids Nueces

1-844-508-4672

STAR Hidalgo

1-855-425-3247 (option 1)

STAR Kids Hidalgo

1-844-508-4674

Member Services:

STAR Nueces

1-877-230-6376

STAR Kids Nueces

1-844-508-4672

STAR Hidalgo

1-855-425-3247

STAR Kids Hidalgo

1-844-508-4674

Please refer to DHP Quick Reference Tool for further contact information.

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 MCDP 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

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

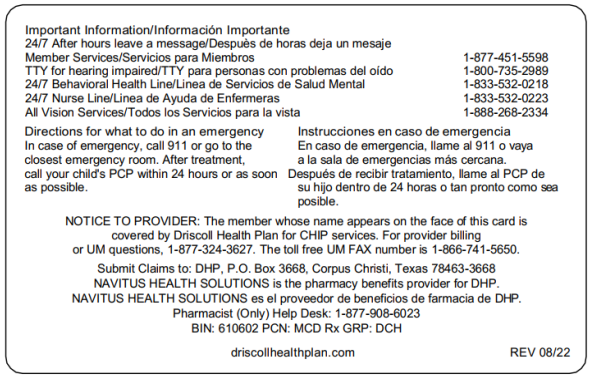
Co-payment Amounts/Co-pagos:

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

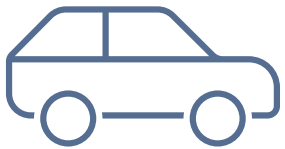
<u>Members 21 and older</u>
- Should receive an exam once every 2 years
- Glasses may be replaced every 2 years

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 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.

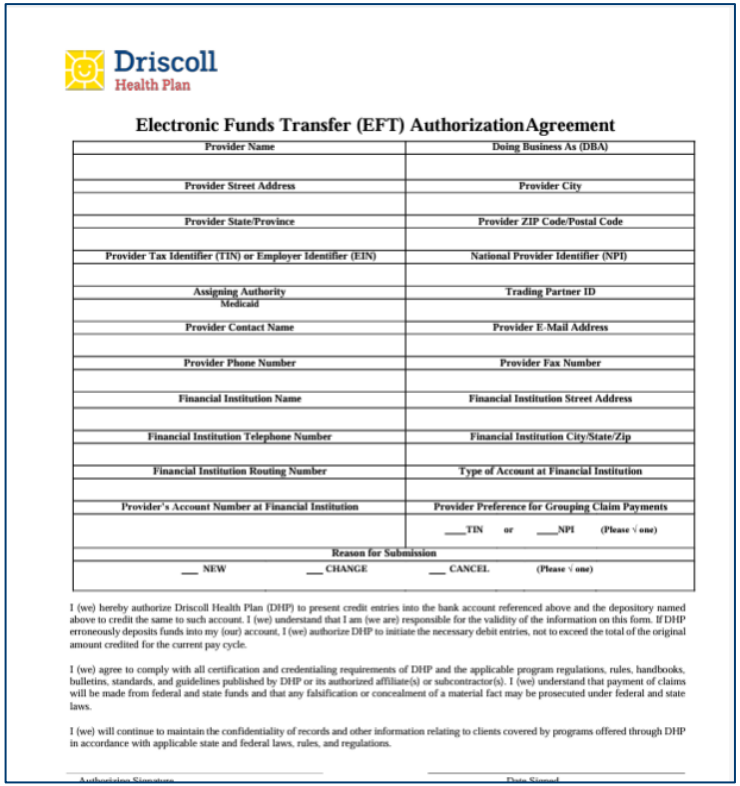
- For a list of when a co-pay may apply, refer to CHIP, Section B, of our Provider Manual.

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 _____

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		

Clinical Practice Guidelines

Driscoll Health Plan has established a set of clinical practice guidelines to ensure high-quality and evidence-based healthcare for its members. These guidelines serve as a framework for healthcare providers, promoting standardized and effective care delivery.

These guidelines are located at:

- Driscollhealthplan.com
- Provider Portal

Or you can contact your Provider Relations Representative for a copy.

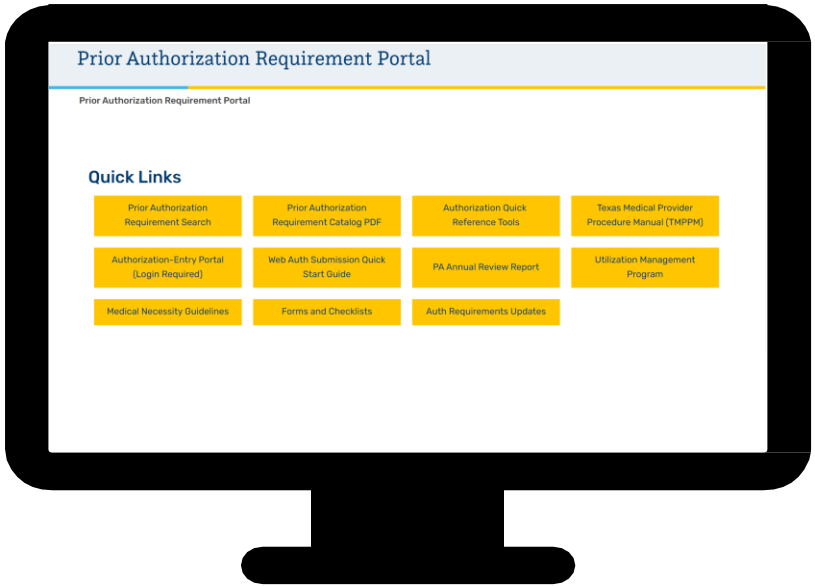
Utilization Management

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



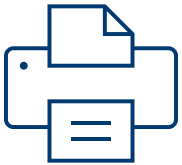
Supporting Information

- 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 https://www.dhpproviderportal.com/ Office staff can request a Provider Portal Account by selecting Request New Account on the Provider Portal Login.



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

Driscoll Health Plan has partnered with Availity to receive both 837I and 837P claims submitted electronically. Through most clearinghouses, you can submit your claims to DHP immediately using the payer ID 74284. We are also able to process and pay claims received on paper or through the TMHP portal. DHP continues to work to resolve the issues by providing the 835 electronic EOPs and processing 270/271 files.

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.

Administrative Claim Appeals

If you need to submit an administrative claim appeal, please ensure it reaches DHP within 120 days of the Explanation of Payment (EOP) date. DHP will process your appeal and respond within 30 days of receiving it. Please note that all administrative claim appeals should be completed within 24 months from the service date.

DHP Administrative Claim Appeal Submission
 driscollhealthplan.com
 DHP.PortalAppeals@dchstx.org
 Fax 361-808-2776

Claims Status and Follow-up

Providers should check claims status and follow-up on claims 30 days after submission.

Methods to check Claims Status	
	driscollhealthplan.com
	Fax 361-808-2079
	Call Customer Service and ask for the status telephonically for up to 8 claims daily

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, less than or equal to $5,000 for provider groups, 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.

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)*	

Thank you!

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