

Oklahoma Department of Corrections

NETWORK PROVIDER MANUAL



2015

Network Provider Manual

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Introduction

The Department of Corrections (DOC) Plan is a managed health care program providing comprehensive health and dental benefits to approximately 20,000 inmates who have been sentenced to a term of incarceration with the Oklahoma DOC.

The DOC Provider Network is administered by the Employees Group Insurance Department (EGID) of the Office of Management and Enterprise Services, an agency of the State of Oklahoma. The DOC plan is a partnership between DOC, providers and EGID in the delivery of health care services and products that helps control costs and assists in the provision of high quality health care.

The *DOC Network Provider Manual* is a summary only and is not intended to be all-inclusive; however, its contents should provide you and your business office personnel vital information regarding every aspect of Network participation. If, after reviewing this document, you require additional information, please contact the DOC Network Management Unit.

Email: EGID.DOCNetworkManagement@omes.ok.gov

Write to: Department of Corrections
Attn: Network Management
P.O. Box 12878
Oklahoma City, OK 73157-2878

Call: 1-405-717-8750
Toll-free 1-866-573-8462

Fax: 1-405-717-8977

Website: gateway.sib.ok.gov/DOC/

Hours: 7:30 a.m. through 4:30 p.m., Monday through Friday, excluding state holidays

The *DOC Network Provider Manual* is a summary only and is not intended to be all-inclusive.

DOC Medical and Dental Claims Administrator

DOC utilizes a medical and dental claims administrator with vast experience in the administration of medical and dental care benefit plans. This administrator is responsible for customer service, claims reporting, quality assurance and claims payment.

Medical and dental claims administrator:

HP Administrative Services, LLC
P.O. Box 268928
Oklahoma City, OK 73126-8928

1-405-782-5218
Toll-free 1-800-262-7683

Electronic submission of claims: NEIC Number 22521

Joining the DOC Provider Network

The DOC Provider Network is comprised of a wide range of medical and dental providers and facilities. Most licensed and/or certified providers and facilities are eligible to apply. The following list includes those providers and facilities eligible to participate within the DOC Provider Network:

- Ambulance
- Ambulatory Surgery Center
- Anesthesiology Assistant
- Audiologist
- Birthing Center
- Certified Nurse Midwife
- Certified Orthotist
- Certified Nurse Practitioner
- Certified Prosthetist
- Certified Registered Nurse Anesthetist
- Chiropractor
- Christian Science Nurse
- Clinical Nurse Specialist
- Christian Science Practitioner
- Dentist
- Dialysis Facility
- Dietitian
- Durable Medical Equipment Vendor
- Genetic Counselors
- Hearing Aid Vendor
- Home Health Care Agency
- Hospital
(Medical and Psychiatric/Substance Abuse)
- Hospice
- Independent Diagnostic Testing Facility
- Infusion Therapy
- Laboratory
- Licensed Alcohol and Drug Counselor
- Licensed Behavioral Practitioner

- Licensed Clinical Social Worker
- Licensed Marriage Family Therapist
- Licensed Professional Counselor
- Long-term Acute Care Facility
- Medical Doctor
- Nursing Homes
- Occupational Therapist
- Ocularist
- Ophthalmologist
- Optometrist
- Oral Surgeon
- Osteopathic Doctor
- Pathology (Group)
- Pathology (Individual)
- Perfusionist
- Pharmacist
- Physical Therapist
- Physician
- Physician Assistant
- Podiatrist
- Psychologist
- Radiology (Group)
- Radiology (Individual)
- Rehabilitation Facility
- Skilled Nursing Facility
- Sleep Study
- Speech Language Pathologist

DOC also provides Network reimbursement to rural health clinics, federally qualified health centers, Veterans Health Administration facilities, military facilities, and Indian Health Services facilities.

A contract and application packet can be obtained from our website at gateway.sib.ok.gov/DOC or by contacting network management by email at EGID.DOCNetworkManagement@omes.ok.gov or by telephone at 1-405-717-8750 or toll-free 1-866-573-8462.

Application Process

The appropriate application must be submitted with the required attachments as noted within the document. The submitted contract and its attachments are reviewed for complete, current information, and if the provider meets the qualifications necessary to participate in the Network, the application is accepted. The application process is delayed when information is not complete or current. Confirmation of the effective date and an executed contract signature page is mailed to the credentialing address listed on the application.

Network Management

Network management is responsible for the recruitment, care and sustainment of the Provider Network. Network management works in alliance with the Network Provider on contractual and policy issues and intercedes on behalf of the Network Provider.

If you have questions or concerns regarding any aspect of the Plan, please contact the network management staff using the contact information previously listed.

Provider Directory

The Provider Directory is available online at gateway.sib.ok.gov/DOC. The *Network Provider Contract* encourages providers to make reasonable efforts to refer patients to Network Hospitals and Providers when additional consults are necessary, or other medically necessary services are required. If you need additional information regarding the Network Provider Directory, please call network management.

Provider Contract Termination

The *Network Provider Contract* gives EGID, DOC and the Network Provider the ability to terminate a contract without cause upon a 30-day, written notice. Letters of termination from the Network provider should be sent certified mail per the terms of the *Network Provider Contract*. The return receipt serves as verification the information has been received. The actual effective date of the termination is 30 days from the date the termination letter is received in the EGID Network Management Unit.

A provider's contract is terminated immediately if their license or certification is suspended or revoked, or if their professional liability insurance is cancelled or not maintained in accordance with the *Network Provider Contract*. Additionally, if a provider is or becomes excluded by the Office of the Inspector General of the United States Department of Health and Human Services, the provider's contract is terminated immediately.

A DOC Network Provider terminating his/her contract with or without cause from the DOC Network is prevented from re-contracting with EGID as a Network Provider for a period of 12 months following the effective date of contract termination unless exceptional circumstances as determined by the EGID Administrator require the DOC Plan to execute a new contract.

Claim Filing Procedures

All claims should be submitted to the medical and dental claims administrator. To expedite processing, the following information must appear on every claim:

1. Inmate's name
2. Inmate's DOC# (if assigned to correctional facility). The inmate's DOC number must be a total of nine digits. In order to achieve this, please use preceding zeros, then the actual inmate DOC number on all claims and correspondence.
3. Inmate's SSN (if assigned to county jail but sentenced to DOC custody)

4. ICD or DSM diagnosis codes
5. CPT, HCPCS, MS-DRG, CDT or ASA codes with appropriate modifiers
6. Itemized charges (also required for all outpatient hospital services)
7. Date(s) of service

Claims are processed according to the inmate's DOC number and/or Social Security number. Please check for accuracy as incorrect data results in processing delays.

Please note, this information is not all-inclusive. For more information, refer to the DOC Billing Guides.

ClaimLink

ClaimLink is a valuable feature of the DOC Network Provider home page. Access to ClaimLink is available on the Network Provider home page at gateway.sib.ok.gov/DOC/ClaimLink.aspx. With ClaimLink, Network Providers can file claims online through direct data entry without the need for intermediary software. ClaimLink provides access to claim status the business day following submission. ClaimLink also gives Providers the ability to check real time eligibility, obtain a *Remittance Advice* (RA), and access claim editing rationale; however, it does not currently provide editing rationale for outpatient facility claims. Outpatient facility claims are edited using the Outpatient Code Editor (OCE) as published by the Centers for Medicare & Medicaid Services (CMS).

Next business day claim status checks and instant access to RAs through a secure provider ClaimLink account can help improve revenue-cycle management by reducing the lag time between an electronic funds transfer (EFT) and receipt of the RA in the mail. Instant access to an RA can also help to speed up account reconciliation processes.

In order to ensure privacy, first-time users must register and create a User ID and password. The Provider's email address and tax identification number (TIN) are required to register. The User ID and password are necessary for future access.

Quick start guides are available on the ClaimLink home page with no login required. The guides provide tutorials that include step-by-step processes for submitting claims, searching claims and obtaining RAs online. Adobe Reader is required to view the guides.

Corrected claims cannot be submitted electronically or online through ClaimLink. Hard copies of corrected claims must be submitted to the correspondence address for the medical and dental claims administrator.

Clearinghouses

Providers can submit claims electronically utilizing clearinghouses in conjunction with the electronic claims payer ID 22521. Contact the medical and dental claims administrator for more information.

All electronic transactions must conform to HIPAA 5010 standards. Claims that are not in compliance are either rejected or denied.

Corrected claims can be submitted electronically for ADA 2012 forms. Hard copies of corrected claims must be submitted to the correspondence address of the medical and dental claims administrator for other claim types.

Paper claims, correspondence and claim inquiries should be submitted to:

HP Administrative Services, LLC
P.O. Box 268928
Oklahoma City, OK 73126-8928

Acceptable claim forms are:

CMS-1500
UB-04
ADA 2012

Claim Payments

As mandated by HB1086, the *Transparency, Accountability, and Innovation in Oklahoma State Government 2.0 Act of 2011*, all payments disbursed by the Office of the State Treasurer are made solely through electronic funds transfer (EFT).

The EFT authorization form for DOC is available at <http://www.ok.gov/sib/documents/EFTForm.pdf>.

All claims are paid directly to Network Providers as required under the terms of the *Network Provider Contract*.

EFT is utilized for all provider payments. RAs are processed for Network Providers on a daily basis.

To ensure issuance of the benefit payment to the proper provider, it is imperative that the provider's name, NPI number, TIN and billing address appear on each claim.

Fee Schedule

The DOC fee schedule is available to Network Providers on our website at gateway.sib.ok.gov/DOC/FeeSchedule/Login.aspx. If you need assistance, please contact network management.

ClaimCheck and Clear Claim Connection

ClaimCheck and Clear Claim Connection are claim processing software programs used to ensure claims are properly coded using industry standard coding edits.

ClaimCheck is designed to detect coding discrepancies automatically. Automated reviews improve accuracy and consistency in claims adjudication and lead to improved claim processing turnaround times. ClaimCheck utilizes National Correct Coding Initiatives (CCI), Current Procedural Terminology (CPT) guidelines as published by the American Medical Association (AMA), and the general standards of medical practice in editing claims. Editing guidelines established by the Centers for Medicare & Medicaid Services (CMS) are also included in ClaimCheck rules.

Clear Claim Connection provides specific, detailed information regarding ClaimCheck's procedure code auditing software and how it evaluates code combinations during the processing of a claim. Clear Claim Connection allows DOC Network Providers online access to claims editing rules and clinical rationale used in the auditing software.

You can access ClaimCheck and Clear Claim Connection through ClaimLink. DOC encourages its Network Providers to utilize this website function to reference the Clear Claim Connection feature of the claims editing system.

In the event you disagree with any determination executed by ClaimCheck, please contact the medical and dental claims administrator. Provide any documented information that supports your position.

Referral Process

The Referral Process is utilized by DOC in the authorizing, scheduling, tracking and monitoring of all services rendered outside of the Medical Services Division established for DOC incarceration facilities.

If it is determined by a DOC Medical Services provider that the inmate cannot be treated effectively or appropriately within the DOC Medical Services Division, the Referral Process is implemented. The DOC Medical Services provider forwards the referral to the DOC regional physician to obtain approval for the inmate to receive treatment outside of the DOC facility. If treatment outside of the facility is approved by the regional physician, the DOC Medical Services provider contacts an outside provider and schedules an appointment.

The regional DOC physician must approve all follow-up visits to external providers. The external provider should not discuss any potential follow-up visits with the inmate. DOC inmates are always accompanied by a guard.

DOC Formulary

The DOC Network Provider must adhere strictly to the medications that comprise the DOC Formulary. All medications must be pre-authorized by the appropriate DOC Medical Services provider. The use of generic medications is preferred and encouraged.

The DOC formulary is available at

[www.ok.gov/doc/Organization/Employee Development & Offender Services/Medical Services/](http://www.ok.gov/doc/Organization/Employee_Development_&_Offender_Services/Medical_Services/)

Electronic Remittance Advice (ERA)

The EDI 835 transaction set, or *Electronic Remittance Advice* (ERA), is part of the HIPAA standard transactions that are designed to improve claims revenue cycle management for providers. It is part of the ASC X12 835 *Health Care Claim Payment/Remittance Advice*. If a provider wishes to enroll in 835 transactions, the enrollment forms are available on our website at

<https://gateway.sib.ok.gov/DOC/ERA.aspx>.

Network Providers should contact Employees Group Insurance Department (EGID) Network Management at 1-405-717-8750 or toll-free 1-888-573-8462, fax 1-405-717-8977, email EGID.DOCNetworkManagement@omes.ok.gov, or send to 3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112 any questions or to check the status of their ERA enrollment. Please allow up to 14 business days for processing prior to checking status.

Network Providers should use the form found on our website to sign up for ERA claim payments which are sent directly to their bank. If a provider changes TIN or NPI Numbers, they must also complete and submit this form with their change request, if ERA has already been established.

Non-Network providers should contact our medical and dental claims administrator toll-free 1-800-262-7683 to check the status of their ERA enrollment.

Overpayments/Underpayments

Providers are notified in writing of all overpayments identified by the medical and dental claims administrator. Overpayments are recovered either by a refund check from the provider and/or benefit reductions of subsequent claims. The provider has 60 days to reply to the initial overpayment letter. If no attempt is made to respond to the medical and dental claims administrator, subsequent benefit payments are reduced until the overpayment is satisfied.

Underpaid claims are adjusted and additional benefits are issued to the appropriate payee.

Coordination of Benefits (COB)

Under the terms of the *Network Provider Contract*, Coordination of Benefits (COB) Rules are subject to change. The following is a brief description of guidelines that apply to COB:

- With the exception of claims when the primary insurance carrier pays zero, DOC pays the remaining balance on covered charges after the primary carrier payment.
- When the primary carrier pays zero, DOC Allowed Charges apply for allowed benefits.

Regardless of the primary carrier's payment, DOC must deny claims for non-covered services and services that exceed plan limits. Plan provisions apply.

Covered Health Care Services

DOC Medical Services Division must pre-authorize all services before they are rendered to the inmate.

- Inpatient hospital services
- Private room
- Intensive care and coronary care unit
- All other hospital services which include physician hospital visits, anesthesia, radiology and laboratory
- Outpatient hospital/surgical facility services
- Emergency room
- Physician services
- Physical, occupational and manipulative therapy
- Maternity care
- Hospital and delivery (including prenatal and postnatal care)
- Laboratory
- Ultrasound (when medically necessary)
- Amniocentesis (when medically necessary)
- Hospice
- Home health care
- Infusion therapy
- Skilled nursing facilities
- Rehabilitation facilities
- Diagnostic X-ray (including ultrasound)
- Oxygen
- Durable medical equipment
- Prostheses
- Mammograms

- Routine eye exams
- Hearing tests

NOTE: This list may not be all-inclusive.

Non-Covered Health Care Services

- Supplies or services that are not medically necessary
- Services by practitioners who are not duly licensed under the laws of any state to perform such services or procedures
- Cosmetic or elective procedures not determined to be medically necessary
- Sex transformation or sexual dysfunction of any nature (except for radical prostatectomy)
- Experimental or investigational procedures
- Assistant surgeon in an outpatient setting (except for laparoscopic cholecystectomy)

NOTE: This list may not be all-inclusive.

Covered Dental Services

DOC Medical Services Division must pre-authorize all services before they are rendered to the inmate.

Class A (Preventive)

Covered services include (but are not limited to):

- Teeth cleaning, bitewing X-rays, routine oral examinations
- Dental X-rays
- Space maintainers for covered dependent children under age 19, to replace prematurely lost teeth
- Emergency palliative treatment

Class B (Basic Restorative)

Covered services include (but are not limited to):

- Extractions, including wisdom teeth
- Oral surgery (including general anesthetics when medically necessary)
- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth
- Certain treatments of periodontal disease
- Endodontic treatment, root canal therapy, injection of antibiotic drugs
- Repair or re-cementing of bridges, crowns, inlays, onlays or dentures

- Relining or rebasing of dentures once every three years
- Treatment for abscesses, cysts or root fragments with evidence of pathosis
- Gross scaling

Class C (Major Restorative Services)

Covered services include (but are not limited to):

- Initial placement of full removable or partial dentures, replacement of existing partial or full removable dentures, or an addition of teeth to a partial removable denture or bridgework as covered by DOC. The existing denture or bridgework must have been installed at least five years prior to its replacement and cannot be repaired.
- Inlays, onlays, fillings or steel crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive cavities or fracture, cannot be restored to proper function with amalgam, silicate, acrylic, synthetic porcelain or composite restoration.

Non-Covered Dental Services

The Plan does **not** cover:

- Cast crowns
- Bridges
- Molar endodontics, except pulpectomy or pulpotomy with prior approval
- Orthodontics
- Implants and treatment associated with implants
- Endodontics in periodically compromised teeth
- Any dental care or supplies not included under covered dental expenses
- Charges for dental services or supplies exceeding the fee schedule allowable
- Dental care or supplies (including prescriptions) that are provided outside of the dental office
- Oral hygiene instruction
- Dental care and supplies for which no charge is made or for which payment would not be required if inmate did not have this coverage
- Separately billed infection control fees
- Services billed by a denturist
- Gel-Kam and take home fluorides
- Oral care and supplies, which are used to change vertical dimension or closure, and cosmetic procedures must have prior approval
- Charges for treatment of accidental injury to natural teeth or gums
- Medical expenses for the treatment of temporomandibular joint dysfunction (TMD)
- Medical services treating an oral condition