

**State of Oklahoma**  
**Department of Correction**  
**Network Long Term Acute Care Facility**  
**Contract**

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# **Oklahoma Department of Corrections**

## **Long Term Acute Care Facility Contract**

This Network Long-Term Acute Care Facility Contract, hereinafter “Contract,” is between the Oklahoma Department of Corrections, hereinafter “DOC,” and the Network Long-Term Acute Care Facility, hereinafter “Facility,” identified on the Signature Page.

### **I. RECITALS**

- 1.1 The DOC is a statutory body created by 57 O. S.(2001),§505 et seq., as amended, to administer and manage the incarceration of persons who have committed criminal offences or are otherwise subjected to criminal sanctions within the State of Oklahoma.
- 1.2 The Facility is duly licensed by the state of residence and is certified to participate in the Medicare program under Title XVIII of the Social Security Act, and/or certified by The Joint Commission or Accreditation Association for Ambulatory Health Care (AAAHC), if applicable, and shall comply with all applicable federal, state, and local laws regulating such a Facility.
- 1.3 The intent of this Contract is to provide access to enhanced quality health care, utilizing Network Facilities at an affordable, competitive cost to the DOC.

In consideration of the mutual covenants, promises and other good and valuable consideration, DOC and the Facility agree as follows:

### **II. DEFINITIONS**

- 2.1 “Allowable Fee” means the maximum amount payable to a Facility by DOC and Inmate for Covered Services furnished pursuant to this Contract.
- 2.2 “ALOS” means the Geometric Average Length of Stay
- 2.3 “Base Rate” means a dollar amount established by DOC by which the MS- LTC-DRG Relative Weight is multiplied to obtain the MS-LTC-DRG Allowable Fee.
- 2.4 “Certification” means a function performed by DOC to review and certify services for medical necessity in identified areas of practice prior to services being rendered.
- 2.5 “CMS” means Centers for Medicare and Medicaid Services.
- 2.6 “Concurrent Review” means a function performed by DOC that determines and updates medical necessity for continued inpatient hospitalization.
- 2.7 “Cost to Charge Ratio” means the most recent statewide average total cost-to-charge ratio for urban Oklahoma Facilities as published by CMS.

- 2.8 “Covered Services” means Medically Necessary services delivered by a Facility pursuant to this Contract and for which an Inmate is entitled to receive coverage by the terms and conditions of a DOC.
- 2.9 “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.
- 2.10 “Facility Services” means those acute care inpatient and outpatient Facility Services that are covered by the DOC.
- 2.11 “Geometric Average Length of Stay” means the current version of the Geometric ALOS published by CMS for each MS-LTC-DRG.
- 2.12 “Inmates” means all persons within the DOC’s custody for whom the DOC is required to furnish Medical Services.
- 2.13 “High Cost Outlier Allowable Fee” shall be determined as outlined in Article 6.4.
- 2.14 “Interrupted Stay” means a case in which a patient is discharged and then admitted directly to an inpatient acute care hospital, an Inpatient Rehabilitation Facility (IRF), a Skilled Nursing Facility (SNF) or a swing-bed and then returns to the same Facility within a fixed period of time. Currently, Medicare has determined the fixed period of time for each provider type is as follows:
- a) Acute care hospital – 9 days or less
  - b) Inpatient Rehabilitation Facility (IRF) – 27 days or less
  - c) Skilled Nursing Facility (SNF) – 45 days or less
  - d) Swing-bed hospital – 45 days or less
  - e) Discharge to patient’s home and readmission to Facility within three days, subject to update in accordance with CMS guidelines.

An Interrupted Stay is treated as one discharge for the purposes of payment and only one MS –LTC DRG payment is made.

- 2.15 “LTC” means a Long-Term Acute Care Hospital with an average length of stay of greater than 25 days. LTC facilities are identified by the last four digits of the Medicare provider number, which range between “2000” and “2299”. Rehabilitation hospitals, Veterans Administration hospitals and psychiatric hospitals are not considered to be a LTC. LTCs

can be a satellite and/or hospital- within-a-hospital or co-located within another facility.

- 2.16 “Medically Necessary” means services or supplies which are provided for the diagnosis and treatment of the medical and/or mental health/substance abuse condition and complies with criteria adopted by DOC. Direct care and treatment are within standards of good medical practice within the community and are appropriate and necessary for the symptoms, diagnosis or treatment of the condition. The services or supplies must be the most appropriate supply or level of service which can safely be provided. For hospital stays, this means that inpatient acute care is necessary due to the intensity of services the Inmate is receiving or the severity of the Inmate’s condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The services or supplies cannot be primarily for the convenience of the Inmate, caregiver or provider. The fact that services or supplies are Medically Necessary does not, in itself, assure that the services or supplies are covered by the DOC.
- 2.17 “Medical Services” means the professional services provided by a Network Provider and covered by a DOC.
- 2.18 “Inmates” means all persons within the DOC’s custody for whom the DOC is required to furnish Medical Services, including eligible current and qualified former employees of participating entities and their eligible covered dependents. Qualified former employees include those who have retired or vested through an eligible State of Oklahoma retirement system, or who have completed the statutory required years of services, or who have other coverage rights through COBRA or the Oklahoma Personnel Act.
- 2.19 “MS-LTC-DRG” means the Medicare Severity- Long Term Care- Diagnosis Related Groups and in an inpatient Facility classification, as published by CMS.
- 2.20 “MS-LTC-DRG Allowable Fee” means the MS-LTC-DRG relative weight as published by CMS multiplied by the Base Rate. For purposes of this contract, the MS-LTC-DRG Allowable Fee, as established by DOC shall serve as the payment rate, unless the reimbursement is to be a Short-Stay Outlier or a High Cost Outlier.
- 2.21 “MS-LTC-DRG Relative Weight” means the current version of the Relative Weight published by CMS for each MS-LTC-DRG.
- 2.22 “Network Facility” means a certified facility that has entered into this Contract with the DOC to accept scheduled reimbursement for covered Medical Services provided to Inmates.
- 2.23 “Non-covered Services” are those services
- a) excluded from coverage by the DOC, in which case the Inmate is liable for the charges; or
  - b) covered by the DOC but inappropriately billed and therefore excluded for reimbursement based on the clinical editing software.

- 2.24 “Outlier Threshold” means a dollar amount published by CMS by which the total billed charges on the claim must exceed the MS-LTC-DRG Allowable Fee in order to qualify for an outlier allowable fee.
- 2.25 “Referral Process” means a process by which the DOC manages the authorization, scheduling, tracking and monitoring of all Medical Service appointments outside the DOC.
- 2.26 “Per Diem” for Short-Stay Outliers means the MS-LTC-DRG Allowable Fee divided by the Geometric ALOS.
- 2.27 “Short-Stay Outlier” means a case that has a length of stay between one day up to and including 5/6 of the ALOS for the MS-LTC-DRG to which the case is grouped. Short-Stay outliers are also eligible for high cost outlier payments if their costs exceed the Outlier Threshold.
- 2.28 “Short-Stay Outlier Allowable Fee” means the lesser of the MS-LTC-DRG Allowable Fee or the Per Diem for Short-Stay Outlier multiplied by the actual length of stay multiplied by One Hundred Twenty percent (120%).

### **III. RELATIONSHIP BETWEEN DOC AND THE FACILITY**

- 3.1 DOC negotiated and entered into this Contract with the Facility. The Facility is an independent contractor that has entered into this Contract to become a Network Facility and is not, nor is intended to be the agent or other legal representative of DOC in the performance of the provisions of this Contract. Nothing in this Contract shall be construed or be deemed to create a relationship contrary to that of independent contractor for the purposes of this Contract.
- 3.2 DOC and the Facility agree that all of the parties hereto shall respect and observe the facility/patient relationship which will be established and maintained by the Facility. The Facility may choose not to establish a facility/patient relationship if the Facility would have otherwise made the decision not to establish a facility/patient relationship had the patient not been an Inmate. The Facility reserves the right to refuse to furnish services to an Inmate in the same manner as they would any other patient.
- 3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies of any third party, including but not limited to, Network Facilities that are not identified by this Contract, except DOC Inmates defined in this Contract.

### **IV. FACILITY SERVICES AND RESPONSIBILITIES**

- 4.1 The Facility shall provide quality, Medically Necessary Facility Services to Inmates, in a cost efficient manner, when such services are ordered by a licensed practitioner, who is a member of the Facility's medical staff and has been awarded the prerequisite clinical privileges to order and/or perform such services. Nothing in this Contract shall be

- construed to require the medical staff of the Facility to perform any procedure or course of treatment which the staff deems professionally unacceptable or is contrary to Facility policy.
- 4.2 The Facility shall provide Facility Services to Inmates in the same manner and quality as those services are provided to all other patients of the Facility.
  - 4.3 The Facility has, and shall maintain, in good standing while this Contract is in effect, all licenses required by law, and if applicable, certification to participate in the Medicare program under Title XVIII of the Social Security Act and/or The Joint Commission.
  - 4.4 The Facility agrees to make reasonable efforts to refer covered Inmates to other Network Facilities with which DOC contracts for Medically Necessary Services that the Facility cannot or chooses not to provide.
  - 4.5 The Facility shall participate in the Referral Process procedures provided in Article VII and for purposes of reimbursement to abide by decisions resulting from that process subject to the Dispute Resolution Process provided in Article IX.
  - 4.6 The Facility shall furnish, at no cost to DOC, any medical and billing records covering any Medical Services, for any Inmate, with the understanding that each Inmate, as a condition of enrollment in the DOC, has authorized such disclosure.
  - 4.7 The Facility shall accurately complete the Network Facility Application which is attached to and made part of this Contract. The Facility shall notify DOC of any change in the information contained in the Application within fifteen (15) days of such change, including resolved litigation listed as “pending” on the original Network Facility Application.
  - 4.8 The Facility shall reimburse DOC for any overpayments made to the Facility within sixty (60) days of the Facility's receipt of the written overpayment notification or shall respond with detail within said time if Facility disputes the request for additional payment. DOC shall provide the Facility individual letters of retraction for each patient sixty (60) days prior to the retraction being made.

As an exception DOC will immediately deduct overpayments due to resubmission of a corrected claim, or if information is received for a claim pending additional information that subsequently impacts a paid claim or a mutually agreed to audit adjustment.

DOC shall be entitled to additional payment if, within two years from the date of payment, DOC notifies Facility, in writing of the overpayment.

If Facility disputes the request for additional payment, the Parties shall work cooperatively and in good faith to resolve the payment issue on an informal basis within sixty (60) days of the first notification of the overpayment. If the Parties’ attempt to resolve the issue is unsuccessful, then the dispute concerning the incorrect payment shall be resolved in

accordance with the Dispute Resolution Process provided in Article X.

- 4.9 The Facility shall submit to an Inmate record audit upon fourteen (14) business days advance notice.
- 4.10 The Facility shall comply with the national standards for the electronic exchange of administrative and financial health care transactions required by the Health Insurance Portability and Accountability Act of 1996, hereinafter "HIPAA".

## **V. DOC SERVICES AND RESPONSIBILITIES**

- 5.1 DOC agrees to pay the Facility compensation pursuant to the provisions of Article VI.
- 5.2 DOC agrees to grant the Facility the status of "Network Facility" and to identify the Facility as a Network Facility on informational materials disseminated to Inmates.
- 5.3 DOC agrees to continue listing the Facility as a Network Facility until this Contract terminates.
- 5.4 DOC agrees to provide the Facility with access to a listing of all Network Facilities via the Internet.
- 5.5 DOC agrees to acknowledge the confidentiality of patient's records and to only release pertinent clinical information in accordance with state and federal guidelines.
- 5.6 DOC shall give fourteen (14) business days' notice prior to an audit. Under no circumstances shall an audit of medical records by DOC delay payment to Facility under Article VI.
- 5.7 DOC shall maintain Certification and Concurrent Review programs in accordance with the Utilization Review Accreditation Commission's, hereinafter "URAC," standards in order to aid its Inmate in making decisions that will maximize medical benefits and reduce their financial risk.
- 5.8 DOC shall reimburse underpayments to the Facility within thirty (30) days of DOC's receipt of underpayment notification, or shall respond with detail within said time if DOC disputes the request for additional payment. Facility shall be entitled to additional payment if, within two (2) years from the date of payment, Facility notifies DOC in writing of the under payment. If DOC disputes the request for additional payment, the Parties shall work cooperatively and in good faith to resolve the payment issue on an informal basis within sixty (60) days of the first notification of underpayment. If the Parties attempt to resolve the issue is unsuccessful, then the dispute concerning the payment shall be resolved in accordance with the Dispute Resolution Rights provided in Article X.
- 5.9 DOC shall comply with the national standards for the electronic exchange of administrative and financial health care transactions required by H IPAA.

## VI. COMPENSATION AND BILLING

- 6.1 The Facility shall only seek payment from DOC for the provision of Covered Services. The payment shall be calculated and limited to the methodologies defined by this Contract.
- 6.2 When the Allowable Fee exceeds billed charges, DOC shall pay the appropriate percentage of the Allowable Fee and Inmate shall pay the appropriate percentage of billed charges unless the Inmate has met the stop loss limitation and then DOC shall pay the Allowable Fee and the Inmate has no liability. A list of the CPT/HCPCS codes and the Allowable Fee for each can be found at the DOC website at [www.ok.gov/sib/providers](http://www.ok.gov/sib/providers). It is DOC's intent to review and update the fee schedule annually. It is DOC's further intent to update the list as it deems necessary when new CPT/HCPCS codes are identified by the American Medical Association or CMS.
- 6.3 When processing inpatient claims, DOC agrees to pay the Facility the Allowable Fee based on appropriate billing according to the following:
- a) DOC shall pay the appropriate percentage of the MS- LTC- DRG Allowable Fee and the Inmate has no liability.
  - b) The MS-LTC-DRG shall be controlling, subject to DOC's approval and Article X of the Contract.
  - c) The MS-LTC-DRG Allowable Fee does not include any physician professional component fees, which are considered for payment according to separately billed Current Procedural Terminology code Allowable Fees.
  - d) DOC shall include the day of admission but not the day of discharge when computing the number of facility days provided to an Inmate. Observation Facility confinements for which a room and board charge is incurred shall be paid based on inpatient benefits.
  - e) DOC shall use the current version of the MS-LTC-DRG grouper to categorize what shall constitute a procedure. DOC's and the Inmate's financial liability shall be limited to the Allowable Fee as determined by DOC.
  - f) The Facility agrees not to charge more for Medical Services to Inmates than the amount normally charged by the Facility to other patients for similar services.
- 6.4 DOC shall determine the Allowable Fee to a Facility for an unadjusted MS-LTC-DRG according to the following formula:

$$\text{MS-LTC-DRG Allowable Fee} = \text{MS-LTC-DRG Relative Weight as published by CMS} \times \text{Base Rate}$$

- 6.5 Short-Stay Outlier mean a case that has a length of stay between one day and up to and including 5/6 of the ALOS for the MS-LTC-DRG to which the case is grouped. In the case

of a Short-Stay Outlier, the Short-Stay Outlier Allowable Fee for the Facility shall be calculated as follows:

$$\text{Per Diem for Short-Stay Outlier} = \text{MS-LTC-DRG Allowable Fee} \div \text{Geometric Average Length of Stay as published by CMS}$$

$$\text{Short-Stay Outlier Allowable Fee} = \text{the lesser of the MS-LTC- DRG Allowable Fee or (Per Diem for Short-Stay Outlier x actual length of stay x 120\%)}$$

Short-Stay Outliers are also eligible for high cost outlier payments if the costs exceed the outlier threshold.

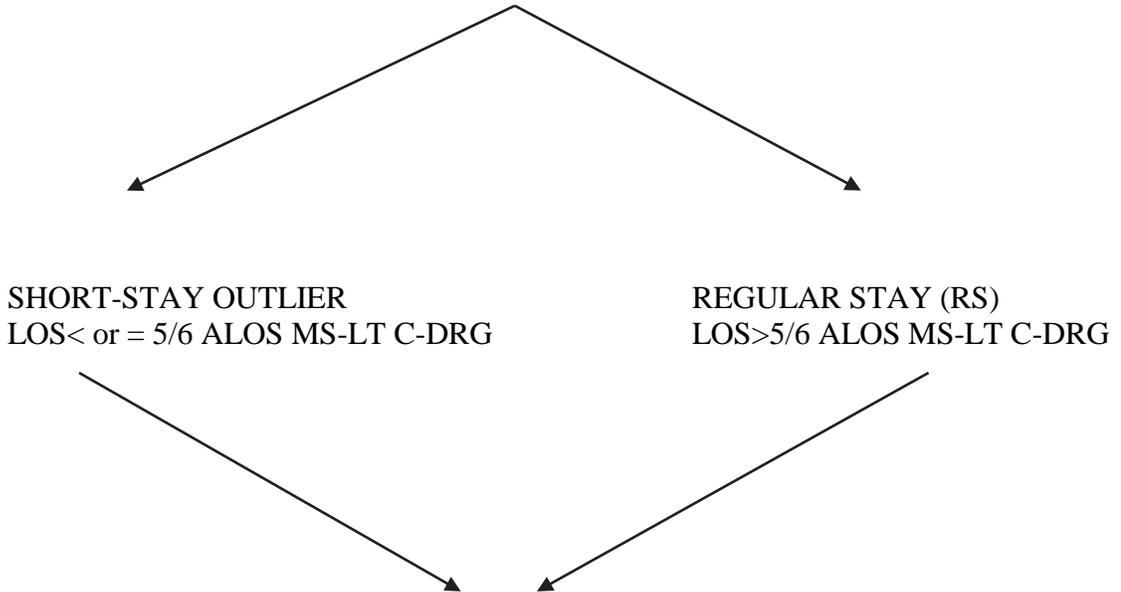
- 6.6 “High Cost Outlier Allowable Fee” means cases that have unusually high cost. In the case of a High Cost Outlier, the High Cost Outlier Allowable Fee for the Facility shall be calculated as follows:

$$\text{High Cost Outlier Allowable Fee} = ([\text{Billed Charges} - \text{Disallowed Charges}] \times \text{Cost to Charge Ratio} - \text{MS-LTC-DRG Allowable Fee} - \text{Outlier Threshold}) \times 80\% + \text{MS-LTC-DRG Allowable Fee}$$

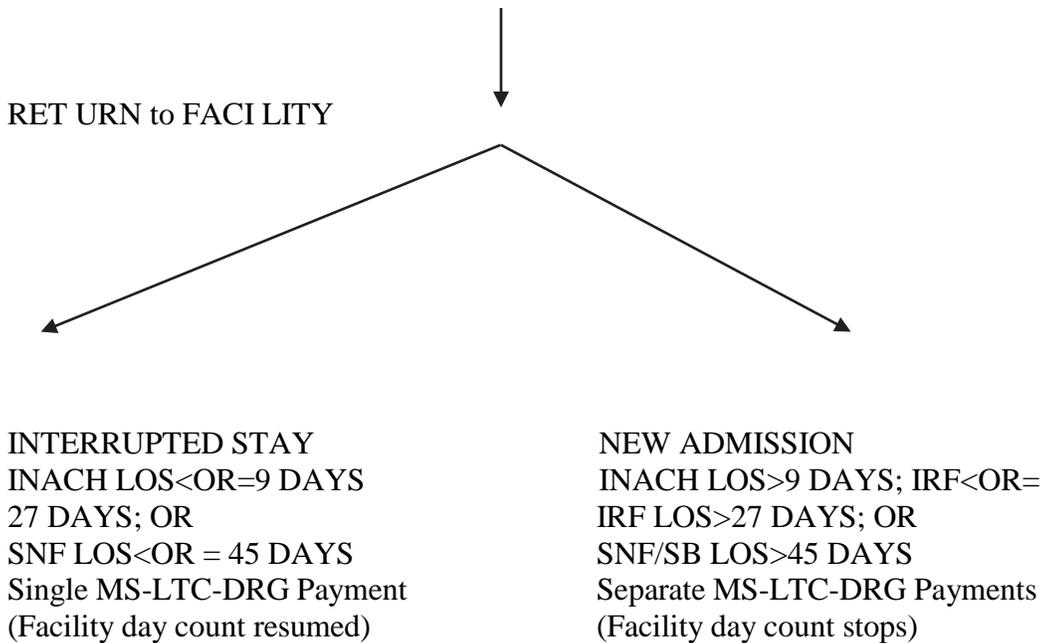
- 6.7 In the case of Interrupted Stays, if the length of stay at the receiving Facility is equal to or less than applicable fixed period of time, it is considered to be an Interrupted Stay case and is therefore treated as a single (one) discharge for the purpose of payment. Only one MS-LTC-DRG payment will be made. Each interrupted period that occurs shall be evaluated individually regarding the number of days at the intervening Facility to determine if it meets the requirements of the Interrupted Stay policy. An Interrupted Stay” is determined in accordance with the following flow chart prepared by CMS.

SHORT-STAY OUTLIER RS AND INTERRUPTED STAYS

ADMISSION TO FACILITY



(Facility day count stops) DISCHARGED to  
Inpatient Acute Care Hospital (INACH) Inpatient Rehabilitation Facility (IRF) Skilled  
Nursing Facility (SNF), or Swing-bed (SB)



**SHORT STAY OUTLIER**

Total LOS < or = 5/6 ALOS

**RS**

Total LOS. 5/6 ALOS MS-LTC-DRG

MS-LTC-DRG

- 6.8 When processing Outpatient claims, DOC agrees to pay the Facility the Allowable Fee based on appropriate billing according to the following:
- a) If a procedure does not have an Allowable Fee, DOC will allow a percentage of the billed charges for Covered Services.
  - b) The facility agrees not to charge more for Medical Services to Inmates than the amount normally charged by the Facility to other patients for similar services.
  - c) The Facility agrees that DOC utilizes a comprehensive claims editing system to assist in determining which charges for Covered Services to allow for payment and to assist in determining inappropriate billing and coding. Said system shall rely on Medicare and other industry standards in the development of its mutually exclusive, incidental, re-bundling, age conflict, gender conflict. Cosmetic, experimental and procedure editing, DOC shall provide the Facility, upon request from Facility, detailed information about the processes employed in the claims editing system adopted by DOC.
- 6.9 In a case in which DOC is primary under applicable coordination of benefit rules, DOC shall pay the amounts due under this Contract. In a case in which DOC is other than primary under the coordination of benefit rules, DOC shall pay the Inmate's liability for out of pocket expenses such as deductibles, copayments or coinsurance, under the primary policy, up to DOC's maximum liability under the terms of the Contract. No payment will be made for any charge that is not an allowed expense or an amount for which the Inmate is contractually held harmless under any coordinating policy.
- 6.10 The Facility may not bill an Inmate for Non-covered Services or the difference between the paid amount and the billed charge.
- 6.11 The Facility shall bill DOC on standard and customary forms acceptable to DOC within 120 days of providing the Facility Services, or receipt of primary payors explanation of benefits, or from discovery that DOC is responsible for payment. The facility shall use the current CPT/HCPCS codes with appropriate modifiers and ICD diagnostic codes, when applicable. The facility shall furnish, upon request at no cost, all applicable medical and billing records, reasonably required by DOC to verify and substantiate the provision of Medical Services and the charges for such services if the Inmate and the Facility are requesting reimbursement through DOC. This provision shall not apply in cases involving litigation, multiple payors, or where the patient has failed to notify the Facility that they were an Inmate.
- 6.12 DOC shall reimburse the Facility within forty-five (45) days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this contract. DOC will not be responsible for the delay or reimbursement due to circumstances beyond DOC's control.

## **VII. REFERRAL PROCESS**

- 7.1 The Referral Process begins with the appropriate DOC provider diagnosing the patient with a condition that requires treatment not available within the DOC's Medical Services Division. The DOC's provider forwards the referral to the DOC's regional physician to obtain approval for the Inmate to access a Network Facility outside of the prison and/or county jail. The regional physician approves or denies the outside referral by checking the appropriate box on the referral form.

- 7.2 The DOC's provider contacts the Network Facility and the appointment is scheduled. In some cases, a telephone conference between the referring DOC provider and the outside provider may be warranted. In the event a procedure needs to be performed that is not indicated on the referral record as approved by the DOC's regional physician, a telephone conference between the outside provider and the referring provider shall be necessary.

## **VIII. LIABILITY AND INSURANCE**

- 8.1 Neither party to this Contract, the DOC nor the Facility, or any agent, employee or other representative of a party, shall be liable to third parties for any act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.
- 8.2 Effective November 1, 2007, licensed medical professionals under contract with DOC who provide medical care to Inmates in DOC custody or control are employees of the State of Oklahoma for purposes of the Oklahoma Governmental Tort Claims Act (OGTCA). A licensed professional who, in good faith, provides services pursuant to this contract, and is performing the duties of his or her employment or tasks lawfully assigned, shall be treated as a state employee under the OGTCA. Coverage under the OGTCA only extends to acts under this contract. Covered professionals shall provide a history of prior claims for a period of five (5) years. In the event a demand, claim, or legal action is filed for covered acts, the covered professional shall immediately notify:

Division of Risk Management  
2401 North Lincoln Blvd. Suite 202  
Oklahoma City, OK 73152 (405) 521-4999  
FAX: (405) 522-4442

Failure to notify shall be deemed failure to cooperate in the defense of the claim and may result in denial of coverage. Covered professionals should consult with their insurance carrier to determine the impact, if any, of coverage as an employee of the state of Oklahoma under the OGTCA.

## **IX. DISPUTE RESOLUTION**

- 9.1 The Facility may participate in the Dispute Resolution Process as established by DOC and detailed in the provider manual. Permitted Facility disputes include: clean claims, untimely claim submission, disagreements in regard to the amount paid on a claim, clinical editing, medical necessity, certification, and other disagreements relating to contractual provisions and issues. Issues not subject to the Dispute Resolution Process include, but are not limited to: Rights beyond the Plan's obligation to Inmates' Allowable Fee, coordination of benefits, and plan coverage and exclusions. In order to initiate the Dispute Resolution Process, Facilities shall contact. Nothing in this Article shall interfere with either party's rights under Article X.

## **X. TERM AND TERMINATION**

- 10.1 It is agreed by the parties that no changes to the Contract which include coverage, fee schedule, or reimbursement methodologies, shall be made with less than sixty (60) days' notice, except revisions to injectable medications, in which case DOC shall implement the Revisions as soon as possible with proper and timely notification to the Facility.

- 10.2 Either party may terminate this Contract with or without cause, upon giving thirty (30) days written notice pursuant to 11.2 at any time during the term of this Contract.
- 10.3 Nothing in this Contract shall be construed to limit either party's remedies at law or in equity in the event of a material breach of this Contract.
- 10.4 Following termination of this Contract, the DOC shall continue to have access, at no cost to the DOC, to the Facility's records of care and services provided to Inmates for five years from the date of provision of the services to which the records refer.
- 10.5 This Contract shall terminate with respect to a Facility upon the loss or suspension of the Facility's license to operate in the state of residence, The Joint Commission's or Medicare certification or failure to maintain Facility's professional and general liability coverage in accordance with this Contract.

## **XI. GENERAL PROVISIONS**

- 11.1 This Contract, including any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party.
- 11.2 The termination notice required by the terms of this Contract, shall be provided in writing and (1) mailed by the United States Postal Service (USPS), postage prepaid, certified mail, return receipt requested; or, (2) delivered by an overnight delivery company with written delivery confirmation; or, (3) hand delivered with written delivery confirmation. Notice to DOC shall be to the attention of DOC Network Manager, P.O. Box 12878, Oklahoma City, Oklahoma 73157-2878. Notice to the Facility shall be to the address listed on the DOC Facility Contract Signature Page. The notice shall be effective on the date indicated on the return receipt or written delivery confirmation. At any place within this Contract that notice is required, it is the intention of the parties that only those with regard to termination by either party of participation in the Contract must be sent by certified mail, a return receipt requested, at no other time when notice is required by this Contract is there an obligation by either party to use certified mail. The Network Newsletter serves as the primary method by which providers receive all other notifications mandated by the terms of the provider contracts. These notices from EGID may be sent via electronic newsletters distributed electronically to each Network Provider's correspondence email address. Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.
- 11.3 Notwithstanding the provisions in Section 11.1, the DOC may designate an Administrator to administer any of the terms of this Contract.
- 11.4 This Contract is the entire agreement between the DOC and the Facility relating to the rights granted and the obligations assumed by the parties concerning the provision of Facility Services to Inmates. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Contract, not expressly set forth in this Contract, are of no force or effect.

- 11.5 This Contract, or any part or section of it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of the DOC and the Facility.
- 11.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules codified at the Oklahoma Administrative Code. Any provision of this Contract, which is not in conformity with existing or future legislation, shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with the laws of the State of Oklahoma.
- 11.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and determination at law or in a court of equity that one term or provision is unenforceable shall not operate so as to void the enforcement of the remaining terms and provisions of this entire Contract, or any one provision, in accordance with the intent and purpose of the parties hereto.
- 11.8 DOC and the Facility agree that this Contract may be formed according to the Oklahoma Uniform Electronic Transaction Act, 12A O.S. § 15-101 et seq. (Act). The Facility acknowledges that the Contract terms are located in Contract DOCPFCv1.6 at <https://gateway.sib.ok.gov/DOC/Contracts.aspx> and after downloading the Contract, and submitting the completed Application, signed and returned the Signature Page to DOC, DOC will note its approval on the Signature Page and return to the Facility. The Contract terms, Application, Signature page and any required information submitted by the Facility are records that may be stored as DOC electronic records under the Act.
- 11.9 All Providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible according to the Excluded Parties List System (EPLS)/Office of Inspector General (OIG) excluded provider lists.
- 11.10 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 must be made solely through electronic funds transfer (EFT). Provider/facility hereby agrees to accept EFT payments by July 1, 2013. Provider acknowledges that all health and dental claims received after July 1, 2013, regardless of the date of service, will be denied pending receipt of additional information if EFT payment information is not on file as of July 1, 2013

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**State of Oklahoma  
Department of Corrections  
Network Facility  
Application Requirements**

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Thank you for your interest in the Department of Corrections Provider Network.

Please complete the attached Application and submit with the required attachments listed below.

Complete all sections of the application. If an area of inquiry is not applicable to the facility, please indicate. If you need additional space to provide complete answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

*Retain the Contract for your records.*

**REQUIRED ATTACHMENTS**

Please attach a copy of each of the following documents to your completed Application:

- Current state(s) license(s)**
- Face Sheet of current general and medical liability insurance policy**  
Insurance Certificate/Face Sheet must have the name or the Facility listed as the insured. The insurance limits must be at the levels in the Contract and must indicate clearly that it is general and medical liability coverage.
- W-9 form for each Federal Tax Identification Number**  
W-9 forms must be signed and list only the Federal Tax Identification Number listed on the Application which will be used on claim forms submitted to HealthChoice.
- Contract Signature Page**
- Electronic Funds Transfer (EFT) Form**
- Copy of voided check or bank letter for Electronic Funds Transfers**
- Copy of Medicare Certification Letter**
- Copy of Joint Commission Accreditation Certificate (if applicable)**
- Copy of AAAHC Accreditation Certificate (if applicable)**

**Incomplete applications will be returned.**

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## Department Of Corrections Network Facility Application

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The completed Network Facility Application should be returned to the Department of Corrections in its entirety, along with any applicable attachments.

You can mail or fax the Application to:

Oklahoma Department of Corrections  
ATTN: Network Management  
P.O. Box 57630  
Oklahoma City, OK 73157-2878  
Phone: 1-405-717-8750 or 1-866-573-8462  
Fax: 1-405-717-8977

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### General Information

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Legal Name of Owner: \_\_\_\_\_

Trade Name/DBA: \_\_\_\_\_

Medicare Facility Classification: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

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### License Information

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State: \_\_\_\_\_

License Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

A copy of facility license is required for each state of practice.

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### Accreditation

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Is this Facility accredited by the Joint Commission:       Yes       No

Joint Commission Program ID Number: \_\_\_\_\_

Date of most current accreditation: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Is this Facility accredited by the AAAHC?       Yes       No

Date of most current accreditation: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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## Insurance Information

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Copy of Insurance Certificate/face sheet is required.

Please provide the following information about the Facility's current general and medical liability insurance coverage.

Name of Carrier: \_\_\_\_\_

Limits of General and Medical Liability      Per Occurrence: \_\_\_\_\_      Expiration Date: \_\_\_\_\_

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## Important Facility Contacts

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CEO/Administrator: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

CFO: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Credentialing Contact: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

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## Address Information

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Federal Tax ID Number: \_\_\_\_\_ National Provider Identification: \_\_\_\_\_

**Attach a completed W9 form for each Federal Tax ID number.**

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### **Physical Address – physical location of the Facility**

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THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY.

Physical Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

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**Mailing Address**

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Mailing Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.

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**Billing/Remit Address – for claims payments and remittance statements**

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ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED.

Name Submitted on Claims: \_\_\_\_\_

Billing Office Name (if applicable): \_\_\_\_\_

Billing Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

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**Additional Location**

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Federal Tax ID Number: \_\_\_\_\_ National Provider Identification: \_\_\_\_\_

**Attach a completed W9 form for each Federal Tax ID number.**

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**Physical Address – physical location of the Facility**

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THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY.

Physical Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

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**Mailing Address- for correspondence/credentialing**

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Mailing Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

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**Billing/Remit Address – for claims payments and remittance statements**

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ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED.

Name Submitted on Claims: \_\_\_\_\_

Billing Office Name (if applicable): \_\_\_\_\_

Billing Address: \_\_\_\_\_

City

State

ZIP

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Please use copies of these pages to report any additional locations.**

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**HOSPITAL AND NON-HOSPITAL BASED SERVICES; if applicable**

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Does the Hospital provide the following specialty services?

- |  |   |
|--|---|
| <input type="checkbox"/> Ambulance                               | <input type="checkbox"/> Infusion Therapy         |
| <input type="checkbox"/> Ambulatory Surgery Center               | <input type="checkbox"/> Laboratory               |
| <input type="checkbox"/> Dialysis                                | <input type="checkbox"/> Long Term Acute Care     |
| <input type="checkbox"/> Durable Medical Equipment               | <input type="checkbox"/> Psych/Substance Abuse    |
| <input type="checkbox"/> Home Health Care                        | <input type="checkbox"/> Rehabilitation           |
| <input type="checkbox"/> Hospice                                 | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Independent Diagnostic Testing Facility | <input type="checkbox"/> Sleep Study              |

Does the Hospital provide the following services by a group of specialists? If yes, please list the provider group name.

- Anesthesiology Group: \_\_\_\_\_
- Emergency Physician Group: \_\_\_\_\_
- Pathology Group: \_\_\_\_\_
- Radiology Group: \_\_\_\_\_

## Electronic Funds Transfer (EFT) Authorization Agreement

### Provider Information

Provider Name: \_\_\_\_\_  
Doing Business As Name (DBA): \_\_\_\_\_

### Provider Address

Street: \_\_\_\_\_  
City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP Code/Postal Code: \_\_\_\_\_

### Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or  
Employer Identification Number (EIN): \_\_\_\_\_  
National Provider Identifier (NPI): \_\_\_\_\_ Provider Type: \_\_\_\_\_

### Financial Institution Information

**A VOIDED CHECK OR A BANK LETTER VERIFYING THE ACCOUNT AND ROUTING NUMBERS IS REQUIRED.**

Financial Institution Name: \_\_\_\_\_  
Financial Institution Routing Number: \_\_\_\_\_  
Type of Account at Financial Institution: \_\_\_\_\_  
Provider's Account Number with Financial Institution: \_\_\_\_\_  
Account Number Linkage to Provider Identifier: \_\_\_\_\_  
 Provider Tax Identification Number (TIN) or  National Provider Identifier (NPI)

You must contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. Online instructions on how you can determine the status of your EFT enrollment is available at <http://www.ok.gov/sib/Providers/EFT/index.html>

### Submission Information

Reason for Submission  
 New Enrollment  Change Enrollment

### Authorized Signature

I hereby authorize the Employees Group Insurance Department (EGID) to initiate credit entries in accordance with HB 1086 Transparency, Accountability and Innovation in Oklahoma State Government 2.0 Act of 2011 to the account indicated above. I hereby authorize the financial institution/bank named above to credit the same to such account.

Written Signature of Person Submitting Enrollment: \_\_\_\_\_  
Printed Name of Person Submitting Enrollment: \_\_\_\_\_  
Printed Title of Person Submitting Enrollment: \_\_\_\_\_  
Submission Date: \_\_\_\_\_

## EFT INSTRUCTIONS

Please complete this EFT form in its entirety. Leaving required fields blank or failing to attach a voided check or bank letter will result in an incomplete application and/or denied claims. If you have any questions regarding the use of this form or any of the information requirements, please contact us using the information listed at the bottom of page 1 of this form. To ensure the security of your information when submitting this form via email, please submit your form and any attachments in an encrypted WinZip file, then submit the password for the WinZip file in a separate email.

### THE EFT FORM IS A **MANDATORY** PART OF YOUR ENROLLMENT APPLICATION

#### **Provider Information**

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Optional

#### **Provider Address**

Street	The number and street name where a person or organization can be found	Required
City	City associated with provider address field	Required
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country	Required
ZIP Code/Postal Code	System of postal-zone codes (ZIP stands for zone improvement plan ) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Required

#### **Provider Identifiers Information**

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Required
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Required (when provider has been enumerated with an NPI)
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for EFT with specific provider type description included by the health plan in its instruction and guidance for EFT enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)	Optional

#### **Financial Institution Information**

Financial Institution Name	Official name of the provider's financial institution	Required
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Required
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Required
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited	Required
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice	Required

#### **Submission Information**

Reason For Submission	Check appropriate box. Please note that EFT cannot be cancelled.	Optional
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#### **Authorized Signature**

Written Signature of Person Submitting Enrollment	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment	Required
Printed Name of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity	Optional
Printed Title of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
Submission Date	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
	The date on which the enrollment is submitted	Optional

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**State of Oklahoma**  
**Department of Corrections**  
**Long Term Acute Care Facility Application**  
**Signature Page**

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The Oklahoma Department of Corrections and the Facility incorporate by reference the terms and conditions of the Oklahoma Department of Corrections Facility Contract (Contract), located in Contract DOCLTACFCv1.8 at <https://gateway.sib.ok.gov/DOC>, into this Signature Page and acknowledge the Contract is an electronic record created according to 12A O.S. § 15-101 et seq. The Oklahoma Department of Corrections and the Facility further agree that the effective date of the Contract is the effective date denoted on the copy of the executed Signature Page returned to the Facility. The original of the signed document will remain on file in the office of the Oklahoma Department of Corrections.

**FOR THE FACILITY:**

\_\_\_\_\_  
Legal Name of Owner (Typed or Printed)

\_\_\_\_\_  
Trade Name/DBA (Typed or Printed)

\_\_\_\_\_  
Federal Tax ID Number

Address of the Facility:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Authorized Officer or Representative (Typed or Printed)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature Date

**FOR DOC:**

\_\_\_\_\_  
Director or Chief Medical Officer  
Department of Corrections  
3400 Martin Luther King Avenue  
Oklahoma City, OK 73111

**Please return the completed Application, Signature Page, and required attachments to:**

**Oklahoma Department of Corrections**  
**Attn: Network Management**  
**P.O. Box 57630**  
**Oklahoma City, OK 73157-7630**  
**Phone: 1-405-717-8750 or 1-866-573-8462**  
**Fax: 1-405-717-8977**

## Electronic Remittance Advice (ERA) Authorization Agreement

### Provider Information

Provider Name: \_\_\_\_\_

Doing Business As Name (DBA): \_\_\_\_\_

### Provider Address

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP Code/Postal Code: \_\_\_\_\_

### Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_ Provider Type: \_\_\_\_\_

### Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)

Provider Tax Identification Number (TIN): \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

### Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: \_\_\_\_\_

Clearinghouse Contact Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

### Submission Information

Reason for Submission

New Enrollment

Change Enrollment

Cancel Enrollment

### Authorized Signature

I hereby authorize the Office of Management and Enterprise Services Employees Group Insurance Department to send electronic remittance advice (ERA/835) as designated herein. I am authorized to elect Electronic Remittance Advice (ERA) transactions on behalf of the indicated party and I acknowledge the same by signing below.

Written Signature of Person Submitting Enrollment: \_\_\_\_\_

Printed Name of Person Submitting Enrollment: \_\_\_\_\_

Printed Title of Person Submitting Enrollment: \_\_\_\_\_

Submission Date: \_\_\_\_\_

Please mail, fax or email the completed form or questions to:  
Office of Management and Enterprise Services Employees Group Insurance Department  
3545 N.W. 58th St, Ste., 110, Oklahoma City, OK 73112  
Phone: 405-717-8790 or 800-543-6044 or Fax: 405-717-8977 or 405-717-8702  
EGID.EFTEnroll@omes.ok.gov or [EGID.NetworkManagement@omes.ok.gov](mailto:EGID.NetworkManagement@omes.ok.gov)

# ERA INSTRUCTIONS

Please complete this ERA Form in its entirety. Leaving any required fields blank will result in an incomplete process. If you have any questions regarding the use of this form, or any of the field requirements, please see our contact information listed at the bottom of page 1 of this form. Information about how to check the status of your ERA is available at [www.ok.gov/sib/Providers/Provider\\_EFT/index.html](http://www.ok.gov/sib/Providers/Provider_EFT/index.html)

## **Provider Information**

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Optional

## **Provider Address**

Street	The number and street name where a person or organization can be found	Required
City	City associated with provider address field	Required
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country	Required
ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Required

## **Provider Identifiers Information**

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Required
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Required (when provider has been enumerated with an NPI)
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for ERA with specific provider type description included by the health plan in its instruction and guidance for ERA enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)	Optional

## **Electronic Remittance Advice Information**

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)	Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment	Required
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## **Electronic Remittance Advice Clearinghouse Information**

Clearinghouse Name	Official name of the provider's clearinghouse	Required; i.e., Emdeon This should be the clearinghouse who is currently handling your electronic claims for HealthChoice, Oklahoma Department of Corrections and/or Oklahoma Department of Rehabilitation Services Any request for routing of ERAs to another destination will require additional setup and testing.
Clearinghouse Contact Name	Name of a contact in clearinghouse office for handling ERA issues	Optional
Telephone Number	Telephone number of contact	Optional

**Submission Information**

Reason For Submission	Check appropriate box.	Required
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**Authorized Signature**

The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment

Required

Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity	Optional
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment	
Submission Date	The date on which the enrollment is submitted	Optional