Oklahoma
Department of Rehabilitation Services

NETWORK PROVIDER MANUAL

2015

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Introduction

The Department of Rehabilitation Services (DRS) provides health and dental benefits to qualified clients.

The DRS Provider Network is administered by the Employees Group Insurance Division (EGID) of the Office of Management and Enterprise Services, a state agency. The DRS program utilizes a partnership approach between providers, clients and vocational rehabilitation (VR) counselors in the delivery of health and dental care services and products. This philosophy serves to manage costs, ensure high quality health care and enhance provider/patient relationships.

The DRS client must be authorized to receive services from a DRS Network Provider to be eligible for benefits. The DRS VR counselor prepares a written authorization for all services to be performed by the provider.

The *DRS 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 network management unit.

Write to: Department of Rehabilitation Services
Attn: Network Management
P.O. Box 57630
Oklahoma City, OK 73157-7630

Call: 1-405-717-8921
Toll-free 1-888-835-6919

Website: **https://gateway.sib.ok.gov/DRS/**

This manual is a summary only and is not intended to be all-inclusive.

Department of Rehabilitation Services (DRS)

Department of Rehabilitation Services
3535 N.W. 58th St., Ste. 500
Oklahoma City, OK 73112-4824

1-405-951-3400
Toll-free 1-800-845-8476
TDD 1-405-951-3400
Website: **www.okrehab.org**

Medical, Dental and Pharmacy Claims Administrators

DRS contracts with nationally recognized companies that possess vast experience in the administration of health and dental care benefit plans. These claims administrators are responsible for claims adjudication, payment and pharmaceutical program management.

Medical and Dental Claims Administrator
HP Administrative Services, LLC
P.O. Box 25069
Oklahoma City, OK 73125-5069
Toll-free 1-800-944-7938

Electronic submission of claims: NEIC Number 22521

Pharmacy Benefit Manager
Express Scripts
P.O. Box 14711
Lexington, KY 40512-4711
Toll-free 1-800-922-1557

Joining the DRS Provider Network

The DRS Provider Network is comprised of over 4,700 providers and facilities. Most providers who are licensed and/or certified are eligible to apply. DRS provides its clients with the ability to utilize health care providers from a wide range of specialties upon receiving authorization from DRS. The following list includes providers eligible to participate in the DRS Provider Network:

- Ambulatory Surgery Center
- Audiologist
- Certified Orthotist
- Certified Prosthetist
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinical Nurse Specialist
- Dentist/Orthodontist/Periodontist
- Doctor of Osteopathy
- Durable Medical Equipment Vendor
- Hearing Aid Vendor
- Home Health Agency
- Hospital
- Independent Diagnostic Testing Facility
- Infusion Therapy
- Laboratory
- Licensed Alcohol and Drug Counselor
- Licensed Behavioral Practitioner
- Licensed Clinical Social Worker
- Licensed Dietician
- Licensed Marriage Family Therapist
- Licensed Professional Counselor
- Long-term Acute Care Facility
- Medical Doctor
- Nurse Practitioners
- Occupational Therapist
- Ocularist
- Optometrist
- Oral Surgeon
- Pathology Group
- Physical Therapist
- Podiatric Doctor
- Psychologist
- Radiology Group
- Rehabilitation Facility
- Skilled Nursing Facility
- Sleep Study Facility
- Speech/Language Therapist

A contract and application packet can be obtained from our website at **https://gateway.sib.ok.gov/DRS** or by calling or writing network management.

DRS does not typically contract with clinics or groups of physicians; however, rural health clinics (which includes federally qualified health centers (FQHC) and city/county/state health departments) are welcome to contract.

DRS Network Management

DRS 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, 7:30 a.m. through 4:30 p.m., Monday through Friday.

Written inquiries should be addressed to:
Department of Rehabilitation Services
Attn: Network Management
P.O. Box 57630
Oklahoma City, OK 73157-7630

or call:
1-405 717-8921
Toll-free 1-888-835-6919
FAX 1-405-717-8977

Application Process

The appropriate application must be submitted with the required attachments noted in the form. The submitted application 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 received 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.

Provider Directory

The Provider Directory is available online at **gateway.sib.ok.gov/DRS**. 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.

Fee Schedule

The DRS fee schedule is available to Network Providers from our website at **gateway.sib.ok.gov/DRS**. If you need assistance, please contact network management.

Network Provider Contract Termination

The *Network Provider Contract* gives EGID, DRS and the Network Provider the ability to terminate a contract without cause with a 30-day, written notice. Letters of termination from the Network Provider must 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 by EGID Network Management.

A provider's contract is terminated immediately if their license is suspended or revoked, or if their professional liability insurance is cancelled or not maintained in accordance with the *Network Provider Contract*.

A DRS Network Provider who terminates their contract with or without cause from the DRS 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 DRS to execute a new contract.

Authorizations

All services for DRS clients performed by Network Providers require advance written authorization by the assigned VR counselor. Providers must supply the VR counselors with the exact billing codes anticipated for the requested services. VR Counselors then prepare the written authorization. Each Network Provider should have a copy of the written authorization **prior** to providing services to the client. VR Counselors fax and mail a copy to the provider and also send a copy of the authorization with the client. Only the services authorized on the written authorization are allowed. Network Providers must bill only the CPT/HCPCS codes on the authorization form. Any variances are denied. **Remember, the provider and the CPT/HCPCS codes listed on the authorization form must match what is filed on the claim form.**

Claim Filing Procedures

Providers are required to file claims for DRS clients.

Claims, correspondence and claim inquiries should be submitted to:
HP Administrative Services, LLC
P.O. Box 25069
Oklahoma City, OK 73125-5069

Acceptable claim forms are:

CMS-1500;
UB-04; and
ADA 2012

To expedite processing, the following information must appear on every claim:

1. Patient's name
2. Patient’s SSN
3. ICD or DSM diagnosis codes
4. CPT, HCPCS, MS-DRG, CDT or ASA codes with appropriate modifiers
5. Itemized charges (also required for all outpatient hospital services)
6. Date(s) of service

To ensure issuance of the reimbursement to the proper provider, it is imperative the provider's name, NPI number, tax identification number (TIN) and billing address appear on each claim.

All claims submitted for outpatient hospital or surgical center services must include an itemized bill to ensure reimbursements are in accordance with the DRS plan of benefits.

Claims are processed according to the Social Security number of the client. Please check for accuracy as incorrect data results in processing delays.

Claims are paid directly to Network Providers.

If you have any questions or a problem with direct claims payments, please contact the medical and dental claims administrator.

ClaimLink

ClaimLink is a valuable feature of the DRS Network Provider home page. 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).

In order to ensure privacy, first-time users must register and create a user ID and password. The provider’s email address and TIN are required to register. The user ID and password are necessary for future access.

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

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.

Access to ClaimLink is available on the Network Provider home page at **http://www.ok.gov/sib/Providers/index.html**.

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 cannot be submitted electronically. Hard copies of corrected claims must be submitted to the correspondence address of the medical and dental claims administrator.

ClaimCheck

ClaimCheck and Clear Claim Connection are software programs within the claims processing system that use industry standard coding edits to ensure claims are properly coded. ClaimCheck is designed to detect coding discrepancies automatically. Automated reviews improve accuracy and consistency in claim adjudication and lead ultimately to improved claim turnaround times.

ClaimCheck utilizes National Correct Coding Initiatives (CCI), Current Procedural Terminology (CPT) guidelines, as published by the American Medical Association, and the general standards of medical practice in editing claims. Editing guidelines established by the Centers for Medicare & Medicaid Services 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 the DRS Network Provider online access to claim editing rules and clinical rationale used in the auditing software. Providers can access ClaimCheck and Clear Claim Connection through ClaimLink. DRS encourages its Network Providers to utilize this website to reference the Clear Claim Connection feature of the claim editing system.

In the event a provider disagrees with any determination executed by ClaimCheck, they should contact the medical and dental claims administrator and provide any documented information that supports their position.

Coordination of Benefits (COB)

On those occasions when a DRS client is covered by more than one group insurance plan, the coordination of benefits rules state a combined payment by the carriers will not exceed 100% reimbursement of eligible charges.

According to COB rules, DRS Network Providers cannot receive reimbursement in excess of the Allowable Fee. **The DRS plan is the payer of last resort. If the primary insurance pays more than the Allowable Fee, no additional benefits are payable to the Network Provider. The patient is not liable for any additional expenses that exceed the Allowable Fee.**

Overpayments/Underpayments

Providers are notified in writing of all overpayments identified by the medical and dental claims administrator. Overpayments are recovered 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.

Electronic Remittance Advice (835)

The EDI 835 transaction set, or electronic remittance advice (ERA), is part of the HIPAA standard transactions 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/DRS/ERA.aspx**.

Network Providers should contact Employees Group Insurance Division (EGID) Network Management at 1-405-717-8921 or toll-free 1-888-835-6919, fax 1-405-717-8977, email **EGID.DRSNetworkManagement@omes.ok.gov**, or send to 3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112 with 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 the provider's bank. If a provider changes TINs or NPI Numbers, they must also complete and submit this form with their change request.

Non-Network providers should contact our medical and dental claims administrator toll-free at 1-800-944-7938 to check the status of their ERA enrollment.

Non-Covered Services

DRS does not cover the following supplies, services and products:

1. Supplies or services that are not medically necessary
2. Cosmetic or elective procedures not determined to be medically necessary
3. Alopecia - hair loss treatment
4. Sex transformation or sexual dysfunction of any nature
5. Weight loss treatment
6. Custodial care
7. Experimental or investigational procedures
8. Room humidifiers, Jacuzzis, saunas, hot tubs, air purifiers, adaptive equipment, air conditioners, vacuum cleaners, even if recommended by a physician

NOTE: This list may not be all-inclusive.