

Oklahoma
Department of Rehabilitation Services
NETWORK PROVIDER MANUAL



2011

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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 Oklahoma State and Education Employees Group Insurance Board (OSEEGIB), a state agency. The DRS program utilizes a partnership approach among providers, clients and counselors in the delivery of health care services and products. This philosophy serves to manage costs, ensures the provision of high quality health care and enhances provider/patient relationships.

The DRS client must be authorized to receive services from a DRS Network Provider to be eligible for DRS benefits. The DRS counselor will prepare a written authorization for all services 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 Provider Relations division utilizing the following methods:

write to:

Department of Rehabilitation Services
ATTN Provider Relations
PO Box 57630
Oklahoma City, OK 73157-7630

call:

1-888-835-6919 (toll free)
(405) 717-8921 (locally)

website:

<https://gateway.sib.ok.gov/DRS/>

The Provider 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 Street, Ste. 500
Oklahoma City, OK 73112-4824

Website: www.okrehab.org

(405) 951-3400 (local)
1-800-845-8476 (toll free)
(405) 951-3400 (TDD)

DRS Third Party Administrators

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

Claims Administration: (Health and Dental)

HP Administrative Services

P.O. Box 25069
Oklahoma City, OK 73125-5069
1-800-944-7938 (toll free)

Electronic submission of claims: NEIC Number 22521

Pharmaceutical Benefits Management: (Pharmacy Payments)

MEDCO Health Solutions

P.O. Box 14711
Lexington, KY 40512-4711
1-800-922-1557 (toll free)

Joining the DRS Provider Network

The DRS Provider Network is comprised of over 6000 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 those providers that are eligible to participate within the DRS Provider Network:

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

The DRS does not contract with clinics or groups of physicians. Contracts are entered into only with individual health care providers.

DRS Provider Relations

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

Should you have questions or concerns regarding any aspect of the plan, please contact the Provider Relations staff, available from 7:45 am through 4:30 pm, Monday through Friday.

Written inquiries should be addressed to:

Department of Rehabilitation Services
ATTN Provider Relations
PO Box 57630
Oklahoma City, OK 73157-7630

or call:

(405) 717-8921 (local)
1-888-835-6919 (toll free)
(405) 717-8977 (FAX)

Network Provider Termination

All DRS Network Providers have the ability to terminate the contract at any time provided a minimum of thirty (30) days notice is given to DRS Provider Relations. Conversely, DRS reserves the right, contractually, to terminate a Network Provider at any time upon thirty (30) days notice.

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 Provider Relations.

Authorizations

Any type of service for the DRS clients by the network providers will require advance written authorization by the assigned counselor. Providers must supply the counselors with the proper CPT and/or HCPCS codes that are anticipated for the requested services. Counselors will then prepare the written authorization. Each network provider should have a copy of the written authorization prior to providing any services to the client. Counselors will fax, mail, and also send a copy of the authorization with the client. Only the services authorized on the written authorization will be allowed. Network Providers must only bill the CPT/HCPCS codes that are on the authorization form. Any variances will be denied. **Remember, the provider and the CPT/HCPCS codes authorized 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
P.O. Box 25069
Oklahoma City, OK 73125-5069**

Acceptable claim forms are:

CMS-1500

UB-04

ADA 2006

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, DRG, CDT, or ASA codes with appropriate modifiers
5. Itemized charges (also required for all outpatient hospital services)
6. Date(s) of service

To assure issuance of the benefit check to the proper provider, it is imperative that the provider's name, NPI number, tax identification number and billing address appear on each claim.

All claims submitted for outpatient hospital or surgical center services must include an itemized bill to ensure that 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 will result in a delay.

Claims are paid directly to Network Providers.

If you have any questions, or a problem with direct claims payments, please contact the appropriate third party administrator.

ClaimCheck

ClaimCheck and Clear Claim Connection are software programs within the claim processing system that are used to assure 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 leads ultimately to improved claim turnaround times. ClaimCheck utilizes National Correct Coding Initiatives (CCI), Current Procedural Terminology 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 and 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 McKesson's claims editing rules and clinical rationale used in the auditing software.

DRS is pleased to make editing rationale information available to our Network Providers through McKesson's Clear Claim Connection. You 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 claims editing system.

In the event you disagree with any determination executed by ClaimCheck, please contact HP Administrative Services. Provide any documented information that will support your position.

Coordination of Benefits (COB)

On those occasions where a DRS client is covered by more than one group insurance plan, the coordination of benefit rules provides a combined payment by more than one coverage carrier that will not exceed 100% reimbursement of eligible charges.

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

Overpayments/Underpayments

The provider will be notified in writing of all overpayments identified by the third party administrator. Overpayments are recovered either by a refund check from the provider and/or benefit reductions of subsequent claims. The provider has thirty (30) days to reply to the initial overpayment letter. If no attempt is made to respond to the third party administrator, subsequent benefit payments will be reduced until the overpayment is satisfied.

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

Non-Covered Services

- Supplies or services that are not medically necessary.
- Cosmetic or elective procedures not determined to be medically necessary.
- Alopecia-hair loss treatment
- Sex transformation, or sexual dysfunction of any nature.
- Weight loss treatment.
- Custodial care.
- Experimental or investigational procedures.
- 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.

Glossary of Terms

Allowable Fee	The maximum charge payable to a physician for a specific procedure in accordance with the established fee schedule. The physician shall charge the usual and customary fee unless the fee schedule limits otherwise.
ClaimCheck	A component of the claim processing system which automatically audits each claim. Reference page (7) for further details.
CDT	Current Dental Terminology Codes. Utilized to identify dental services rendered to the patient. These codes can be referenced in the Current Dental Terminology manual as established by the American Dental Association.
COB	Coordination of Benefits. The COB rule applies when a client is covered by more than one group insurance plan. Each health plan pays amounts that ideally, pay up to, but no more than 100% of the client's liability.
Covered	Refers to those services that are eligible according to the schedule of rates. DRS will pay the allowed amounts for all covered services.
CPT	Current Procedural Terminology Codes. Utilized to identify the specific medical services rendered. These codes can be referenced in the Current Procedural Terminology manual as established by the American Medical Association.
DSM	DSM codes are used to identify specific mental disorder diagnoses. These codes can be referenced in the Diagnostic and Statistical Manual of Mental Disorders which is published by the American Psychiatric Association.
Eligible Charge	The maximum charge allowed in determining the benefit under the Health Plan for a covered service or supply. The eligible charge for a covered service or supply will be limited to the lesser of the amount charged by the provider for the service or supply or the fee schedule as approved by DRS Commission.
EOB	Explanation of Benefits. The Network Provider will receive an Explanation of Benefits. This document explains the adjudication and payment of each claim.
Fee Schedule	The maximum allowed charge for a covered service or supply that will be considered in determining any benefit payable under the DRS Rates. The fee schedule, as amended periodically, is established by the Director and approved by the DRS Commission. The Network Provider agrees to accept the fee schedule amount and will not balance bill the patient. The beneficiary is not responsible for any expenses in excess of the fee schedule.
CMS-1500	This medical claim form is the most prevalent type currently utilized by health care practitioners.
ICD	International Classification of Diseases. A statistical classification system that arranges diseases and injuries into groups, represented by numeric codes, according to criteria established by the World Health Organization.

Inappropriate Billing	The ClaimCheck system automatically audits each claim and edits procedures which are deemed inappropriate for a variety of reasons including, but not limited to, unbundling or coding errors. Reference page (7) for details.
Outpatient	Medical services rendered at a hospital or surgical facility, not requiring an admission, are considered outpatient. This does not include services rendered in the physician's office.
Overpayment	Overpayments occur due to a variety of reasons including, but not limited to, erroneous claim processing, inaccurate provider network status information or incorrect eligibility determinations. When an overpayment is identified, a refund request will be sent to the Network Provider.
Prior Authorization	A mandatory provision of the DRS Plan in which a participant must obtain approval in advance of an episode of care in order to receive services under the DRS Plan for covered services provided in that episode of care. <u>Services supplied without prior authorization will be denied.</u>
Third Party Administrator (TPA)	An individual(s) or organization with whom DRS, in conjunction with the Board, has contracted with to provide certain administrative services to or on behalf of the Health Plan. The administrative services include, but are not necessarily limited to, claims adjudication, payment, and pharmacy management.
TMD	Temporomandibular Joint Dysfunction
UB-04	The UB-04 is the most prevalent medical claim form utilized by hospitals and other facilities.
Underpayment	Underpayments occur for a variety of reasons, including but not limited to, erroneous claim processing, inaccurate provider network status information or incorrect eligibility determinations. When the underpayment is identified, additional benefits will be released by the third party administrator if deemed appropriate.

**Oklahoma Department of Rehabilitation Services
AUTHORIZATION FOR PURCHASE**

COUNSELOR NAME AND MAILING ADDRESS

01, User
2227 W. Lindsey, Suite 1200
Norman, OK 73069

Authorization Number 1732

Vendor Number 706042005-00001

Phone (360) 111-1111
Fax (405) 447-5909

VENDOR NAME AND MAILING ADDRESS

Center for Alcohol & Drug Treatment
1492 Ironwood Drive SW
Omak, OK 98972

You are hereby authorized to furnish the following services or merchandise to the Participant identified in Section 1 of this Authorization for Purchase. If any goods or services other than those authorized are needed, or if you will be referring medical services to another medical provider, you must secure approval from the Counselor identified above before proceeding. The Department of Rehabilitation Services will not be responsible for goods or services provided prior to authorization.

1. Participant Information

AUTHORIZATION DATES

Participant Name Application, Alan
Participant ID 2553
Case ID 2561
SSN 033-55-9701

Begin 12/09/2010
End 06/30/2011

2. Service Authorization

ITEM NUMBER	DESCRIPTION	PROCEDURE CODE	UNITS	RATE	DOLLAR AMOUNT
1	Diagnosis and Treatment of Impairments 90010 - Office and other outpatient medical service, new patient; limited service	90010	3.00	\$35.50	\$106.50
AUTHORIZATION SIGNATURE			DATE		TOTAL \$106.50

3. Special Instructions

Unless otherwise prearranged with the counselor, submit claims to:

**HP Administrative Services/DRS
PO Box 25069
Oklahoma City, OK 73125-0069**

HP Administrative Services, LLC will utilize an editing software program for standardizing billing practices; changes in payment may result. For inquiries, call 1 (800) 944-7938.