OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division

HealthChoice

# Facility Contract

HealthChoice

# Facility Contract

This Contract is intended for use by:

- Hospital (medical and mental health/substance abuse).
- Independent Freestanding Emergency Department.
- Inpatient hospice facility.
- Long-term acute care facility.
- Rehabilitation facility.
- Skilled nursing facility.

HealthChoice

# Facility Contract

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HealthChoice is a managed health care program providing comprehensive health and dental benefits to over 186,000 state, education and local government employees, former employees, survivors and their covered dependents. The HealthChoice Plans are a partnership between providers, Members and the Office of Management and Enterprise Services Employees Group Insurance Division in the delivery of health and dental care services and products that helps control costs, assists in the provision of high-quality health and dental care, and enhances provider/patient relationships. The HealthChoice benefit structure offers financial incentives to encourage plan Members to utilize HealthChoice Network Providers.

HealthChoice requires two addresses on the Facility Application.

- Physical address – this address is used for the location where health care services are performed. The service address will be used for the online provider directory.
- Mailing address – this address will be utilized for all legal, contractual notices as defined in section XII (2) of this Contract. All notices will be sent electronically. This address is used for claims processing and appears in box 33 of the CMS-1500 claim form or box 2 on the UB-04 claim form.

REQUIRED ATTACHMENTS

*Please attach each of the following documents to your completed application:*

- ☐ Current state(s) license(s).
- ☐ Current CMS certification letter, if applicable.
- ☐ Current accreditations, if applicable.
- ☐ Face sheet of current liability insurance policy.
  - Insurance certificate must have the name of the Facility listed as the insured.
  - Insurance limits must be at the levels required in this Contract.
- ☐ W-9 form for each federal tax ID number used to file claims.

**Incomplete applications will be returned unreviewed.**

HealthChoice

# Facility Contract

This Facility Contract is between the Office of Management and Enterprise Services Employees Group Insurance Division, (hereinafter, EGID), and the Facility (hereinafter, the Facility) who agrees to the terms of this agreement (hereinafter, this Contract) by signing the appropriate Contract signature page. The designation of "Facility" in this agreement refers to the organization that signs this agreement.

EGID administers self-funded Medical and Dental plans that are identified by the trade name, HealthChoice. HealthChoice Plans are intended to financially encourage Members to utilize Network Providers.

It is hereby agreed between EGID and the Facility named on this Contract signature page, that the Facility shall be a provider in EGID's network of providers.

This Contract is entered into for the purpose of defining the conditions for reimbursement by EGID to the Facility. It in no way is meant to impact the Facility's decision as to what it considers appropriate Medical or Dental treatment.

## I. RECITALS

1. EGID was established by, and operates pursuant to, the Oklahoma Employees Insurance and Benefits Act, 74 O.S. § 1301 *et seq.* to administer and manage certain insurance benefits for state, education, local government, and other eligible employees and retirees.

2. The Facility is an organization, as defined by EGID, which is duly licensed under the laws of the state of operation and meets additional credentialing criteria established by EGID.

3. The intent of this Contract is to provide access to enhanced quality Medical and Dental Services, utilizing managed care components at an affordable, competitive cost to EGID and its Members.

4. Failure to abide by any of this Contract's provisions may result termination of this Contract.

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

# II. DEFINITIONS

1. "**ADA**" means the American Dental Association.

2. "**Allowable Fee**" means the maximum fee payable to a Facility for a specific procedure in accordance with the provisions in Article VI of this Contract.

3. **"ALOS"** means the Geometric Average Length of Stay.

4. "**Base Rate**" means a dollar amount established by EGID by which the MS-DRG Relative Weight is multiplied to obtain the MS-DRG Allowable Fee.

5. "**Certification**" means a function performed by EGID to review and certify that services or supplies are Medically Necessary and/or meet coverage criteria in identified areas of practice, as defined in Article VII of this Contract, prior to services being rendered or receipt of supplies or equipment as identified on EGID's website.

6. "**CMS**" means the Centers for Medicare & Medicaid Services.

7. **"Concurrent Review"** means a function performed by EGID that determines and updates continued Medically Necessary inpatient hospitalization.

8. "**Covered Services**" means Medically Necessary services delivered by the Facility pursuant to this Contract and for which a Member is entitled to receive coverage by the terms and conditions of a HealthChoice Plan.

9. "**CPT**" means Current Procedure Terminology.

10. "**Credentialing Plan**" means a general guide and process for the acceptance, cooperation and termination of participating Facilities, Independent Health Organizations and Practitioners.

11. "**Day Treatment**" means a partial hospitalization program for those individuals with mental, emotional, and/or addictive disorders who do not require 24 hour inpatient care. It is an intensive course of treatment, where the individual spends at least 8 hours during the day at the facility.

12. "**Dental**" means belonging to the study and practice of dentistry or a dental specialty for the prevention, alleviation, or management of an adverse dental condition.

13. **"Dental Services"** mean the professional services provided by an oral/maxillofacial surgeon or dentist and covered by a HealthChoice Plan.

14. "**DSM**" means Diagnostic and Statistical Manual of Mental Disorders.

15. "**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) of the Social Security Act (42 U.S.C. § 1395dd(e)(1)).

16. "**Facility**" means an organization, as defined by EGID, which is duly licensed under the laws of the state of operation and meets additional credentialing established by EGID.

17. "**Facility Services**" means those inpatient and outpatient services that are covered by a HealthChoice Plan.

18. "**Geometric Mean Length of Stay**" (GMLOS) means the current version of the geometric mean length of stay published by CMS for each MS-DRG.

19. "**HCPCS**" means Healthcare Common Procedure Coding System.

20. "**HealthChoice Plan**" means the EGID HealthChoice benefit plan designed to maximize a Member's insurance benefit and financially encourage Members to use Network Providers.

21. **"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 a patient's home and readmission to a Facility within three days, subject to update in accordance with CMS guidelines.

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

22. "**ICD**" means International Classifications of Diseases.

23. "**Length of Stay**" means the length of an inpatient episode of care, calculated from the day of admission to the day of discharge, and based on the number of nights spent in hospital.

24. **"LTCH"** means a Long-Term Acute Care Hospital with an average length of stay greater than 25 days. LTCH 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 an LTCH facility. LTCH facilities can be a satellite and/or hospital-within-a-hospital or co-located within another facility.

25. "**Marginal Factor**" means a factor used in the Outlier Allowable Fee calculation.

26. "**Medical**" means belonging to the study and practice of medicine for the prevention, alleviation or management of a physical or mental defect, illness, or condition.

27. "**Medically Necessary**" means services or supplies that, under the provisions of this Contract, are determined to be:

a. Appropriate and necessary for the symptoms, diagnosis or treatment of the Medical or Dental condition.
b. Provided for the diagnosis and treatment of the Medical or Dental condition.
c. Within standards of acceptable, prudent Medical or Dental practice within the community.
d. Not primarily for the convenience of the Member, the Member's Facility or another provider.
e. Any condition which, if left untreated, could deteriorate into a life-threatening situation.
f. The most appropriate supply or level of service that can safely be provided.
g. For hospital stays, this means that inpatient care is necessary due to the kind of services the Member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
h. The fact that services or supplies are Medically Necessary does not, in itself, assure that the services or supplies are covered by the Plan.
i. Performed in the most appropriate place of service.

28. "**Medical Services**" mean the services provided by a Network Facility and covered by a HealthChoice Plan.

29. "**Members**" means a person who meets the eligibility requirements of and is enrolled in a HealthChoice Plan.

30. "**MS-DRG**" means Diagnosis Related Groups and is an inpatient facility classification, as published by CMS. The current version of the CMS MS-DRG grouper will be used to determine the MS-DRG.

31. "**MS-DRG Allowable Fee**" means the MS-DRG Relative Weight multiplied by the Base Rate for non-transfer cases.

32. "**MS-DRG Relative Weight**" means the current version of the Relative Weight published by CMS for each MS-DRG.

33. **"MS-LTC-DRG"** means the Medicare Severity-Long Term Care-Diagnosis Related Groups and in an inpatient Facility classification, as published by CMS.

34. **"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 EGID, shall serve as the payment rate, unless the reimbursement is to be a Short-Stay Outlier or a High Cost Outlier.

35. **"MS-LTC-DRG Relative Weight"** means the current version of the Relative weight published by CMS for each MS-LTC-DRG.

36. "**Network Provider**" means a Practitioner who or Facility that is duly licensed under the laws of the state in which the "Network Provider" operates, satisfies additional credentialing criteria as established by EGID, and has entered into a contract with EGID to accept scheduled reimbursement for Covered Medical and Dental Services and supplies provided to Members.

37. "**Non-Covered Services**" are those services a) excluded from coverage by the HealthChoice Plan, in which case the Member is liable for the charges; or b) covered by the HealthChoice Plan but inappropriately billed or not considered to be Medically Necessary and therefore excluded for reimbursement based on the clinical editing, in which case the Member is not liable for the charges.

38. "**Outlier**" means a discharge which has unique characteristics and is considered to be outside established parameters for each MS-DRG. A discharge is considered an Outlier if the billed charges exceed the sum of the Outlier Threshold plus the MS-DRG Allowable Fee.

39. "**Outlier Allowable Fee**" means [billed charges - (MS-DRG Allowable Fee + Outlier Threshold)] multiplied by the Marginal Factor.

40. "**Outlier Threshold**" means a dollar amount by which the total billed charges on the claim must exceed the MS-DRG Allowable Fee in order to qualify for an additional Outlier amount.

41. "**Outpatient Service(s)**" means Medically Necessary Facility Services for treatment rendered by the Facility to a Member without an admission.

42. **"Pre-Determination"** means the itemization of proposed services and the expected charges prior to treatment.

43. "**Residential**" means an approved treatment facility which provides temporary accommodations. It is a structured, safe and therapeutic environment in which residents receive psychotherapy appropriate to an individualized treatment plan.

44. **"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.

45. **"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 120%.

46. "**Skilled Nursing Facility**" means an approved treatment facility rendering services prescribed by a physician that could not be given safely or reasonably by a person who is not medically skilled and would need continuous supervision of the effectiveness of the treatment and progress of the condition of the Member. These services are not custodial in nature.

47. "**Transfer Allowable Fee**" means (MS-DRG Allowable Fee/Geometric Mean Length of Stay) multiplied by (Length of Stay + 1 day).

# III. RELATIONSHIP BETWEEN EGID AND THE FACILITY

1. EGID and the Facility agree that all of the parties hereto shall respect and observe the Facility/patient relationship that 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 a Member. The Facility reserves the right to refuse to furnish services to a Member in the same manner as it would any other patient.

2. EGID has negotiated and entered into this Contract with the Facility on behalf of the individuals who are Members of a HealthChoice Plan. The Facility is an independent contractor who has entered into this Contract to become a Network Provider and is not, nor is intended to be, the employee, agent or other legal representative of EGID 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 the independent contractor for the purposes of this Contract.

3. Nothing in this Contract is intended to be construed or be deemed to create any rights or remedies in any third-party, including but not limited to, a Member or a Network Provider other than the Facility named in this Contract.

# IV. FACILITY SERVICES AND RESPONSIBILITIES

1. For the purpose of reimbursement, the Facility shall provide services to Members that are Medically Necessary and covered under a HealthChoice Plan.

2. The Facility agrees to provide quality, Medically Necessary Medical or Dental Services to Members, in a cost-efficient manner and, if necessary, at the direction and under the supervision of a licensed physician and within the scope of the physician's routine services. Nothing in this Contract shall be construed to require medical staff of the Facility to perform any procedure or course of treatment which the staff deems professionally unacceptable or is contrary to the Facility's policy. The Facility shall provide Medical or Dental Services to Members in the same manner and quality as those services are provided to all other patients of the Facility.

3. The Facility agrees to make reasonable effort to refer Members to Network Providers, with which EGID contracts, for Medically Necessary services that the Facility cannot or chooses not to provide. Failure of the Facility to use Network Providers will result in a review pursuant to the Credentialing Plan.

4. The Facility shall participate in the Certification and Concurrent Review procedures provided in Article VII and for purposes of reimbursement to abide by decisions resulting from that review subject to rights of reconsideration and appeal.

5. The Facility shall maintain all licenses and certifications required by law and regulations as deemed required under the terms of this Contract.

6. The Facility shall accurately complete a HealthChoice Facility Application which is incorporated herein by reference. The Facility shall notify EGID Network Management of any change in the information contained in the application at least 15 business days prior to such change. Such changes include addresses, tax identification number and contact information.

7. The Facility shall furnish, at no cost to EGID, any Medical or Dental records covering any services, for any Member, with the understanding that each Member, as a condition of enrollment in a HealthChoice Plan, has authorized such disclosure.

8. The Facility shall reimburse EGID for any overpayments made to the Facility within 90 days of written notification or shall respond with detail within said time if the Facility disputes the request for additional payment.

a. EGID shall provide the Facility individual letters of retraction for each Member 60 days prior to the retraction being made.

b. As an exception, EGID 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 upon audit adjustment.

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

d. If the 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 60 days of the first notification of the overpayment.

9. The Facility shall submit to a Member record audit upon three business days advance notice.

## V. EGID SERVICES AND RESPONSIBILITIES

1. EGID agrees to pay the Facility compensation pursuant to the provisions of Article VI.

2. EGID agrees to continue listing the Facility as a Network Provider until this Contract terminates.

3. EGID agrees to provide appropriate identification for Members at the time of enrollment in a HealthChoice Plan which shall provide an address, telephone number or website for verifying eligibility and benefits.

4. EGID acknowledges the confidentiality, privacy and security regulations pertaining to Members' Medical or Dental records and comply with all applicable laws and regulations.

5. EGID shall maintain a Pre-Determination, Certification and Concurrent Review program.

## VI. COMPENSATION AND BILLING

1. The Facility shall only seek payment from EGID for the provision of Covered Medical and Dental Services except as provided in sections VI (2), VI (15) and VI (20). The Facility agrees to accept the amount of the Allowable Fee or billed charges, whichever is less, for Covered Services as payment in full and agrees to only request payment from the Member for deductible, coinsurance and amounts for defined Non-Covered services attributable to the Member's HealthChoice Plan. The payment shall be calculated and limited to the methodologies defined by this Contract.

2. EGID shall reimburse the Allowable Fee set by EGID for each procedure or the Facility's billed charge, whichever is less. This reimbursement shall be allowed when the Member has received Covered Medically Necessary Services subject to the following policy limitation and conditions:

   a. EGID may reduce the payment by any deductibles, coinsurance and copayments according to the Member's HealthChoice Plan in effect at the time charges are incurred. Complete descriptions of HealthChoice Plans are available on EGID's website.
   b. EGID shall have the right to categorize what shall constitute a procedure. EGID and the Member's financial liability shall be limited to the procedure's Allowable Fee or billed charges, whichever is less, as determined by EGID, paid by applying appropriate coding methodology, whether the Facility has billed appropriately or not.

c. The Facility agrees not to charge more for Medical or Dental Services to Members than the amount normally charged by the Facility to other patients for similar services. The Facility's usual and customary charges may be requested by EGID and verified through an audit.

3. Skilled Nursing Facility services, day treatment and Residential treatment will be reimbursed utilizing a per diem. In no event shall a per diem qualify as an Outlier.

4. The Facility agrees that EGID utilizes a comprehensive claim 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 CMS and other industry standards in the development of its mutually exclusive, incidental, re-bundling, age conflict, gender conflict, cosmetic, experimental and procedure editing.

5. When processing inpatient claims, EGID shall determine the MS-DRG Allowable Fee for non-transfer cases according to the following formula:

MS-DRG Allowable Fee = MS-DRG Relative Weight x Base Rate.

a. The reimbursement shall be allowed when the Member has received Medically Necessary Covered Services subject to the following policy limitations and conditions:

- *EGID shall pay the appropriate percentage of the MS-DRG Allowable Fee or billed charges, whichever is less, and the Member shall pay the remainder of the MS-DRG Allowable Fee or billed charges, whichever is less, unless the Member has met the stop loss limitation, and then EGID shall pay 100% of the MS-DRG Allowable Fee or billed charge, whichever is less, and the Member has no liability.*
- *The MS-DRG shall be controlling, subject to EGID's approval and Article X of the contract.*
- *The MS-DRG Allowable Fee does not include any physician professional component fees, which are considered for payment according to separately billed CPT/HCPCS codes.*
- *EGID shall include the day of admission but not the day of discharge when computing the number of facility days provided to a member. Observation facility confinements for which a room and board charge is incurred shall be paid based on inpatient benefits.*
- *In the case of a transfer, the Transfer Allowable Fee for the transferring Facility shall be calculated as follows:*

Transfer Allowable Fee = (MS-DRG Allowable Fee/Geometric Mean Length of Stay) x (Length of Stay + 1 day).

- *The total Transfer Allowable Fee paid to the transferring Facility shall be capped at the amount of the MS-DRG Allowable Fee or billed charges, whichever is less, for a non-transfer case. EGID shall allow payment to the receiving Facility, if it is also the final discharging Facility, at the MS-DRG Allowable Fee or billed charges, whichever is less, as if it were an original admission.*

b. EGID shall use the current version of the CMS MS-DRG grouper to categorize what shall constitute a procedure. EGID's and the Member's financial liability shall be limited to the Allowable Fee or billed charges, whichever is less, as determined by EGID.

c. For Outlier cases, EGID shall base its payment to the Facility using an Outlier Allowable Fee plus the MS-DRG Allowable Fee. The following formula shall be utilized to calculate the Outlier Allowable Fee:

Outlier Allowable Fee = [billed charges – (MS-DRG Allowable Fee + Outlier Threshold)] x Marginal Factor.

6. When processing inpatient LTCH claims, EGID agrees to pay the LTCH Facility the Allowable Fee based on appropriate billing according to the following:

a. EGID shall pay the appropriate percentage of the MS-LTC-DRG Allowable Fee and the Member shall pay the remainder of the MS-LTC-DRG Allowable Fee unless the Member has met the stop loss limitation, and then EGID shall pay 100% of the MS-LTC-DRG Allowable Fee and the Member has no liability.

b. The MS-LTC-DRG shall be controlling, subject to EGID'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 CPT code Allowable Fees.

d. EGID may reduce its payment by any deductibles, coinsurance and co-payments owed by the Member.

e. EGID shall include the day of admission but not the day of discharge when computing the number of facility days provided to a Member. Observation Facility confinements for which a room and board charge is incurred shall be paid based on inpatient benefits.

f. EGID shall use the current version of the MS-LTC-DRG grouper to categorize what shall constitute a procedure. EGID's and the Member's financial liability shall be limited to the Allowable Fee as determined by EGID.

g. The LTCH Facility agrees not to charge more for Medical Services to Members than the amount normally charged by the Facility to other patients for similar services.

7. EGID shall determine the Allowable Fee to an LTCH Facility for an unadjusted MS-LTC-DRG according to the following formula:

MS-LTC-DRG Allowable Fee = MS-LTC-DRG Relative Weight x Base Rate

8. Short-Stay Outlier means 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 LTCH Facility shall be calculated as follows:

Per Diem for Short-Stay Outlier = MS-LTC-DRG Allowable Fee / Geometric Average Length of Stay

Short-Stay Outlier Allowable Fee = 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 eligible for high cost outlier payments if the costs exceed the outlier threshold.

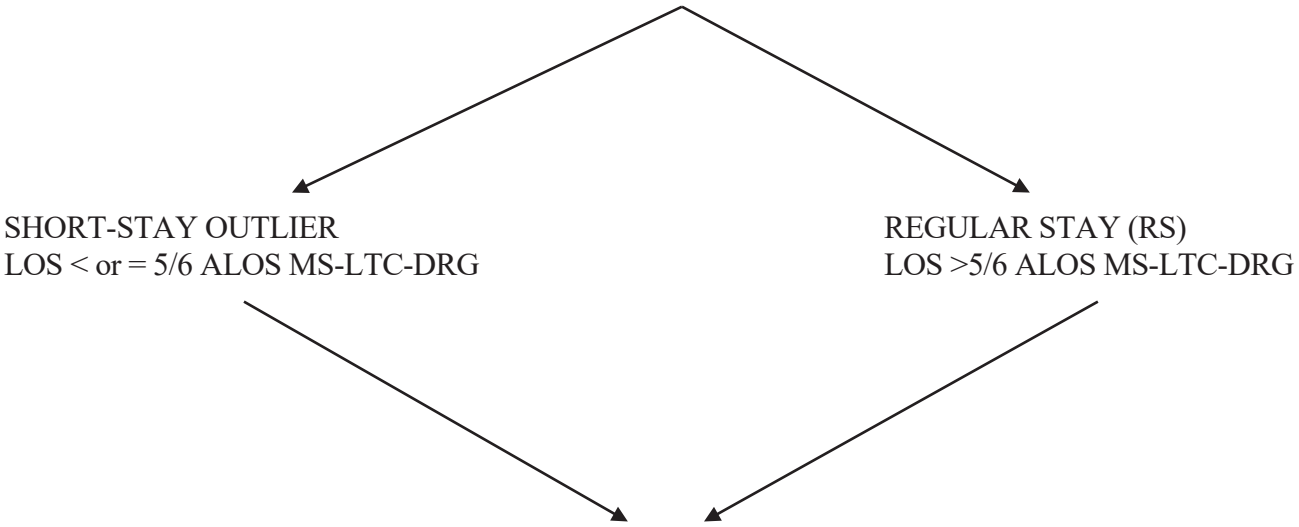
9. High Cost Outlier Allowable Fee means cases that have unusually high cost. In the case of a High Cost Outlier, the High Cost Outlier Allowable Fee for the LTCH Facility shall be calculated as follows:

High Cost Outlier Allowable Fee = ([Billed Charges – Disallowed Charges) x Cost to Charge Ratio] – MS-LTC-DGR Allowable Fee – Outlier Threshold) x 80% + MS-LTC-DRG Allowable Fee

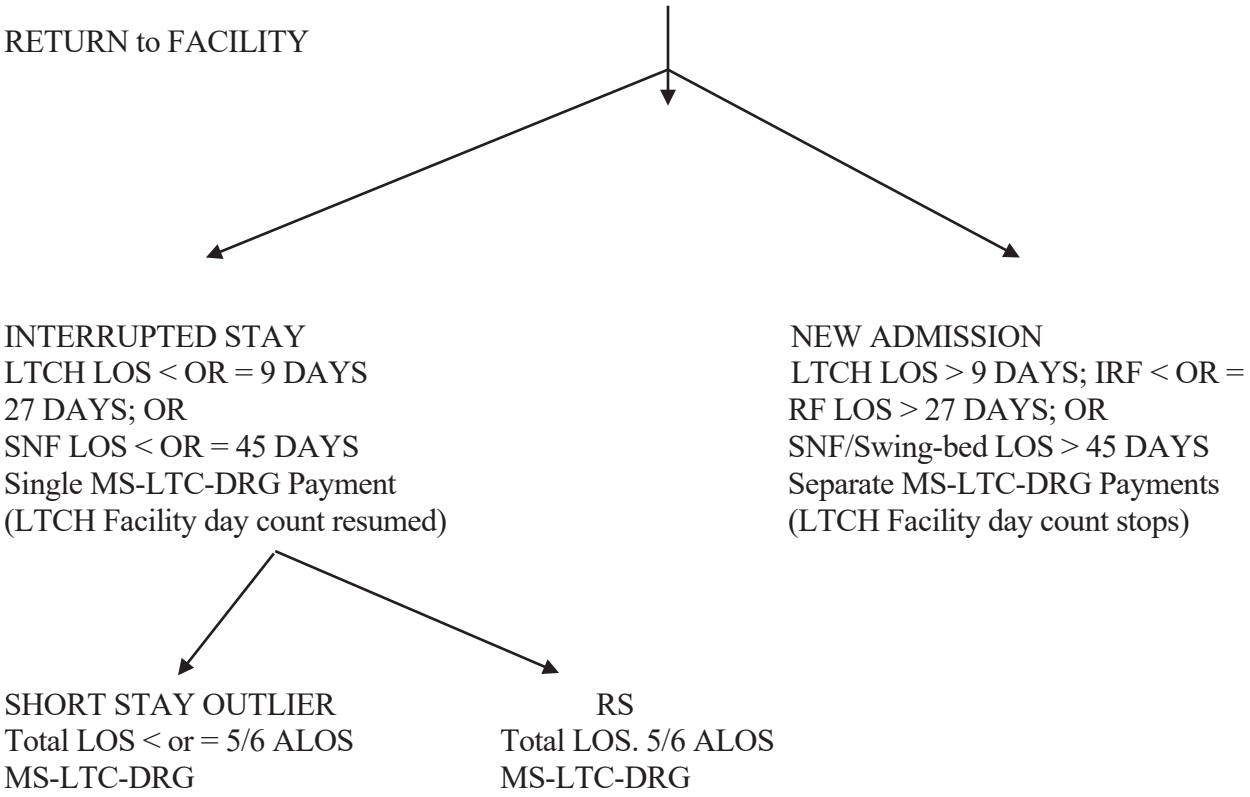
10. In the case of Interrupted Stays, if the length of stay at the LTCH Facility is equal to or less than applicable fixed period of time, it is considered to be an Interrupted Stay case and is therefore treated as a single (one) discharge for the purpose of payment. Only one MS-LTC-DRG payment will 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 OUTLIERS AND INTERRUPTED STAYS

**ADMISSION TO FACILITY**




(Facility day count stops) DISCHARGED to an LTCH, IRF, SNF, or Swing-bed



11. When processing outpatient claims, EGID shall reimburse the Allowable Fee or the Facility's billed charges for that procedure, whichever is less. The reimbursement shall be allowed when the Member has received Covered Medically Necessary Services.

12. A list of the CPT/HCPCS codes and the Allowable Fee for each can be found on the EGID website. EGID shall review and update the fee schedules quarterly or as needed.

13. A Facility's urban/rural status is determined by EGID. Generally, counties which are designated by the U.S. Census Bureau as a part of a Metropolitan Core Based Statistical Area (CBSA) are considered urban.

14. The Facility agrees that the only charges for which a Member may be liable and be billed by the Facility shall be for Medical or Dental Services not covered by a HealthChoice Plan, or as provided in sections VI (2), VI (16) and VI (20). The Facility shall not waive any deductibles, copayments and coinsurance required by EGID.

15. The Facility shall not collect amounts in excess of plan limits unless the Member has exceeded those established limits.

16. The Facility shall refund to the Member within 30 days of discovery any overpayment made by the Member.

17. In a case in which HealthChoice is primary under applicable coordination of benefit rules as defined in the HealthChoice Provider Manual, EGID will calculate the benefits to be paid without considering the other plan's benefits. In a case in which HealthChoice is other than primary under the coordination of benefit rules, EGID will use the Standard Allowable Calculation methodology for Coordination of Benefits, up to EGID's maximum liability under the terms of this Contract.

18. The Facility shall bill EGID on forms acceptable to EGID within 180 days of providing the Medical or Dental Services. The Facility shall use the current revenue codes, ADA, CPT codes with appropriate modifiers, HCPCS codes, and ICD or DSM diagnosis codes, when applicable. The Facility shall furnish, upon request at no cost, all information, including Medical or Dental records and x-rays, reasonably required by EGID to verify and substantiate the provision of Medical or Dental Services and the charges for such services if the Member and the Facility are seeking reimbursement through EGID.

19. EGID shall reimburse the Facility within 45 days of receipt of billings that are accurate, complete, including all information requested by EGID reasonably required to verify and substantiate the billing, and otherwise in accordance with Article VI of this Contract. See 74 O.S. § 1328. EGID will not be responsible for delay of reimbursement due to circumstances beyond EGID's control.

20. The Facility shall not charge a Member for Medical and Dental Services denied by the Certification or Concurrent Review procedures described in Article VII, unless the Facility has obtained a written waiver from that Member. Such a waiver shall be obtained only upon the denial of Medical and Dental Services and prior to the provision of those

Medical and Dental Services. The waiver shall clearly state that the Member shall be responsible for payment of Medical or Dental Services denied by EGID.

21. EGID shall have the right at all reasonable times and, to the extent permitted by law, to inspect and duplicate all documentation or records relating to Medical or Dental Services rendered to Members at no cost to EGID or the Member.

22. EGID shall have the right to adjust the Allowable Fee based on clinical editing and/or the use of modifiers as documented in the HealthChoice Provider Manual.

23. The Facility agrees that EGID's subrogation rights or the existence of third-party liability does not affect the Facility's agreement to accept the current Allowable Fee or billed charges, whichever is less, described in this Contract. Unrecorded alleged or recorded liens that are intended to secure charges for treatment rendered to or on behalf of a Member for amounts in excess of the Allowable Fee or billed charges, whichever is less, or which exceed the Member's deductible and coinsurance liability as required by the Contract, are rendered invalid by the Facility's submission of a Members' claims to EGID.

# VII. CERTIFICATION, CONCURRENT REVIEW AND PRE-DETERMINATION

1. The Facility shall adhere to and cooperate with EGID's Certification and Concurrent Review procedures. These procedures do not guarantee a Member's eligibility or that benefits are payable but assure the Facility that the Medical or Dental Services to be provided are Medically Necessary and/or meet coverage criteria under the plan.

2. EGID shall maintain review procedures and screening criteria that take into account professionally acceptable standards for quality Medical and Dental Services in the community. EGID shall consider all relevant information concerning the Member before Medically Necessary services are approved or denied.

3. The Facility shall notify EGID of any inpatient admission, transplant procedure, specific outpatient procedures, supplies or services as indicated on the certification list found on EGID's website. The Facility shall request Certification at least three business days prior to the services or supplies being administered. The Facility shall request Certification within one business day after services for an Emergency Medical Condition. Such notification shall be at no charge to EGID or the Member. The Facility's reimbursement shall be penalized 10% if Certification is approved retrospectively. The Facility shall receive no reimbursement if services are not confirmed as Medically Necessary.

4. The Facility shall request Certification before the admission or referral of Members to Non-Network Providers. EGID shall review emergency referrals to non-network hospitals to determine whether the admission was Medically Necessary, and an Emergency Medical Condition as defined in this Contract.

5. The Pre-Determination, Certification and Concurrent Review requirements are intended to maximize insurance benefits. The requirements assure that Medical or Dental Services are provided to the Member at the appropriate level of care in the most appropriate setting. In no event is it intended that the procedures interfere with the Facility's decision to order admission or discharge of the Member to or from a hospital.

6. EGID shall not retrospectively deny any previously approved care. The Facility or its designee shall update EGID as the Member's condition or diagnosis changes. Updated information may result in a change of the originally approved length of stay, supplies or services.

7. Upon the Member's request, EGID shall reconsider any non-approved services. The Facility may submit a formal written appeal to EGID.

# VIII. LIABILITY AND INSURANCE

1. Neither party to this Contract, nor any agent, employee or other representative of a party, shall be liable to third parties for any negligent act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.

2. The Facility, at its sole expense, shall maintain a minimum of $1 million per occurrence and $1 million aggregate of general and medical liability insurance coverage. EGID shall be notified 30 days prior to cancellation. If coverage is lost or reduced below specified limits, this Contract may be cancelled by EGID. Exceptions to this liability coverage requirement are listed below:

   a. A Skilled Nursing Facility, at its sole expense, shall maintain a minimum of $100,000 per occurrence of insurance coverage for general and medical liability insurance coverage.

3. If applicable the Facility, in lieu of the general and medical liability insurance requirements set out in section VIII (2) above, may prove that as a federally supported health center, as deemed eligible by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, it has been granted medical malpractice liability protection with the federal government acting as its primary insurer through the Federal Tort Claims Act and the Federally Supported Health Centers Assistance Act of 1992 and 1995, later codified as 42 U.S.C. Section 233 (g) – (n).

4. If applicable the Facility, in lieu of the general and medical liability insurance requirements set out in section VIII (2) above, may prove that it is has been granted medical malpractice liability protection with the State of Oklahoma or a political subdivision acting as its primary insurer through the Oklahoma Governmental Tort Claims Act, 51 O.S. §§ 151, *et seq*.

5. If providing Medical or Dental Services outside of the State of Oklahoma, and if applicable, the Facility, in lieu of the general and medical liability insurance requirements set out in section VIII (2) above, may prove that it has been granted medical malpractice

liability protection with a governmental entity outside of the State of Oklahoma acting as its primary insurer through said governmental entity's statutes, rules or regulations.

## IX. MARKETING, ADVERTISING AND PUBLICITY

1. EGID shall encourage its Members to use the services of a Network Facility.

2. EGID shall have the right to use the name, office address, telephone number, website address and specialty of the Facility for purposes of informing its Members and prospective Members of the identity of Network Providers.

3. The Facility, upon prior approval of EGID, shall have the right to publicize the Facility's status in EGID's network of providers.

## X. DISPUTE RESOLUTION

1. EGID and the Facility agree that their authorized representatives will meet in a timely manner and negotiate in good faith to resolve any problems or disputes that may arise in performance of the terms and provisions of this Contract. Nothing in this article shall interfere with either party's rights under Article XI.

## XI. TERM AND TERMINATION

1. The terms of this Contract shall commence on the effective date on the signature page and shall remain in effect until terminated by either party subject to section XI (2).

2. Either party may terminate this Contract with or without cause, upon giving 30 days written notice pursuant to section XI (5) at any time during the term of this Contract.

3. Nothing in this Contract shall be construed to limit either party's remedies at law or in a court of equity in the event of a material breach of this Contract.

4. This Contract shall terminate if the Facility does not maintain general and medical liability coverage in accordance with this Contract, upon the loss or suspension of the Facility's license to operate in the state of operations, CMS certification, accreditation, or the loss or suspension of a license to practice medicine in the state of practice for any of the principle or operating physicians that comprise the Facility as detailed in section I (2). This Contract shall terminate upon the insolvency of either party.

5. The termination notice required by the terms of this Contract shall be provided in writing, facsimile or via email communications to EGID.NetworkManagement@omes.ok.gov. A confirmation notice to the Facility shall be emailed or mailed to the mailing address on record. The termination shall be effective on the date indicated on the confirmation.

6. Following the termination date, this Contract shall be of no further force or effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the termination date of this Contract.

7. Following the termination of this Contract, EGID shall continue to have access, at no cost to EGID, to the Facility's records of care and services provided to Members for seven years from the date of provision of the services to which the records refer as set forth in Article VI.

## XII. GENERAL PROVISIONS

1. This Contract or 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.

2. The primary method by which the Facility shall receive notifications mandated by the terms of this Contract is the *Network Newsletter*. The *Network Newsletter* shall be distributed electronically to the Facility's correspondence email address.

3. It is agreed by the parties that no changes to this Contract, which include coverages, fee schedules, or reimbursement methodologies, shall be made with less than 60 days' notice to all affected parties, except revisions to injectable medications, in which case EGID shall implement the revisions as soon as possible with proper and timely notification to the Facility.

4. Notwithstanding the provisions of section XII (1) of this Contract, EGID may appoint an administrator to administer any of the terms of this Contract referenced herein, and any and all duties or acts required of EGID under this Contract and to receive any notices required by this Contract.

5. This Contract, together with its exhibits, contains the entire agreement between EGID and the Facility relating to the rights granted and the obligations assumed by the parties concerning the provision of Medical and Dental Services to Members. 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.

6. This Contract, or any part, section, or exhibit of, or attached to it, may be amended at any time during the term of this Contract by mutual written consent of duly authorized representatives of EGID and the Facility in accordance with section XII (2).

7. This Contract is subject to all applicable Oklahoma Statutes and rules and regulations 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.

8. 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 have no effect on the remaining terms and provisions of this entire Contract, or any one provision, in accordance with the intent and purpose of the parties hereto.

9. The Facility certifies that neither it, 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.

10. EGID and the Facility agree that this Contract may be formed according to the Oklahoma Uniform Electronic Transactions Act, 12A O.S. § 15-101, *et seq*. (Act). The Facility acknowledges that the Contract terms are located on EGID's website and after downloading this Contract, and submitting the completed application, signing and returning the signature page to EGID, EGID 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 EGID electronic records under the Act. The parties agree and consent to the use of electronic signatures solely for the purposes of executing the agreement or any related transactional document. Such electronic signature shall be deemed to have the same full and binding effect as a handwritten signature.

11. The HealthChoice fee schedules are deemed confidential pursuant to Oklahoma statutes and should not disseminated, distributed or copied to persons not authorized to receive the information.

12. As mandated by 62 O.S. § 34.64(H), all payments disbursed by the Office of the State Treasurer must be made solely through electronic funds transfer (EFT). The Facility hereby agrees to accept EFT payments.

# Facility Contract Signature Page

EGID and the Facility, incorporate by reference the terms and conditions of this Contract into this signature page. EGID and Facility further agree that the effective date of this Contract is the effective date denoted on the copy of the executed signature page returned to the Facility.

**FOR THE FACILITY**:

_____
Legal name

_____
Trade name/DBA

_____
Federal Tax ID

_____
Primary NPI (attach list if necessary)

_____
Authorized officer name and title

_____
Authorized officer signature

Primary service address:

_____

_____

_____

**FOR EGID:**

_____
Yasmine Barve
Administrator
Employees Group Insurance Division
Office of Management and Enterprise Services

**Return Signature Page, Application and Attachments to:**

EGID.NetworkManagement@omes.ok.gov
Or fax: 405-717-8977

HealthChoice

## Network Facility Application

Complete all fields in this application; **incomplete applications will be returned.** Return the application and all required attachments listed below to:

OMES EGID
EGID.NetworkManagement@omes.ok.gov or fax to 405-717-8977 or 405-717-8702.

Include each of the following documents:

- Current state license.
- Face sheet of current general and medical liability insurance policy.
- W-9 form for each federal tax identification number (TIN).
- Copy of Medicare certification.
- Copy of accreditation by a nationally recognized organization that is approved by state or federal guidelines.

### General information

Legal name of owner

Trade name/DBA

CMS classification | CMS number

State licensing board | License number | License expiration

**Physical address** – The physical address, phone number, website and email will appear on the website provider directory.

Practice name

Physical address

City | State | ZIP code

Phone | Fax

Website for publication | Email for publication

**Mailing address** – Mailing information will be utilized for all payments. Email information will be utilized for all legal and contractual notices as defined in section 12.2 of the provider contract and 11.1 of the facility contracts, as well as payment-related notices/documents. An email address must be included. All notices will be sent electronically.

Mailing office name

Mailing address

City | State | ZIP code

Phone | Fax

Contact person | Contact email

**Hospital and nonhospital-based services (if applicable)**

Please indicate if the facility provides any of the following specialty services:

☐ Ambulance
☐ Ambulatory surgery center
☐ Dialysis
☐ Durable medical equipment
☐ Home health care
☐ Hospice
☐ Independent diagnostic testing facility
☐ Infusion therapy
☐ Laboratory
☐ Long-term acute care
☐ Mental health/substance abuse
☐ Rehabilitation
☐ Skilled nursing facility
☐ Sleep study

Does the facility provide the following services by an independent group of specialists? If yes, please list the provider group name.

Anesthesiology group

TIN | NPI | Phone

Emergency physician group

TIN | NPI | Phone

Pathology group

TIN | NPI | Phone

Radiology group

TIN | NPI | Phone

**Facility contacts**

CEO | Phone

Email

CFO | Phone

Email

Administrator | Phone

Email

Contract/managed care contact | Phone

Email