PROVIDER MANUAL

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Introduction and Guide to Manual

Purpose and Introduction

HealthLink, Inc. and HealthLink Administrators, Inc. (collectively "HealthLink") is committed to working together with our care provider partners to make a real impact on the health of their patients – our Members That's why we continue our focus to streamline our processes to help make it easier for care provider partners to find and use the information they need for their business interactions with us. With this collaboration, it's one more way that we're working to ensure Members have access to high-quality, affordable healthcare.

This Provider Manual ("Manual") contains important information regarding key administrative requirements, policies, and procedures. While this Manual covers a wide array of policies, procedures, forms, and other useful information that can be found and maintained on our website at www.healthlink.com, a few key topics are:

- Claims submission
- Pricing and administrative policies and requirements
- Credentialing
- Utilization management

As a participant in our diverse network, the Agreement with HealthLink requires that our care provider partners comply with HealthLink policies and procedures including those contained in this Manual. Pricing may be denied, in full or in part, should the Providers or Facilities fail to comply with this Manual. However, in the event of a direct conflict between the Agreement and this Manual, the Agreement will govern. The provisions in this Manual apply unless otherwise required by the Agreement.

Provider versus Facility

This Manual is intended to support all entities and individuals who have executed a Provider or Facility Agreement with HealthLink.

The use of "Provider" within this Manual refers to entities and individuals contracted with HealthLink who submit professional Claims. They may also be referred to as Professional Providers in some instances.

The use of "Facility" within this Manual refers to entities contracted with HealthLink that submit institutional Claims, such as Acute General Hospitals and Skilled Nursing Facilities.

General references to "Provider Inquiry," "Provider Website," "Provider Network Manager," and similar terms apply to both Providers and Facilities.

Capitalization

Capitalized terminology shown in this Manual is the same capitalized terminology shown in the HealthLink Facility Agreement or HealthLink Provider Agreement referred to in this Manual as "Agreement."

Updates to the Provider Manual

This Manual may be updated at any time and is subject to change. If there is a material change to this Manual, then HealthLink will make reasonable efforts to notify our care provider partners in advance of such change through web-posted newsletters or email communications. In such cases, the most recently published information will supersede all previous information and be considered the current directive.

Important disclaimer

Please note this Manual is not intended to be a complete catalog of all HealthLink policies and procedures. Other policies and procedures not included in this Manual may be posted on the HealthLink website or published in specifically targeted communications, including but not limited to newsletters. This Manual does not contain legal, tax or medical advice. Care provider partners should consult their advisors for advice on these topics.

Background

HealthLink was incorporated in October 1984 by a consortium of St. Louis metropolitan hospitals and joined the WellPoint family of companies (now the Elevance Health family of companies) in 2002. HealthLink builds regional provider networks and makes them available by contract to a multitude of Payors of health benefits, including insurers, third party administrators, union trust funds and employers. HealthLink contracts with more than 40,000 providers and more than 430 hospitals and other healthcare facilities in its core service area of Missouri and Illinois. HealthLink serves nearly 160,000 medical Members and thousands of Workers' Compensation Members of health plans that access a HealthLink network program. HealthLink offers several options including Open Access, PPO, and Anthem Workers' Compensation (AWC) network programs.

Business Focus

HealthLink is a preferred provider administrator or network organizer that contracts with Providers and Facilities and arranges for the delivery of healthcare services to Payors that sponsor or administer plans and requires each party to comply with specific obligations in the business relationship.

On one side of health service transactions, HealthLink contracts with Providers and Facilities to deliver healthcare services at discounted rates in exchange for patient volume, prompt payment, promotion, and other specified terms. On the other side of the transaction, HealthLink contracts with healthcare Payors referred to in this Manual as "Payors" that agree to reimburse participating Providers and Facilities directly, promptly, and according to contract rates. Payors include contracted health carriers, third-party Claims administrators, and self-funded self-administered health & welfare trust funds or employers. Under the terms of this arrangement, HealthLink brings to the market multiple Payors that offer various health benefit programs utilizing Providers and Facilities' services, thus offering access to more Payors under a single contract arrangement and offering Payors access to networks, enabling them to focus on their core business of health benefit administration.

HealthLink offers Providers and Facilities a variety of programs and services, including, but not limited to, provider networks for health benefit programs and Workers' Compensation programs. HealthLink also offers medical review consultative services and Claims repricing as core business practices. Claim repricing permits HealthLink to offer Providers and Facilities a central source for Claims filing and enables HealthLink to retain contracted rates.

Legal and Administrative Requirements Overview

Confidentiality of Patient Information

Medical records and other health and enrollment information of Members must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular Member.
- Maintain such records and information in a manner that is accurate and timely; and
- Identify when and to whom Member information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Member, HealthLink Providers and Facilities are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical records (including mental health records) and enrollee information.

Coordination of Benefits

HealthLink is a pricing network and does not direct how coordination of benefits is performed. Coordination of benefits may vary, and procedures are specified in the Claim Administrator / Payor health plan document. To verify which health plan is primary when a Member has two or more health plans, the Provider or Facility should contact the Claims Administrator and or the Payor listed on the Member's ID card.

Copyright

HealthLink®, Inc., is an Illinois corporation. HealthLink, Inc. is an organizer of independently contracted provider networks, which it makes available by contract to a variety of Payors of health benefits, including insurers, third party administrators or employers. HealthLink has no control or right of control over the professional, medical judgment of contracted Providers and Facilities, and is not liable for any acts or failures to act, by contracted Providers or Facilities. HealthLink, Inc. is not an insurance company and has no liability for benefits under benefit plans offered or administered by Payors. HealthLink® is a registered trademark of HealthLink, Inc.

Medical Records Inspection

Providers and Facilities must document all services provided to Members accessing HealthLink's networks and programs. Upon the request of any federal or state government agency that has jurisdiction or authority over HealthLink, Providers and Facilities must permit inspection of the books, records, and information regarding the provision of health care services to Members. In addition, Providers and Facilities must comply with requests from HealthLink or its Payors to provide information contained within the medical record for purposes related to health care operations and benefit consideration. Providers and Facilities agree to supply necessary information at no copying costs to HealthLink, its affiliated Payors or Members.

Member Rights and Responsibilities

The delivery of quality health care requires cooperation between Members, their Providers and Facilities and their health care plans. One of the first steps is for Members, Providers and Facilities to understand Member rights and responsibilities. Therefore, HealthLink has adopted a Members' Rights and Responsibilities statement, which can be accessed by going to healthlink.com. Select **Members**, select **Forms and Guidelines**, then select **Member Rights and Responsibilities**. Members or Providers who do not have access to the website can request copies by contacting HealthLink or by calling the number on the back of the Member ID card.

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Member information received from HealthLink to ensure no misrouted PHI is included. Misrouted PHI includes, but is not limited to, information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance advice. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact HealthLink Customer Service to report receipt of misrouted PHI.

Multi-Payor Distribution System

HealthLink contracts with numerous Payors, which include insurers, self-funded, employer sponsored benefit programs, health, and welfare trust funds and third-party administrators. HealthLink is not tied to any single Payor organization. Rather,

There are several ways to identify a Payor:

1. The Member's ID card lists the Claims Administrator/Payor and HealthLink.
2. HealthLink is identified on the remittance advice or explanation of benefits as the source of discount taken for the covered service delivered to a Member enrolled in a plan contracted to access the HealthLink network programs.
3. Providers and Facilities can access Payor information on Availity Essentials for each Member.
4. HealthLink's Customer Service.

HealthLink Payors have agreed to incorporate HealthLink's networks, fee arrangements and certain administrative services, including Claim pricing and quality assurance, into the health plans offered. Further, Payors are solely responsible for administering benefit plan provisions, determining enrollee eligibility, and paying Claims according to the benefit plan for Open Access, PPO, and Workers' Compensation clients.

In HealthLink's agreements with contracted Payors, HealthLink agrees to:

1. Develop and maintain relationships with Providers and Facilities.
2. Provide Utilization Management services, as elected by client.
3. Perform quality assurance services.
4. Price Providers and Facilities' Claims according to HealthLink contractual allowance; and
5. Provide customer service support.

Network Arrangements

All participating Providers and Facilities, contracted through HealthLink or through affiliate networks, are part of the network organized by HealthLink, and are independent contractors who exercise independent medical judgment, and over whom HealthLink has no control or right of control. Providers and Facilities are not agents or employees of HealthLink, its parent or affiliated companies.

Open Practice

Providers must accept a reasonable number of Members of health plans accessing HealthLink's programs, as mutually agreeable at the time the Provider applies for participation in HealthLink programs, and as notified thereafter. Provider shall give HealthLink thirty (30) days prior written notice when Provider no longer accepts new patients.

Provider Accessibility and Availability

Providers participating in the HealthLink network agree to be available or to arrange for medical/coverage for HealthLink Members 24 hours a day, seven (7) days a week to address medical concerns.

Availability of Services

Type of Care	Guideline
Emergency	Within four (4) hours based on medical need
Urgent	Within four (4) hours based on medical need
Routine Care with Systems	Within one (1) week based on medical need
Type of Care	**Guideline**
Baseline Physical Exams	Within thirty (30) days
Well Child Care (< age one)	Within three (3) weeks
Well Child Care (> age one)	Within six (6) weeks
Prenatal Care First Trimester Second Trimester Third Trimester High Risk Pregnancy	 Within one (1) week Within one (1) week Within three (3) days Within three (3) days or immediately for emergency care
Wait Time in Physician Office Scheduled Unscheduled (worked in)	 Within thirty (30) minutes waiting room/fifteen (15) minutes exam room Within sixty (60) minutes waiting room or exam room
Telephone Response After Hours Emergency Urgent Non-Urgent	 Within thirty (30) minutes Immediate Within one (1) hour Same day

All Providers are required to arrange for coverage during an absence and must disclose information to Members by telephone or answering service.

Behavioral Health Treatment

Behavioral Health Providers and Facilities should be available to Members in acute distress and require close observation that is only available in an acute inpatient psychiatric setting. Behavioral Health

Outpatient Providers and Facilities should be available for Members who can be safely and effectively treated in an office or outpatient facility setting.

Provider Administrative Fees

HealthLink contracted Providers and Facilities are assessed a monthly provider administrative fee in accordance with the HealthLink Agreement.

HealthLink will separately invoice Provider or Facility for the administrative fees based on the methodology set forth in the Agreement. Each such invoice will be sent to the Provider or Facility within 3 business days following the end of the calendar month. Provider or Facility shall pay HealthLink by the due date of each invoice. HealthLink's invoice will be supplemented by an itemized monthly activity report listing each Member, date of service, amount of billed charge, and amount allowed.

If Provider or Facility is delinquent in administrative fee payments, HealthLink reserves the right to begin collection proceedings for the delinquent amount. Failure to comply with collection proceedings may result in remanding the delinquent account to an external collection agency, suspension, or termination of the Provider or Facility's HealthLink Agreement.

Inquiries regarding provider administrative fees can be emailed to: PAF_Unit@HealthLink.com.

Privacy Policy Statement

Information regarding HealthLink's Corporate Privacy Policy Statement that sets forth guidelines regarding a Member's right to access and amend information in HealthLink's possession is available by selecting the "Privacy Statement" at the bottom of the Provider Landing page of our public provider website. To access this information, go to healthlink.com, scroll down and select **Privacy**.

Provider and Facility Digital Engagement

HealthLink recommends Providers and Facilities utilize digital tools for transactions such as Claim status and submitting demographic changes. Providers and Facilities should refer to the guidance included throughout this Manual where digital tools are available.

Provider and Facility Responsibilities

Providers and Facilities are responsible for notifying HealthLink when changes occur within the Provider practice or Facility. Providers and Facilities should reference the Agreement for specific timeframes associated with change notifications.

Examples of these changes include, but are not limited to:

- adding a new practitioner to the group
- change in ownership
- change in Tax Identification Number
- making changes to demographic information or adding new locations
- selling or transferring control to a third party
- acquiring other medical practice or entity
- change in accreditation
- change in affiliation
- change in licensure or eligibility status, or
- change in operations, business, or corporation

Referring to Non-Participating Providers

HealthLink's mission is to provide its Members with access to affordable quality health care. Providers and Facilities put Members at risk of higher out of pocket expenses when referred to non-participating providers.

Providers and Facilities are reminded that per the Agreement with HealthLink they are required in most circumstances to refer Members to Network/Participating Providers. Providers and Facilities who establish a pattern of referring Members to non-participating providers are subject to disciplinary action, up to and including termination from the Network. HealthLink understands there may be instances in which a Network/Participating Provider must refer to a non-participating provider. For additional information on in-network and out-of-network referrals, Providers and Facilities should refer to the applicable sections of the Agreement with HealthLink.

Substance Use Disorder (SUD) Confidentiality Protections for Members

The U.S. Department of Health & Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office for Civil Rights announced a final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR part 2 ("Part 2"). Part 2 programs are federally assisted programs that offer substance use disorder (SUD) diagnosis, treatment, or referral for treatment, and are subject to specific confidentiality regulations outlined in 42 CFR Part 2.

Prior to submitting Claims or other information subject to Part 2 to any third party, including to us, the regulation requires Part 2 regulated Providers and Facilities to obtain compliant consent from their patients and to include specific language outlining the Part 2 protections on the submitted Claim materials. This consent must allow for the use and disclosure of records for treatment, payment, and healthcare operations (TPO). Without this consent, the Providers or Facilities are prohibited by Part 2 from submitting Claims for payment or disclosing information protected under Part 2. Enforcement of 42 CFR Part 2 begins in February 2026. And any Claim submitted without the required language is not identifiable as information subject to Part 2.

For more information, access the Fact Sheet 42 CFR Part 2 Final Rule provided by HHS. Please contact your HealthLink Provider Relationship Account Manager with any questions.

Network Programs and Services

Network Programs and Services Overview

	Network included in HealthLink Program			
HealthLink Program	**HMO** (Tier 1)	**PPO** (Tier II)	**Workers' Compensation**	**Out-of-Network***
Open Access III (OAIII)	✓	✓		✓
Open Access II (OAII)	✓			✓
Open Access I (OAI)	✓			
PPO		✓		✓
Workers' Compensation			✓	

* Note out-of-network coverage is provided in accordance with the Member's health plan.

Open Access Network Programs

HealthLink Open Access is a non-gatekeeper network program, and certain Payors may require pre-certification (refer to the Utilization Management section of this manual). Members may self-refer to participating Providers and Facilities.

Open Access III (OAIII) is a three-tier program: This program has three levels of benefits. The highest level of benefit is available to Members who self-refer to HealthLink HMO participating Providers or Facilities. A second, lower level of benefit is available to Members who self-refer to HealthLink PPO participating Providers or Facilities. The third lowest level of benefit is available to Members who self-refer to out-of-network Providers or Facilities. HealthLink HMO contracted Providers and Facilities participate in Tier I. HealthLink PPO contracted Providers and Facilities participate in Tier II. Out-of-network Providers and Facilities are considered Tier III.

Open Access II (OAII) is a two-tier program: This program has two levels of benefits. The highest level of benefit is available to Members who self-refer to HealthLink HMO participating Providers and Facilities. A second, lower level of benefit is available to Members who self-refer to out-of-network providers. Only HealthLink HMO contracted Providers and Facilities participate in the OAII network program.

Open Access I (OAI) is a single-tier program: This program has one level of benefit. Members may self-refer to HealthLink HMO participating Providers and Facilities only. There are no PPO or out-of-network benefits. Only HealthLink HMO contracted Providers and Facilities participate in the OAI network program.

If a Provider or Facility is contracted in both the HMO and PPO networks, the Member's highest level of benefits will be applied at Tier I.

Directory of Services

Provider Contracting and Provider Relations

To meet the service needs of Providers and Facilities, HealthLink has assembled an experienced staff consisting of Provider Network Managers, Provider Relationship Account Consultants/Managers and Customer Service Representatives.

Contact a **Customer Service Representative** by calling (800) 624-2356 for questions/comments concerning general HealthLink inquiries.

The **Provider Relationship Account Consultants/Managers** serve as a liaison and are responsible for orientation, ongoing training, and policy/procedure consultation. Provider Relationship Account Consultants/Managers assist with administrative policies and procedures, problem resolution and service needs.

- Go to healthlink.com, select **Providers**. Select **Provider Toolbox**, select **Contact a Provider Relationship Account Consultant/Manager**.

The **Provider Network Managers** serve as the primary contacts for Network contracting.

Provider Newsletter

In-Touch is a newsletter informing our Providers and Facilities of any updates to HealthLink. A new edition is released as needed with the latest updates for Claims, billing, medical and other important news. In-Touch newsletters, current and historical publications can be found on healthlink.com.

HealthLink Digital Tools

HealthLink Provider Website

HealthLink.com is a public website designed to make navigation easy and useful for Providers and Facilities. The website holds timely and essential information to assist providers when working with HealthLink. Go to healthlink.com and select **Providers**.

Resources available on the Provider Home page of healthlink.com include:

- Availity Essentials
  - Secure Portal Access
- Provider Toolbox
  - Important Updates
  - Find a Doctor
  - Medical and Clinical Policies
  - Health Care Guidelines
  - Confidentiality Protocols
  - Programs and Services
  - Digital Publications
  - Contact a Provider Relationship Account Consultant/Manager
- Provider Communications
  - Register to Receive Digital Provider Communications and Publications
- Forms and Manuals
  - HealthLink Provider Manual
  - Join Our Participating Provider Network
  - Provider and Facility Demographic Change Form

    - Provider Fee Schedule Request Form
    - Provider and Facility Termination of Participation Form
    - Individual Authorization Form
    - Psychotherapy Notes Authorization Form
- Standard Policies
    - HealthLink Provider Manual
    - CAQH ProView™
    - Electronic Data Interchange
    - HealthLink Network Programs and Services
    - HealthLink Pricing Policies
    - HIPAA Updates
    - Important Reminder for Workers' Compensation Providers
    - Medical Policies & Clinical UM Guidelines
    - Clinical Practice, Preventive Health, and Behavioral Health Guidelines
- Patient Utilization
    - Availity Digital Authorizations
    - Access Availity's Multi Payer Digital Authorization Application
    - Behavioral Health Medical Guidelines
    - Pre-Certification List with Carelon
    - Medical Policies & Clinical UM Guidelines
    - Clinical Practice, Preventive Health and Behavioral Health Guidelines
    - UM Contact Information
- Join Our Network
    - Join Our Participating Provider Network
    - Program Summary
    - HealthLink Standards of Participation

Availity Essentials

HealthLink offers providers an array of online tools through Availity Essentials a secure portal. Engage and obtain the information needed instantly online at www.availity.com.

- Claim status inquiry – confirm receipt by HealthLink, status of pricing and date sent to Payor. Also locate the Payor's name and contact information for verification of Claims processing/payment.
- Member eligibility – verify a member's active/inactive status with HealthLink and locate the Payor's name and contact information for verification of eligibility and benefits.
- Provider enrollment and network management application – Options to manage your network (amendments, change of ownership, contract or network termination, TIN change). Including a dashboard for real-time status of a submitted contract change request. This application is currently only available to providers located in AR, IL, IN & MO. All others submit the appropriate form available on the HealthLink website at: https://www.healthlink.com/provider/formsandmanuals

Take advantage of these online benefits

- **Accessibility** – Online functions are available 24 hours a day from any computer with internet access.
- **Compliance** – Availity Essentials is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

Getting Started

To register for access to Availity Essentials, go to https://www.availity.com and select Get Started.

If the Tax Identification number is already registered on Availity Essentials, reach out to the registered site administrator for your organization.

Organization Maintenance

For questions regarding Availity registration or organization maintenance, visit https://www.availity.com/contact-us. Call 800-AVAILITY (800-282-4548) for Availity Client Services available Monday to Friday from 8 a.m. to 8 p.m. ET (excluding holidays).

Online Provider Directory & Demographic Data Integrity

Providers and Facilities can confirm Network participation status by using the **Find a Doctor** tool. A search can be done on a specific provider name or by viewing a list of local in-network Providers and Facilities using search features such as provider specialty, zip code, and plan type.

Accessing the Online Provider Directory:

- Go to healthlink.com
- Select **Find a Doctor**.
- To search our online Provider Directory, select *People, Places, Tests/Imaging, or All Providers*.

Before directing a Member to another Provider of Facility, verify that the Provider or Facility is participating in the Member's specific network.

To help ensure Members are directed to Providers and Facilities within their specific Network, utilize the Online Provider Directory:

- Go to healthlink.com
- Select **Find a Doctor**
- Select the Member's Network on the front of the Member's ID card.

Providers and Facilities who have questions on network participation status listed in the online directory should contact HealthLink Customer Service at the number on the back of the Member's ID card.

Updating Demographic Data with HealthLink

It is critical that Members receive accurate and current data related to Provider availability. Providers and Facilities must review the online care provider directory information and verify and update it, if needed at least every 90 days. Providers and Facilities must notify HealthLink of any demographic changes. All requests must be received 30 days **prior** to the change/update. Any requests received within less than 30 days' notice may be assigned a future effective date. Contractual terms may supersede effective date requests.

Important: If updates are not submitted 30 days prior to the change, Claims submitted for Members may be the responsibility of the Provider or Facility.

Providers who fail to verify their information every ninety (90) days may be removed from the online Provider directory. Providers will be reinstated to the online Provider directory once verification is completed.

Types of demographic data updates can include, but are not limited to:

- Accepting New Patients
- Address – Additions, Terminations, Updates (including physical, billing, and customer addresses)
- Email Address
- Hospital Affiliation and Admitting Privileges
- Languages Spoken
- Name change (Provider/Organization or Practice)
- National Provider Identifier (NPI)
- Network Participation
- Phone/Fax Number
- Provider Leaving Group, Retiring, or Joining another Practice*
- Specialty
- Tax Identification Number (TIN) (must be accompanied by a W-9 to be valid)
- Termination of Provider Participation Agreement**

Send HealthLink this information online at, healthlink.com**,** select **Providers**. Select **Forms and Manuals**, select **Provider and Facility Demographic Change Form** or **Provider and Facility Termination of Participation Form**.

* Note: To request participation for a new provider or practitioner, even if joining an existing practice, providers or practitioners must first begin the Application process. Go to healthlink.com, select **Providers**. Select **Join Our Participating Provider Network**.

** For notices of termination from a HealthLink network, Providers and Facilities should refer to the termination section in the Agreement for specific notification requirements. Allow the number of days' notice of termination from HealthLink's network as required by the Agreement (i.e., 90 days, 120 days, etc.).

Credentialing

Credentialing is the process HealthLink uses to evaluate and select healthcare practitioners and health delivery organizations (HDOs) to provide care to Members to help ensure that HealthLink's standards of professional conduct and competence are met. HealthLink's Program Summary includes a complete list of the provider types within HealthLink's credentialing scope. The credentials of health care practitioners and HDOs are evaluated according to HealthLink's criteria, standards, and requirements as set forth in the Program Summary and applicable state and federal laws, regulatory, and accreditation requirements. The Program Summary is not intended to limit HealthLink's discretion in any way to amend, change or suspend any aspect of HealthLink's Credentialing Program nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. HealthLink further retains the right to approve, suspend, or terminate individual practitioners and HDOs in those instances where it has delegated credentialing decision-making. HealthLink's Credentialing Program also includes the recredentialing process which incorporates re-verification and the identification of changes in the practitioner's or HDO's credentials that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed to assess whether practitioners and HDOs continue to meet HealthLink credentialing standards. All applicable practitioners and HDOs in HealthLink's network within the scope of the Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by applicable state contract or state regulations. Additional information regarding HealthLink's Credentialing Program can be found in the Program Summary, which applicable terms are incorporated into this Provider Manual by reference, available online. Go to healthlink.com, Select **Providers** and then **Join Our Network** then select the Program Summary.

Standards of Participation

Provider Contracting Process

Step 1	Submit the **Join Our Network** request to the Provider Contract Administration department; and HealthLink will send an appropriate contracting packet. Providers are required to submit their application via CAQH. **IMPORTANT NOTE:** HealthLink cannot begin the process of adding new providers until the application has been completed and/or updated on CAQH. Status must indicate either **"Initial Profile Complete"** or **"Reattestation."**
Step 2	Complete all forms included in the packet and return the completed packet to the specialist listed on the email that handles your territory. Their name and email address will be provided or send to: CPU@healthlink.com
Step 3	**Credentials Review** The Credentialing Department will review Provider credentials (for providers in scope). Credentials must be approved to participate in the HealthLink provider networks. This **does not** complete the contracting process.

Step 4	**Agreement Execution** When approved by the Credentials Committee, contract administration will review the entire request and send it for execution.
Step 5	**System Loading** Provider or Facility profile will be loaded into HealthLink's systems using the National Provider Identifier(s) (NPI) provided.
Step 6	**Provider Notification** Upon completion of the above processes, Provider or Facility will receive a welcome letter of approved network(s) participation status. The executed copy of the contract signature pages will be forwarded for brand new contracts. **Please note** *upon receipt of the welcome letter, Providers can begin rendering healthcare services to HealthLink Members.*

IMPORTANT: Provider must be approved by HealthLink (credentialing approved and contracting completed) before providers can begin providing covered healthcare services to HealthLink Members as a Network/Participating Provider.

The entire process may take up to ninety (90) business days from the date of receipt of a completed contracting packet.

Professional Standards

In addition to HealthLink's credentialing standards, Providers must also meet the following professional standards:

1. Providers must enter into the current Agreement and abide by and comply with all terms and conditions of the Agreement and fulfill all obligations imposed on the Provider under such Agreement. Concurrent with HealthLink's periodic recredentialing, the Provider must enter into the then current written Agreement.
2. Providers who participate in the networks or programs of any other corporate affiliate in the Elevance Health family of companies must be in good standing with such affiliates, abiding by and complying with all terms and conditions of the affiliate's provider agreement and fulfilling all obligations imposed on the Provider under the affiliate's provider agreement.
3. Provider's primary office location must be located within the HealthLink service area.
4. Providers must not be restricted from participating in one or more of HealthLink's networks or programs by an exclusive or other arrangement with any person or entity other than HealthLink.
5. In certain geographical areas, Providers may be required to participate in one or more of the HealthLink networks or programs through an intermediary with whom HealthLink has an exclusive or other restrictive arrangement.
6. Providers must maintain active hospital privileges with at least one or more of the network hospitals pertaining to HealthLink's specific networks or programs of interest, where applicable. Providers may also access hospital coverage by using the services of in-network hospital-based providers.
7. Providers who participate in concierge practices must still be available to provide services to Members who participate in HealthLink's networks or programs who are not interested in paying a fee for the additional concierge services. Providers cannot charge Members additional fees, beyond the Member's coinsurance, copay, or deductible for covered services.
8. Providers must not receive, give, provide, or condone any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member to other providers or facilities.
9. Providers must maintain professional liability insurance coverage, on a per occurrence basis, in the amount of $1,000,000, and $3,000,000 in the aggregate.

10. Providers must be available to treat patients at least twenty (20) hours per week, if the provider's specialty is primary care physician or OB/GYN.
11. Providers must offer or arrange for twenty-four (24) hours, seven (7) days per week coverage for HealthLink Members.
12. Providers may be excluded from participation if the Provider's application or other information obtained as part of the application or review process:
    a. is found to be incomplete,
    b. contains unacceptable information,
    c. is believed or determined to contain untrue, misrepresented, or fraudulent statements, or
    d. contains information or is determined to be unacceptable by HealthLink, for any reason(s) listed above, or for any other reason, including, without limitation, the following reasons:
        i. Provider's liability Claims history or outcomes of litigation raises questions regarding the care that may be provided by the Provider.
        ii. Provider's background raises questions regarding the ethical conduct of the Provider.
        iii. Provider's application was previously denied by HealthLink or one of its affiliates, within the past thirty-six (36) months.
        iv. Provider's Agreement or participation under a provider agreement with HealthLink was previously suspended, terminated, or non-renewed.
        v. review of the Provider's practice indicates that the Provider practices, or provides services, in a manner that might unreasonably increase HealthLink's cost of providing health care services to Members.
        vi. Provider is in or joining a professional practice or a professional group practice that is currently being investigated by the Special Investigations Unit and/or the Clinical Investigations Unit; or
        vii. Provider is in or joining a professional practice or a professional group practice that has demonstrated continued non-compliance with HealthLink policies and procedures and/or the policies and procedures of any HealthLink affiliate.

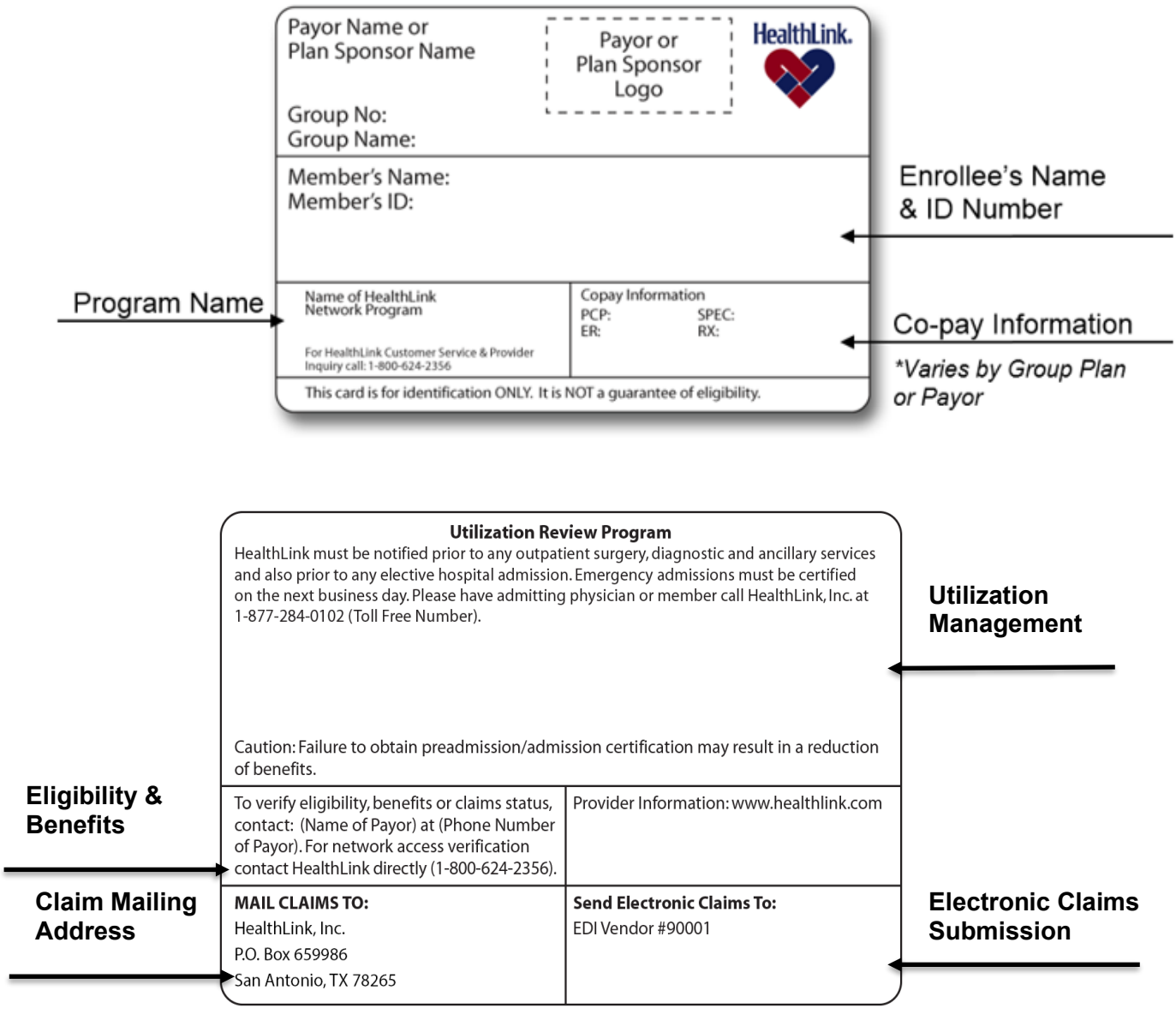
Member ID Card

Member ID Card

It is important that Providers, Facilities, and their staff can locate all the necessary information on Member's ID cards. The following items are required for each HealthLink Member ID card:

- Payor Name (and/or Group Name)
- Payor Logo (and/or Group Logo)
- HealthLink Logo and HealthLink Network Program (PPO, OAIII, etc.)
- Toll-free number and internet website for benefit verification, eligibility, and other relevant information
- Member's name
- Member's ID number
- Group name
- Group ID number
- Utilization Management Nationwide number
- Customer Service Nationwide number
- Claims filing address
- Disclaimer

If Member presents an ID card with a HealthLink logo, the Claims address and Customer Service contact information will be noted on the ID card.



Office Visit Copayment

The office visit copayment varies by Payor health plan. Typically, a specific dollar amount copayment is indicated on the Member's ID card if the health plan coverage includes a flat copayment. Collect copayment at the time of service. If the health plan has a co-insurance percentage and/or deductible, the amount payable by the Member may vary as benefits are used during the health plan benefit year. Co-insurance, deductibles and out-of-pocket maximums may not be printed on the Member's ID card (except when required by law).

File your Claim as directed on the Member's ID card. The explanation of payment (EOP) or remittance advice provides details on services paid for by the health plan and the amount payable by the Member, if any. Providers are responsible for collecting any monies due from Members.

Explanation of Benefits (EOB)

EOBs are sent by Payors to Members and explanations of payments (EOPs) or remittance advice are sent to Providers or Facilities. Providing necessary information about Claim payment and Member

responsibility. EOBs are reviewed by HealthLink upon Payor implementation and compliance is checked periodically thereafter.

Both Member and Provider EOBs should include the following elements:

- Name and address of Payor*
- Toll-free number of Payor*
- Member name/address*
- Member ID number*
- Provider Tax Identification Number (TIN)*
- Provider participation status (PPO, OAIII)
- Claims date of service*
- Type of service
- Total billed charges*, allowed amount*, discount amount*
- Excluded charges
- Explanation of excluded charges (code and associated key)
- Amount applied to deductible
- Copayment/co-insurance amount
- Total Member responsibility amount*
- Total payment made and to whom*
- Benefit level information (annual deductible amount, annual out-of-pocket amount and/or lifetime maximum amount applied)
- ERISA disclosure (if applicable)
- Discount remark “Discount for HealthLink Participation” *

** Required on all EOBs*

Claims Submission

Service Area

HealthLink’s provider networks are currently located in Missouri, Illinois and Arkansas.

Claim Submission Filing Tips

For optimum Claim processing:

- File Claims within 30 days following the date of service or hospital discharge date.
- Complete standard Claim forms utilizing current CPT/HCPC, Revenue Code and Modifier guidelines.
- Submit Claims electronically through Provider or Facility’s local vendor or to the appropriate address on the back of the Member’s ID card.

HealthLink prices the Claim based upon contractual allowances. The Payor determines benefits, eligibility, and then issues an explanation of payment or remittance advice to the participating Provider or Facility.

Electronic Claims Submissions

Providers and Facilities should submit Claims electronically whenever possible. Except workers’ compensation Claims, all Claims can be sent electronically to HealthLink resulting in cost efficiencies and faster processing. To get started contact the Provider or Facility’s clearinghouse and begin the necessary testing to assure the electronic pathway between Provider or Facility and HealthLink is working.

HealthLink Electronic Payor ID number: 90001

If Providers or Facilities must file Claims on paper, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04) will cause Claims to be rejected and returned to the Provider or Facility. More information and the most current forms can be found at www.cms.gov.

HealthLink’s Claims Mailing Address:

HealthLink
P.O. Box 659986
San Antonio, TX 78265

CPT Coding

The most current version of the CPT® Professional Edition manual and the Health Care Procedure Coding System (HCPCS) National Level II Expert is considered by HealthLink as the industry standard for accurate CPT, HCPCS, and modifier coding.

Duplicate Claims

Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claim pricing via Availity Essentials.

ICD-10 CM Codes

Providers and Facilities are required to use the ICD-10CM Codes (ICD-10 Codes) or successor codes and coding practices services. In all cases, medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider or Facility. For example, it is important for Providers and Facilities to code all conditions that co-exist at the time of an encounter and that require or affect patient care, treatment, or management. In addition, coding guidelines require that the Provider or Facility code to the highest level of specificity, which includes fully documenting the patient's diagnosis.

Overpayments

While Payors contracted or affiliated with HealthLink make reasonable efforts to pay Claims properly upon receipt, occasionally overpayments may occur. If a Provider or Facility becomes aware of an overpayment or mistake in payment (either through the provider's discovery, from the health plan's administrator or health carrier, or through a written notification from HealthLink), the Provider of Facility is required to refund the amount due to the health plan.

In the event a Payor sends a request for return of monies due to an overpayment, Providers and Facilities should refund the overpayment to the Payor.

For questions about the HealthLink contracted amount, Providers and Facilities can contact HealthLink Customer Service at 1-800-624-2356.

Processing Guidelines

Payors retain authority with respect to eligibility, coverage, and the benefits under the benefit plan. Coverage recommendations are subject to all terms and conditions of the applicable benefit plan, including specific exclusions, limitations, and applicable state and/or federal law.

Claim Disputes

Claim Inquiry: A question about a Claim or Claim pricing is called an inquiry. Claim Inquiries may not result in changes to Claims pricing. Providers and Facilities should call the Customer Service number on the back of the Member ID Card.

If a Provider or Facility disagrees with the outcome of a Claim priced by HealthLink, the Provider or Facility may begin the Claim Dispute process.

There are four common, Claim-related issues defined briefly here:

- ***Claim Pricing Disputes:*** A request to investigate or re-price a HealthLink Claim can be submitted by Provider or Facility. Claim Pricing Disputes could result in changes to Claims pricing; if changes are made HealthLink will resend the Claim and pricing information to the Payor for adjudication. Providers and Facilities will **not** be penalized for filing a Claim Pricing Dispute, and no action is required by the Member. For more information on requests for investigation/reconsideration please refer to *the Claim Pricing Dispute* section within this Manual.
- ***Claim Correspondence:*** Claim Correspondence is when HealthLink requires more information to finalize a Claim. Typically, HealthLink makes the request for this information through a letter or part of the Claim may be denied, but it is only because more information is

required to process the Claim. Once the information is received, HealthLink will use it to price the Claim.

- ***Clinical/Medical Necessity Appeals:*** An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary or experimental / investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the *Clinical Appeals* section within this Manual.
- ***Claim Payment Appeal:*** If a Provider or Facility disagrees with the Payment received by a Claims Administrator the Provider or Facility must appeal the payment directly with the Claims Administrator per the instructions on the explanation of payment (EOP) or remittance advice.

Claims Pricing Disputes

A Claim Pricing Reconsideration request may be submitted to HealthLink for multiple reasons, including:

- Contractual payment issues
- Disagreements over reduced or zero-priced Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that denied for no authorization when an authorization was obtained
- Timely filing issues*

IMPORTANT: Claim pricing disputes do not include situations in which an authorization or Claim for a service was denied as not medically necessary or experiment/investigational. For more information, *see* Clinical Disputes, below.

* HealthLink will reconsider pricing a Claim that has been denied due to failure to meet timely filing if the Provider or Facility can: 1) provide documentation the Claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

HealthLink requires the following information when submitting a Claim Pricing Dispute

- Provider or Facility name, address, phone number, email, TIN and NPI.
- Member's name and date of birth.
- A listing of disputed Claims, which should include the HealthLink Claim number and the date(s) of service(s)
- An explanation of the dispute including the expected allowed amount.

How to Submit a Claim Pricing Dispute

Requests for investigation or reconsideration can be sent to

HealthLink Appeals
PO Box 659987
San Antonio, TX 78265

Claim Pricing Appeal

If a Provider or Facility is dissatisfied with the outcome of a Claim Pricing Dispute determination, Providers or Facilities may submit a Claim Pricing Appeal.

HealthLink accepts Claim Pricing Appeals in writing within 30 calendar days of the Claim Pricing Dispute determination or according to the Agreement.

Claim Pricing Appeals received beyond this timeframe will be considered untimely and upheld unless good cause can be established.

When submitting a Claim Pricing Appeal, Providers and Facilities should include as much information as possible to help HealthLink understand why the Provider or Facility believes the Claim Pricing

Dispute determination was in error. If a Claim Pricing Appeal requires clinical expertise, it will be reviewed by appropriate HealthLink clinical professionals.

HealthLink will make every effort to resolve the Claim Pricing Appeal within 60 calendar days of receipt.

HealthLink will send the Provider or Facility the decision in a determination letter.

If the decision results in a Claim adjustment, the pricing sheet will be sent separately.

Required Documentation for Claims Pricing Appeal

HealthLink requires the following information when submitting a Claim Pricing Appeal:

- Provider or Facility name, address, phone number, email, TIN and NPI.
- Member's name and date of birth.
- A listing of disputed Claims, which should include the HealthLink Claim number and the date(s) of service(s)
- All supporting statements and documentation

How to Submit a Claim Pricing Appeal

Mail all required documentation to:

HealthLink Grievance & Appeal Department
P.O. Box 659987
San Antonio, TX 78265

Clinical Appeals

Clinical appeals refer to a situation in which an authorization or Claim for a service was denied as not medically necessary or experiment/investigational. Medical necessity appeals/prior authorization appeals are different than Claim Pricing Disputes and should be submitted in accordance with the Clinical appeal process.

Clinical Appeals can be used if Providers or Facilities disagree with clinical decisions. Clinical Appeals are requests to change decisions based on whether services or supplies are Medically Necessary or experimental/investigative. UM Program Clinical Appeals involve certification decisions, Claims or predetermination decisions evaluated on these bases. Clinical Appeals can be made in writing for appeals regarding prior authorization adverse decisions.

HealthLink Members may designate a representative to exercise their complaint and appeal rights. When a Provider or Facility is acting on behalf of a Member as the designated representative, the complaint or appeal may be directed to Customer Service, using the phone number on the back of the Member ID card. These types of issues are reviewed according to HealthLink's Member Complaint and Appeal Procedures. Customer Service will help Providers and Facilities determine what action must be taken and if a Designate of Representative ("DOR") form is needed.

Required Documentation for Clinical Appeal

HealthLink requires the following information when submitting a Claim Pricing Appeal:

- Provider or Facility name, address, phone number, email, TIN and NPI.
- Member's name and date of birth.
- DOR form, if needed.
- A listing of disputed Claims, which should include the HealthLink Claim number and the date(s) of service(s)
- All supporting statements and documentation

How to Submit a Clinical Appeal

Mail all required documentation to:
HealthLink Grievance & Appeal Department
P.O. Box 659987
San Antonio, TX 78265

HealthLink Pricing Policies

Claim editing services provided by HealthLink are available to all Payors, however not all Payors request such services for the benefit plans they sponsor. For Payors who have requested such services, HealthLink prices professional Claims based on its contracts using a proprietary software product from a vendor, McKesson ClaimsXten®. The Claim's processing logic is annually reviewed and updated by McKesson. HealthLink can customize portions of the ClaimsXten software and utilize various resources in making customization determinations. These include National Correct Coding Initiative (NCCI), Medicare guidelines and physician specialty societies.

Professional Pricing Policies

These policies serve as a guide to assist providers in accurate Claims submissions and to outline the basis for allowed amounts for HealthLink Members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination of reimbursement. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Professional Pricing Policies are published online, go to healthlink.com; select **Providers**; choose **Policies and Procedures**. HealthLink reserves the right to review and revise policies as necessary.

Preventable Adverse Events ("PAE")

Acute Care General Hospitals (Inpatient)

Three (3) Major Surgical Never Events

When any of the Preventable Adverse Events ("PAEs") set forth in the grid below occur with respect to a Member, the acute care general hospital shall neither bill, nor seek to collect from, nor accept any payment from the Plan or the Member for such events. If the acute care general hospital receives any payment from the Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, acute care general hospitals shall cooperate with HealthLink in any HealthLink initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Member, acute care general hospital is encouraged to report the PAE to the appropriate state agency, The Joint Commission ("TJC"), or a patient safety organization ("PSO") certified and listed by the Agency for Healthcare Research and Quality.

Preventable Adverse Event	Definition / Details
1. Surgery Performed on the Wrong Body Part	Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
2. Surgery Performed on the Wrong Patient	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.

3. Wrong surgical procedure performed on a patient	Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.

CMS Hospital Acquired Conditions ("HAC")

HealthLink follows CMS' current and future recognition of HACs. Current and valid Present on Admission ("POA") indicators (as defined by CMS) must be populated on all inpatient acute care Facility Claims.

When a HAC does occur, all inpatient acute care Facilities shall identify the charges and/or days, which are the direct result of the HAC. Such charges and/or days shall be removed from the Claim prior to submitting to the Plan for payment. In no event shall the charges or days associated with the HAC be billed to either the Plan or the Member.

Providers and Facilities (excluding Inpatient Acute Care General Hospitals)

Four (4) Major Surgical Never Events

When any of the Preventable Adverse Events ("PAEs") set forth in the grid below occur with respect to a Member, the Provider or Facility shall neither bill, nor seek to collect from, nor accept any payment from the Plan **or** the Member for such events. If a Provider or Facility receives any payment from the Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Providers and Facilities shall cooperate with HealthLink in any HealthLink initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Member, Providers and Facilities are encouraged to report the PAE to the appropriate state agency, The Joint Commission ("TJC"), or a patient safety organization ("PSO") certified and listed by the Agency for Healthcare Research and Quality.

Preventable Adverse Event	Definition / Details
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2. Surgery Performed on the Wrong Patient	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
3. Wrong surgical procedure performed on a patient	Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
4. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.

Anthem Workers' Compensation

About Anthem Workers' Compensation

Anthem Workers' Compensation (AWC) PPO is a specialty network program that offers contracted Workers' Compensation Payors access to a network of Providers and Facilities who have contracted with HealthLink to provide health care services at negotiated discounted rates for treatment of work-related illness and injury covered by the employer's Workers' Compensation plan. Claims are administered by the Workers' Compensation Payor.

Neither HealthLink nor AWC are insurance carriers or Claims Administrators in these arrangements. Claims are administered by the Workers' Compensation Payor. In exchange for access to HealthLink's networks and certain related administrative services, contracted Payors agree to guide plan participants to Providers and Facilities for treatment of work-related injuries and illnesses. They also agree to administer Claims promptly and to make payments to participating Providers and Facilities in accordance with the Agreement.

Eligibility and Verification Disclosure

Provider or Facility is responsible for identifying the injured employee of a covered employer at the time of the initial visit. AWC may provide employers with a form to be completed at the time of an injury. The employee should bring the form to the Provider or Facility on the initial visit. Providers may use a different form if it includes the requested information. To verify the existence and extent of coverage, contact the employer's Workers' Compensation Payor.

Be prepared to:

- Identify as an AWC Provider or Facility.
- Provide patient name and the name of the employer.
- Obtain the name and extension number of the person providing information for member's record.
- Disclose financial interest Provider or Facility may have in the referred Facility, if applicable.

Remember – Verification of benefits does not guarantee that all services are covered by the Workers' Compensation Payor. For example, if the Claim investigation shows that the treatment plan, in part or in full, is related to a health condition and not to a work injury or accident, the portion of the treatment that is associated with a pre-existing health condition is not payable under Workers' Compensation. Benefits are subject to patient eligibility at the time of the work-related injury and all other terms and condition of the employer's Workers' Compensation plan.

AWC Claims Filing Process

Provider or Facility may submit Claims for services rendered to patients enrolled in the AWC program to the patient's Workers' Compensation employer or Payor. The Payor will forward the Claim to HealthLink for pricing. HealthLink will price and forward the Claim along with copies of all reports, to the Payor, employer and/or primary care physician. The Payor will send Claim payments and copies of the adjudication report directly to the provider. The adjudication report provides an explanation of the payment and documentation for adjustments or discounts. For optimum processing and payment, submit Claims within 60 days following the date of service.

The Claim filing process is outlined below:

1. Ask the patient for any pertinent information at the time of an injury or refer to the AWC listing of employers covered by this program.
2. Contact the Payor's office provided by the patient to verify eligibility and confirm benefit coverage.
3. Complete standard claim forms utilizing current CPT-4/HCPC and Revenue Code Guidelines, including the following information:
    - Employer.

- Patient name and social security number.
- Patient diagnosis or symptoms, using ICD-10 CM code and/or written description.
- Date the patient was first seen for the identified diagnosis or condition.
- Date(s) patient received care.
- Description of service(s) using CPT-4 coding and/or HCPCS coding including appropriate modifiers.
- Itemized charges for service(s) rendered (charges should reflect the actual fee for the service described).
- Rendering Physician Name, NPI, Group Name, Address, TIN, Group NPI, and location services were rendered.
- Details of accident or occupation-related incident, if applicable.
- Description and office/operative notes for any "unlisted service."
- A copy of operative notes for any surgical procedure.

4. HealthLink reprices Claims based on its contracts using coding policies and procedures based on a software product, *Claims Xten*.
5. The Claim and repricing sheets are forwarded to the designated Payor for Claim adjudication and payment.
6. The Workers' Compensation plan's third-party administrator or Workers' Compensation carrier will determine benefit eligibility and issue payment.
7. Providers and Facilities may not balance bill patients for services covered by the Workers' Compensation benefit plan.

Treatment Procedures for Providers and Facilities

The following treatment procedures should be followed for an injured employee:

1. Complete an AWC Physical Capability Form or work status form for each injured worker at each visit.
2. Examine and treat the injured worker.
    a. If the injured worker is treated and released the same day, submit Claims for services, along with a copy of the Physical Capability Form and/or the physician's notes to AWC or to the Workers' Compensation Payor obtained from the injured worker.
    b. If the injured worker has follow-up appointments, notify the Payor as follows:
        - Mail or fax the Physical Capability Form.
        - Mail or fax copies of the physician's notes, reports, test findings and recommendations.
        - Mail all Claims for services to the applicable Payor.
3. If a referral to a specialist is necessary, contact the Payor by phone for medical necessity and the Payor's benefit determination prior to making the appointment for the referral.
4. After the medical necessity and Payor's benefit determination are obtained, an appointment can be scheduled with the specialist. Send any necessary records, films, and reports to the specialist. Mail or fax a copy of the referral form to the Payor obtained from the injured worker.

Procedures for Specialists

A specialist physician referred to as "Specialist" in this Manual may receive a referral from a Provider of Facility.

1. A representative of the Payor may contact the Specialist after the initial appointment for the Specialist's assessment and treatment recommendations.

2. If additional services or referrals are required, Provider or Facility may contact the Payor prior delivering to services or referring to other Specialists. If medical necessity and the Payor's benefit determination are required from the employer or adjuster for benefits to be available, the Payor will be responsible for contacting the adjuster for authorization and advising the specialist.
3. The Specialist should refer injured employees enrolled in Workers' Compensation plans using the AWC program to participating Providers and Facilities in HealthLink's network whenever medically appropriate.
4. The Specialist should mail or fax all reports directly to the Payor.
5. Claims should include the Social Security Number and birth date of the injured employee.

Serious/Life-Threatening Injuries

Life-threatening or emergency care cases do not require prior medical necessity determination and the Payor's benefit determination from AWC for immediate treatment, admission and/or referral.

For serious injuries, follow these procedures:

- The Provider or Facility should send all bills; copies of emergency room reports and physician notes to the Payor.

AWC Claim Pricing Disputes

Refer to the Claim Pricing Disputes section of this Manual.

Medical Policies and Clinical Utilization Management (UM) Guidelines

Elevance Health's Office of Medical Policy & Technology Assessment ("OMPTA") develops medical policy and clinical UM guidelines (collectively, "Medical Policy") for HealthLink. The principal component of the process is the development of medical necessity and/or investigational and not medically necessary position statements or clinical indications that are objective and based on medical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments may include, but are not limited to devices, biologics, specialty pharmaceuticals, gene therapies, and Professional health services.

Medical Policies are intended to reflect current scientific data and clinical thinking. While Medical Policy sets forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures, Federal and State law, as well contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

The Medical Policy & Technology Assessment Committee (MPTAC) is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments and geographic areas. Voting membership may include external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks, internal medical directors, and Chairs of MPTAC Subcommittees. Non-voting Members may include internal legal counsel and internal medical directors.

Additional details regarding the Medical Policy development process, including information about MPTAC and its Subcommittees, is provided in ADMIN.00001 Medical Policy Formation.

Medical Policy and Clinical Utilization Management ("UM") Guidelines Distinction

Medical Policy and clinical UM guidelines differ in the type of determination being made. Both set forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures. In general, Medical Policy may be developed to address experimental or investigational technologies (including a novel application of an existing technology) and services where there is a

significant concern regarding Member safety. Clinical UM guidelines address Medical Necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay (GLOS), place of service and level of care.

Accessing Medical Policies and Clinical UM Guidelines

HealthLink Medical Policies are available online, which provides transparency for Providers, Facilities, Members, and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the HealthLink website but are available upon request.

To locate Medical Policy online, go to healthlink.com, select **Providers,** under **Provider Toolbox** select **Medical and Clinical Policies**. Search for policies or select "Full List page" to view. Page link is included below:

- Medical Policy and Clinical UM Guidelines

Other Criteria

In addition to Medical Policy and Clinical UM Guidelines HealthLink maintains for medical necessity decisions, HealthLink may adopt criteria developed and maintained by other organizations. Where HealthLink has developed a policy that addresses a service also described in one of these other sets of criteria, HealthLink policy supersedes. To access the other criteria, go to healthlink.com, select **Providers,** under **Provider Toolbox** select **Medical and Clinical Policies**, accept the Acknowledgement, and scroll to **Other Criteria,** and select the specific criteria needed.

Utilization Management

Utilization Management Program

The Utilization Management ("UM") Program goal is to have Members receive the appropriate quantity and quality of healthcare services, delivered at the appropriate time, and in a setting consistent with their medical care needs. Providers and Facilities agree to abide by the following UM Program requirements in accordance with the terms of the Agreement and the Member's Health Benefit Plan. Providers and Facilities agree to cooperate with HealthLink in the development and implementation of action plans arising under these programs. Provider or Facility shall comply with all requests for medical information to complete HealthLink's UM review. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined within this section.

Utilization management decisions are based on medical necessity and appropriateness of care and service, and HealthLink never rewards its employees or agents for denials of coverage.

UM Definitions

1. **Adverse Determination**: A denial, based on a determination that a service is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health plan. This may apply to prospective, continued stay, or retrospective reviews.
2. **Business Day:** Monday through Friday, excluding HealthLink company holidays.
3. **Continued Stay Review:** Utilization review that is conducted during a Member's ongoing stay in a Facility or course of treatment. Continued Stay Review includes continuation of services (Urgent Care & Extensions).
4. **Notification:** The telephonic and/or written/electronic communication to the applicable Provider(s), Facility and the Member documenting the UM determination.
5. **Pre-certification/Pre-authorization Requirement:** List of services that require Pre-Service Review by UM prior to service delivery. The UM team performs Pre-Service Review, the Provider submits the pertinent information as soon as possible to UM prior to service delivery.
6. **Pre-Service (Prospective) Review:** A review for Medical Necessity conducted on a health care service or supply prior to its delivery to the Member.

7. **Post Service (Retrospective) Review**: A utilization review conducted after the health care service (or supply) has been provided to the Member.
8. **Discharge Planning:** The coordination of medical services and supplies, medical personnel, and family to facilitate the Member's timely discharge to a more appropriate level of care following an inpatient admission.
9. **Urgent Care Review:** A review evaluating a request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:
    - Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, or
    - Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or
    - In the opinion of a practitioner who is a licensed or certified Professional providing medical care or behavioral healthcare services with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Program Overview

Utilization Management (UM) may be required for Pre-certification/Pre-authorization, Pre-Service (Prospective) Review, Continued Stay Review or Post-Service (Retrospective) Review. UM may be conducted via multiple communication paths.

The determination that services are medically necessary is based on the information provided and is not a guarantee that benefits will be paid. It is important to note that **even if HealthLink determines through UM that a service is medically necessary, the service may be subject to certain exclusions, limitations, and other conditions under the Member's health benefit plan.** Further, to the extent permitted by law, the HealthLink allowed amount could be limited, for example, when:

- The information submitted with the Claim, or on the medical record, differs from that given for the pre-Claim UM review.
- The Member is not eligible for coverage when the service is provided.

The review may consider such factors as the Medical Necessity of services provided, and whether the service involves cosmetic or experimental/investigative procedures.

Inpatient medical admissions require UM review. Inpatient medical services may include but are not limited to acute hospitalizations, units described as "sub-acute," "step-down," and "skilled nursing Facility," designated skilled nursing beds/units; comprehensive outpatient rehabilitation facilities; rehabilitation units; inpatient hospice; and sub-acute rehabilitation facilities or transitional living centers. These services are subject to admission review for determination of Medical Necessity and appropriateness, site of service and level of care.

Non-inpatient medical services may require Pre-Service Review.

The list of Pre-certification/Pre-authorization Requirements can be accessed online. Go to healthlink.com, select **Providers,** select **Patient Utilization** select Pre-Certification List.

Retrospective Utilization Management

Medical records and pertinent information regarding the Member's care may be reviewed to make a Claim determination.

Failure to Comply with Utilization Management Program

Utilization Management components may vary from health plan to health plan. Please refer to the enrollee ID card for specific instructions. Failure to pre-certify elective services may result in participating provider financial penalties from the benefits administrator and in accordance with the health benefit program.

The list of Pre-certification/Pre-authorization Requirements can be accessed online. Go to healthlink.com, select **Providers,** select **Patient Utilization** , select Pre-Certification List.

Submit Authorization Requests Digitally

Providers and Facilities can submit medical and behavioral health outpatient and inpatient preapproval requests for many HealthLink Members more efficiently with the Availity Essentials Authorization Application. Using the multi-payer Authorization application for submitting prior authorizations offers a streamlined and efficient experience for Providers requesting inpatient and outpatient medical services for Members covered by HealthLink plans. Providers can also use the Availity Authorization application to check authorization status, regardless of how the authorization was submitted.

NCQA Accreditation

HealthLink provides a comprehensive and integrated Medical Management program that includes both Utilization Management and Medical Case Management.

The Utilization Management component operates under the Anthem UM Services, Inc. (AUMSI) licenses and program. AUMSI is a wholly owned subsidiary of our parent company, Elevance Health. AUMSI maintains a National Utilization Management (UM) NCQA Accreditation for which HealthLink is included.

Carelon Medical Benefits Management, Inc.

Carelon Medical Benefits Management, a wholly owned subsidiary of HealthLink's parent company, Elevance Health, provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million Members across 50 states, D.C. and U.S. territories, Carelon Medical Benefits Management promotes optimal care using evidence-based clinical guidelines and real-time decision support for both providers and their patients. Carelon Medical Benefits Management platform delivers significant cost-of-care savings across an expanding set of clinical domains, including radiology, cardiology, oncology, specialty drugs, sleep medicine, musculoskeletal care, and genetic testing. Payors may or may not elect to have Carelon Medical Benefits Management review the services below.

- Diagnostic Imaging Ambulatory

Visit Carelon Medical Benefits Management's program websites to find program information, clinical guidelines, interactive tutorials, worksheets & checklists, FAQs, and access to the provider portal.

Submit Pre-certification requests to CARELON MEDICAL BENEFITS MANAGEMENT

Ordering and servicing Providers may submit pre-certification requests to Carelon Medical Benefits Management in one of the following ways:

- Access the provider portal directly at providerportal.com. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- Call the Carelon Medical Benefits Management Contact Center toll-free number: 800-240-5057.

For technical questions, contact Web Support at 800-252-2021. For any other questions, contact your HealthLink Provider Relationship Account Consultant/Manager.

Clinical Practice Guidelines

HealthLink considers clinical practice guidelines to be a key component of health care. HealthLink adopts nationally recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of our Members. Several national organizations such as the National Heart, Lung and Blood Institute, American Diabetes Association, and the American Heart Association produce guidelines for asthma, diabetes, hypertension, and other conditions.

Providers can access the up-to-date listing of the medical, preventive, and behavioral health guidelines online. Go to healthlink.com, select **Providers**, select Provider Toolbox, select Health Care Guidelines.

With respect to the issue of coverage, each Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures, and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the clinical practice guidelines.

Audit

At any time HealthLink may request on-site, electronic, or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

Fraud, Waste and Abuse Detection

HealthLink is committed to protecting the integrity of health care programs and the effectiveness of operations by preventing, detecting, and investigating fraud, waste, and abuse (FWA). Combating FWA begins with knowledge and awareness.

- *Fraud – intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit. This includes, knowingly soliciting, receiving, and/or offering compensation to encourage or reward referrals for items or services and/or making prohibited referrals for certain designated health services.*
- *Waste – includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered driven by intentional actions but occurs when resources are misused.*
- *Abuse – when health care providers or suppliers do not follow appropriate medical billing practices or medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.*

The Special Investigations Unit (“SIU”) investigates suspected incidents of FWA for all types of services. HealthLink may take corrective action with a Provider or Facility including but not limited to refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agency.

Important Links

Availity.com HealthLink’s secure provider portal

Forms and Manuals submit forms online directly to the appropriate department.

HealthLink.com public site for provider resources

In Touch provider newsletter

Join Our Participating Provider Network

Patient Utilization resources for utilization management and precertification

Provider Toolbox easy-to-use tools and resources for your practice

Standard Policies procedures and guidelines for conducting business with HealthLink