Administrative Manual

Inquiries, Complaints, Grievances & Appeals

Chapter 9

HealthLink®

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Inquiries, Complaints, Grievance and Appeals

Participating Physicians, Hospitals, and Other Health Care Professionals:

HealthLink provides several avenues for participating health care professionals to obtain information and assistance.

General Inquiries
Typical general inquiries concern covered services and covered persons of health plans that are contracted with HealthLink. These types of inquiries can be most efficiently addressed with health care providers contacting the plan administrator. The plan administrator's name and telephone number appears on the membership identification card and can be verified by any of the following three means if the patient presents without an identification card:

1. HealthLink Customer Call Center – 800-624-2356

2. HealthLink IVR System – 877-660-2472

3. HealthLink *ProviderInfoSource*® – https://providerinfosource.healthlink.com

Other general inquiries include questions about the participation status of a particular health care provider or claim status. This kind of inquiry can be most efficiently addressed when health care providers either call the HealthLink Customer Service Center or visit www.healthlink.com.

For larger patient account management projects involving claim status inquiries, health care professionals may submit a request for HealthLink's assistance in claims research. Contact the HealthLink Network Consultant who supports your practice or facility.

General Correspondence and Complaints
A participating practitioner or health care facility may voice his or her concern or dissatisfaction with an issue by calling HealthLink Customer Service at 1-800-624-2356, from 7:30 a.m. to 5:30 p.m. weekdays or the HealthLink Network Consultant who supports your practice or facility. HealthLink will make every effort to resolve your problem at the time of inquiry. If a resolution will take a longer period of time, you will be advised of the planned course of action.

Grievances and Administrative Appeals
(excluding clinical or medical necessity determinations)
If a participating health care provider remains dissatisfied with the resolution to the issue, he or she may initiate a grievance or appeal by sending documentation, including a cover letter explaining the nature of the complaint, its effect on the practice and/or patient, and if known, the cause of the problem. The more specific the information is, the easier it is for HealthLink to investigate and resolve.

Grievances and Administrative Appeals include, but are not limited to, the following:

- Contractual disputes, such as contract allowances, timeliness of claims filing, sanctions on out-of-network referral or failure to pre-certify required service
- Quality or timeliness of service provided by HealthLink or its agents or contracted business partners (e.g., a particular payor, EDI vendor)
- Issues regarding the quality, accessibility or availability of a particular type of care within the HealthLink network of participating providers;
- *Issues involving the application of the HealthLink contracted allowed amount on a particular identified claim;
- Issues regarding a HealthLink medical policy
- Issues regarding clinical coding guideline; or
- Other HealthLink administrative procedures and processes, such as claims pricing, pre-authorization, etc.

**Grievances involving payment discrepancies must be made in writing within 90 days of the payment.*

These written grievances and appeals should be directed to:

HealthLink Grievance & Appeal Department
P.O. Box 411424
St. Louis, Missouri 63141-1424

For a request to be considered, the provider must include documentation about extenuating circumstances or new information. To file a grievance or administrative appeal, the practitioner will:

- Submit a formal written request, or print and complete the form below:
  Participating Provider Request for Review Form
  * verify an address is included within the body of the letter or on provider letterhead for HealthLink to mail the response
- Include any substantiating documentation that was not previously reviewed
- Send the document/form to the address noted above

HealthLink will acknowledge receipt of all letters and respond with the resolution or directions to the appropriate plan administrator, if the issue involves a benefit determination based upon plan coverage and eligibility. The resolution letter will typically follow within 30 calendar days of HealthLink's receipt of the grievance or appeal.

HealthLink offers participating health care providers two levels of internal review. If a participating health care provider remains dissatisfied with the resolution to the issue or has additional relevant information to present, he or she may initiate a second level review by request, including any additional relevant information. Please refer to the process outlined above.

Clinical Appeals

Health care professionals may appeal (upon their own behalf or upon behalf of their patients who are enrolled in the HealthLink network program) adverse medical necessity determinations recommended by HealthLink medical management to the contracted plan.

These appeals should be directed to:

HealthLink Grievance & Appeals Department
P.O. Box 411424
St. Louis, Missouri 63141-1424.

For an appeal request to be considered, the health care provider must include documentation regarding extenuating circumstances or new information. To file an appeal, the practitioner will:

- Submit a formal written request, or print and complete the form below:
  Participating Provider Request for Review Form
  * verify an address is included within the body of the letter or on provider letterhead for HealthLink to mail the response
- Include any substantiating documentation that was not previously reviewed
- Send the documentation by mail as outlined above

When all information is received from the health care provider, the HealthLink Grievance and Appeal staff will coordinate file preparation for review by a physician reviewer who was not involved in the original review and determination.

Thereafter, HealthLink will respond with a resolution letter that includes the appeal determination, rationale and instructions on how to initiate a second level appeal in the event the health care provider remains dissatisfied. The timeframe for responses varies by type of appeal; however, generally expedited appeals are processed within three days of receipt of all the necessary information and request and typically involve concurrent inpatient care; standard pre-service appeals are processed within 15 days of receipt of all the necessary information and request; and standard post-service appeals, within 30 days of receipt of all the necessary information and request.

Please Note:

- Appeals submitted by a health care provider on behalf of members are those in which the member has liability and require the member's written consent.
- If applicable, contractual provisions that are mutually agreed upon between HealthLink and the participating provider will supersede the processes outlined within these policies regarding participating health care providers' grievance and appeal process.