Administrative Manual

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Introduction

Welcome to HealthLink®, Inc.

We thank you for being part of HealthLink's networks of participating physicians, hospitals and other health care professionals. Our primary objective is to provide outstanding service within the framework of a common goal – providing enrollees with convenient access to quality health care at a reasonable cost.

This administrative manual was created as a resource to help you and your staff understand HealthLink programs, policies and guidelines. As business practices evolve, we will keep you informed through periodic updates to this manual as well as through other communication channels, i.e. Provider Newsletter – *In-Touch*, HealthLink websites, and other direct mailings. We encourage you to contact us if you have any questions or comments regarding HealthLink's programs or services.

About HealthLink

Background

HealthLink was incorporated in January 1985 by a consortium of St. Louis metropolitan hospitals, and joined the WellPoint family of companies in 2002. HealthLink, Inc. is an operating subsidiary of WellPoint, Inc., the nation's largest publicly traded commercial health benefits company serving the health care needs of approximately 34 million members nationwide. HealthLink builds regional provider networks and makes them available by contract to more than 150 Payors of health benefits, including insurers, third party administrators, union trust funds and employers. HealthLink contracts with more than 25,000 physicians and other health care professionals and more than 300 hospitals and facilities in its core service area of Missouri, Arkansas Indiana and Southern Illinois. HealthLink expanded its network service arrangements into Northern Illinois, Ohio, Kentucky, and Wisconsin adding access to approximately 100,000 physicians. HealthLink serves nearly one million medical enrollees and two million Workers' Compensation enrollees of health plans that access a HealthLink network program. The company offers several network options including PPO, AWC+ and Open Access network programs, as well as access to the industry's most comprehensive portfolios of wellness and cost management programs and administrative services.

Business Focus

HealthLink is a preferred provider administrator or network organizer that contracts with physicians, hospitals and other health care professionals and arranges for the delivery of health care services to Payors that sponsor, administer or insure plans. The company contracts with health care providers and Payors, requiring each party to comply with specific obligations in the business relationship.

On one side of health service transactions, HealthLink contracts with health care providers to deliver health care 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 health care Payors that agree to reimburse participating physicians, hospitals and other health care professionals directly, promptly and according to contract rates, and whose plan or insured members are encouraged to use the HealthLink network. Forms of encouragement may include "soft" directing patients to physicians, hospitals and other health care professionals in the network, which is typically characterized by benefit design: offering contracted plan members financial incentives in terms of increased benefit coverage and reduced out-of-pocket costs and premium contributions for use of HealthLink participating physicians, hospitals and other health care professionals. 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 participating providers' services, thus offering providers 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 participating physicians, hospitals, other health care professionals and Payors a variety of programs and services, including, but not limited to, Open Access networks for health benefit programs and Workers' Compensation programs. HealthLink also offers medical review consultative services and claims pricing as core business practices. Claim pricing permits HealthLink to offer participating providers a central source for claims filing and enables HealthLink to retain its contract rates within its organization.

URAC Accreditation

Utilization Review Accreditation Committee (URAC), an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation and certification programs. URAC's mission is to promote continuous improvement in the quality and efficiency of health care delivery by achieving a common understanding of excellence among purchasers, providers, and patients through the establishment of standards, programs of education and communication, and a process of accreditation.

The URAC accreditation process demonstrates a commitment to quality services and serves as a framework to improve business processes through benchmarking organizations against nationally recognized standards.

HealthLink has been awarded Health Utilization Management accreditation from URAC.

HealthLink's Purpose, Vision, and Values as a WellPoint Company

With a reputation for innovation, WellPoint is committed to establishing a relationship with customers, physicians, hospitals and other health care professionals as trusted partners.

Purpose Statement
Together we are transforming health care with trusted and caring solutions.

Vision
To be America's valued health partner.

Values

- Accountable
- Caring
- Easy to do business with
- Innovative
- Trustworthy

HealthLink Network Programs

HealthLink supports a continuum of health benefit products offered by Payors. HealthLink's programs as outlined in Chapters 3 and 8 are as follows:

- HealthLink PPO
- HealthLink Open Access
- HealthLink AWC+

Geographic Service Area

HealthLink's provider networks are currently located in the following states:

- Arkansas
- Illinois*
- Indiana
- Kentucky
- Missouri
- Ohio

*UniCare Life & Health Insurance Company (UniCare) and HealthLink, Inc. (HealthLink) are both separately incorporated and capitalized subsidiaries of WellPoint, Inc. Certain N. Illinois providers are contracted directly with UniCare. Through "affiliate" terms outlined in the UniCare contract, providers are considered HealthLink participating providers allowing health care access to HealthLink members.

Network Arrangements

Physician participation includes a mix of primary care physicians and specialists. Hospital participation includes tertiary and community hospitals as well as specialty hospitals in pediatric and rehabilitative care. HealthLink provides access to contracted ancillary health care services through network hospital contracts and independent physician agreements.

All participating physicians, hospitals and other health care professionals, contracted through HealthLink or through our 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. They are not agents or employees of HealthLink, its parent or affiliated companies.

Multi-Payor Distribution System

HealthLink is not tied to any single Payor organization. Rather, HealthLink contracts with more than 150 Payors, that include insurers, self-funded, employer sponsored benefit programs, health and welfare trust funds and third party administrators. There are several ways to identify a Payor:

1. The patient's enrollee ID card names the claims Payor and HealthLink is identified on the remittance advice or explanation of benefits as the source of a discount taken for the covered service that was delivered to a patient who is enrolled in a plan contracted to access the HealthLink network programs;

2. Monthly claims activity reports identify the claims Payor by name and phone number for each patient account;

3. *ProviderInfoSource*® can identify the Payor by name and phone number for each patient account.

4. HealthLink's Customer Service staff;

5. Claims Interactive Voice Response system (IVR); and

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 they offer. Further, Payors are solely responsible for administering benefit plan provisions, determining enrollee eligibility and paying claims according to the benefit plan for PPO, Open Access and State of Illinois Open Access clients.

In its agreements with contracted Payors, HealthLink agrees to:

1. Develop and maintain relationships with its physicians, hospitals and other health care professionals;

2. Provide Utilization Management services, as contracted;

3. Perform quality assurance services;

4. Price participating practitioners' claims according to HealthLink contractual allowance;

5. Provide customer service support; and

6. Assist in marketing efforts.

Enrollee Rights and Responsibilities

HealthLink believes that health care should be physician-driven and based on a strong relationship between doctor and patient. The following lists of Enrollee Rights and Responsibilities acknowledge some fundamental elements of this relationship.

Enrollee Rights

1. To receive considerate and respectful care and services from participating physicians, hospitals and other health care professionals, and considerate and respectful services from HealthLink staff.

2. To receive medically necessary care and services.

3. To receive from one's physician (or the hospital/office personnel) complete and understandable information about one's illness, possible treatments and likely outcome, and to discuss this information with the attending physician(s). No restriction shall be placed on the dialogue between practitioner and patient.

4. To participate in any decision-making related to care.

5. To know the names and roles of the attending health care professionals.

6. To consent to or refuse a treatment as permitted by law. If one refuses a recommended treatment, he or she will receive other needed, reasonable and available care.

7. Consideration of privacy concerning medical care. Case discussion, consultations and treatments should be conducted discreetly, with only necessary individuals present.

8. To have all communications and records pertaining to medical care treated as confidential, released only with the enrollee's permission or as permitted by law.

9. To review medical records and to have the information explained, except when restricted by law.

10. To be informed of complaint and grievance procedures and to file a complaint if dissatisfied with the health care received.

11. To receive information about HealthLink, its services and its participating physicians, hospitals and other health care professionals in a clear and concise manner.

Enrollee Responsibilities

1. To select and establish a relationship with a medical practitioner.
2. To seek medical care at the earliest possible time when one experiences symptoms that may indicate illness or injury.
3. To provide, to the best of one's knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications or other health-related matters.
4. To communicate to medical personnel if one does not clearly understand what is expected or how to take prescribed medications.
5. To follow the treatment plan recommended by the physician primarily responsible for care.
6. To keep scheduled appointments.
7. To take medications as prescribed or communicate the reason for not doing so.
8. To adhere to any prescribed diet or exercise program, or to consult with the prescribing health care professional to adjust the requirements or resolve problems.
9. To recognize the effect of lifestyle and preventive care on personal health.
10. To read all benefit plan information and to follow instructions regarding claims, eligibility and hospitalization.
11. To carry one's health identification card and to identify oneself as an enrollee of a HealthLink program when seeking health care services.
12. To provide, to the best of one's knowledge, accurate and complete information about current health coverage to physicians, hospitals and other health care professionals.

Distribution of this Manual

The most current version of this manual is available at http://providerinfosource.healthlink.com. If you do not have internet access, please contact your Network Consultant.

Provider Newsletter – *IN-TOUCH*

In-Touch is a newsletter informing our physicians, hospitals and other health care professionals of any updates to HealthLink. A new edition is released quarterly with the latest updates for claims, billing, medical and other important news. Please join *ProviderInfoSource®*, to receive the *In-Touch* electronically.

Copyright and Contract Issues

HealthLink®, Inc., is an Illinois corporation. HealthLink 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 physicians, hospitals and other health care professionals, and is not liable for any acts or failures to act, by contracted providers. 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. and a separately incorporated and capitalized subsidiary of WellPoint, Inc.

The contents of this HealthLink Administrative Manual are descriptive and supplement your contract. If there is any inconsistency between the manual and your agreement with HealthLink, the agreement will control.

Provider Responsibilities

HealthLink Standards of Participation

As part of the contracting process each healthcare professional/provider must satisfy the applicable selection standards before he or she is eligible to apply for participation in one or more of HealthLink's programs/networks.

If any applicant does not meet the selection standards outlined below, the applicant's request to participate in HealthLink programs/networks will not be processed.

1. The healthcare professional/provider must enter into the then current written provider agreement and abide by and comply with all terms and conditions of the provider agreement and fulfill all obligations imposed on the healthcare professional/provider under such provider agreement. Concurrent with HealthLink's periodic recredentialing, the healthcare professional/provider must enter into the then current written participation agreement.

2. The healthcare professional/provider who participates in the networks/programs of any other corporate affiliate in the WellPoint 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 fulfill all obligations imposed on the healthcare professional/provider under the affiliate's such provider agreement.

3. The healthcare professional/provider's primary office location must be located within the HealthLink service area.

4. The healthcare professional/provider must not be restricted from participating in one or more of HealthLink's programs/networks by an exclusive or other arrangement with any person or entity other than HealthLink.

5. In certain geographical areas, the healthcare professional/provider may be required to participate in one or more of the HealthLink programs/networks through an intermediary with whom HealthLink has an exclusive or other restrictive arrangement.

6. Active hospital privileges must be maintained by the healthcare professional/provider with at least one or more of the network hospitals pertaining to HealthLink's specific programs/networks of interest, where applicable. The healthcare professional/provider may also provide for hospital coverage by using the services of in-network hospital-based providers.

7. The healthcare professional/provider practice must not consist of a boutique, concierge, or retainer-type arrangement with its patients.

8. The healthcare professional must not receive, give, provide or condone any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a covered person to other healthcare professionals or facilities.

9. The healthcare professional/provider must maintain professional liability insurance coverage, on per occurrence basis, in the amount of $500,000, and $1,000,000 in the aggregate. The healthcare professional/provider is encouraged to 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. If the healthcare professional is a primary care physician or OB/GYN, he or she must be available to treat patients at least twenty (20) hours per week.

11. The healthcare professional/provider must provide or arrange for twenty-four (24) hours, seven days per week coverage for members who participate in HealthLink's programs/networks.

12. The healthcare professional/provider agrees that he or she may be excluded from participation if the professional/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. the healthcare professional/provider's liability claims history or outcomes of litigation raises questions regarding the care that may be provided by the healthcare professional or provider;

        ii. the healthcare professional/provider's background raises questions regarding the ethical conduct of the healthcare professional/provider;

        iii. the healthcare professional/provider's application was previously denied by HealthLink or one of its affiliates within the past thirty-six (36) months;

        iv. the healthcare professional/provider's provider agreement or participation under a provider agreement with HealthLink was previously suspended or terminated;

v. review of the healthcare professional/provider's practice indicates that the healthcare professional/provider practices, or provides services, in a manner that might unreasonably increase HealthLink's cost of providing health care services to its member;

vi. the healthcare professional is 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. the healthcare professional is 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 other corporate affiliate in the WellPoint family of companies.

Credentialing Scope

HealthLink credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing services covered under the Health Benefits Plan and doctors of dentistry providing Health Services covered under the Health Benefits Plan including oral maxillofacial surgeons.

HealthLink also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master's level clinical social workers who are state licensed; master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently. In addition, Medical Therapists (e.g., physical therapists, speech therapists and occupational therapists) and other individual health care practitioners listed in HealthLink's Network directory will be credentialed.

HealthLink credentials the following Health Delivery Organizations (HDOs): hospitals; home health agencies; skilled nursing facilities; (nursing homes); free-standing surgical centers; lithotripsy centers treating kidney stones and free-standing cardiac catheterization labs if applicable to certain regions; as well as behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

Credentials Committee
The decision to accept, retain, deny or terminate a practitioner's participation in a Network or Plan Program is conducted by a peer review body, known as HealthLink Credentials Committee (CC).

The CC will meet at least once every forty-five (45) days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will chair the CC and serve as a voting member (the Chair of the CC). The CC will include at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to HealthLink Covered Individuals and who falls within the scope of the credentialing program, having no other role in HealthLink Network Management. The Chair of the CC may appoint additional Network practitioners of such specialty type, as deemed appropriate for the efficient functioning of the CC.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network Providers.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate Credentialing staff, medical directors, and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information.

HealthLink may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The

CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy
HealthLink will not discriminate against any applicant for participation in its Plan Programs or Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, HealthLink will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners/ HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in HealthLink Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of HealthLink Plan Programs or Networks. This application may be a state mandated form or a standard form created by or deemed acceptable by HealthLink. For practitioners, the Council for Affordable Quality Healthcare ("CAQH"), a Universal Credentialing Datasource is utilized. CAQH is building the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.

HealthLink will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, HealthLink will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

Practitioners Verification Element

- License to practice in the state(s) in which the practitioner will be treating Covered Individuals.
- Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.

- DEA, CDS and state controlled substance certificates
- The DEA/CDS must be valid in the state(s) in which practitioner will be treating Covered Individuals. Practitioners who see members in more than one state must have a DEA/CDS for each state.
- Malpractice insurance
- Malpractice claims history
- Board certification or highest level of medical training or education
- Work history
- State or Federal license sanctions or limitations
- Medicare, Medicaid or FEHBP sanctions
- National Practitioner Data Bank report

HDOs Verification Element

- Accreditation, if applicable
- License to practice, if applicable
- Malpractice insurance
- Medicare certification, if applicable
- Department of Health Survey Results or recognized accrediting organization certification
- License sanctions or limitations, if applicable
- Medicare, Medicaid or FEHBP sanctions

Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet HealthLink credentialing standards.

During the recredentialing process, HealthLink will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of HealthLink Credentialing Program are required to be recredentialed every three years unless otherwise required by contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to HealthLink for review. If the candidate meets HealthLink screening criteria, the credentialing process will commence. To assess whether participating HealthLink Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing

programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in HealthLink Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, HealthLink may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO.

Recredentialing of HDOs occur every three years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Plan Programs or Networks must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. HealthLink may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring
To support certain credentialing standards between the recredentialing cycles, HealthLink has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General (OIG)
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management (OPM)
4. State licensing Boards/Agencies
5. Covered Individual/Customer Services Departments
6. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal HealthLink Departments
8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including but not limited to: review by the Chair of HealthLink CC, review by the HealthLink Medical Director, referral to the CC, or termination. HealthLink credentialing departments will report providers to the appropriate authorities as required by law.

Appeals Process

HealthLink has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of HealthLink's Plan Programs

or Networks. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and HealthLink may wish to terminate practitioners or HDOs. HealthLink also seeks to treat practitioners and HDOs and applying providers fairly, and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in HealthLink's Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank ("NPDB").

Additionally, HealthLink will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of HealthLink to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of HealthLink's Plan Programs or Networks and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's or HDO's suspension or loss of licensure, criminal conviction, or HealthLink's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Covered Individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

Reporting Requirements

When HealthLink takes a professional review action with respect to a practitioner's or HDO's participation in one or more Plan Programs or Networks, HealthLink may have an obligation to report such to the NPDB and/or Healthcare Integrity and Protection Data Bank ("HIPDB"). Once HealthLink receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook and the HIPDB Guidebook, the process set forth in the NPDB Guidebook and the HIPDB Guidebook will govern.

HealthLink Credentialing Program Standards

I. Eligibility Criteria
Health Care practitioners

Initial applicants must meet the following criteria in order to be considered for participation:

A. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals;

B. Possess a current, valid, and unrestricted Drug Enforcement Agency ("DEA") and/or Controlled Dangerous Substances ("CDS") registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals; the DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS for each state; and

C. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

D. For MDs, DOs, DPMs and oral & maxillofacial surgeons, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties ("ABMS"), American Osteopathic Association ("AOA"), Royal College of Physicians and Surgeons of Canada ("RCPSC"), College of Family Physicians of Canada ("CFPC"), American Board of Podiatric Surgery ("ABPS"), American Board of Podiatric Orthopedics and Primary Podiatric Medicine ("ABPOPPM") or American Board of Oral and Maxillofacial Surgery ("ABOMS")) in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement.

   1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:

      a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC or CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten consecutive years of clinical practice. OR

      b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR

      c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in HealthLink Network AND the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

   2. Practitioners meeting one of these three alternative criteria (a, b, c) will be viewed as meeting all HealthLink education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to HealthLink review and approval. Reports submitted by delegate to HealthLink must contain

sufficient documentation to support the above alternatives, as determined by HealthLink.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission ("TJC"), National Integrated Accreditation for Healthcare Organizations ("NIAHO") or an AOA accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network/Participating Provider to provide inpatient care.

II. Criteria for Selecting Practitioners
New Applicants (Credentialing)

A. Submission of a complete application and required attachments that must not contain intentional misrepresentations;

B. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;

C. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;

D. No evidence of potential material omission(s) on application;

E. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;

F. No current license action;

G. No history of licensing board action in any state;

H. No current federal sanction and no history of federal sanctions (per OIG and OPM report nor on NPDB report);

I. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS for each applicable state.

J. Initial applicants who have NO DEA/CDS certificate will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he has applied for a DEA the credentialing process may proceed if all of the following are met:

    1. It can be verified that this application is pending.

    2. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained.

    3. The applicant agrees to notify HealthLink upon receipt of the required DEA.

    4. HealthLink will verify the appropriate DEA/CDS via standard sources.

    5. The applicant agrees that failure to provide the appropriate DEA within a ninety (90) day timeframe will result in termination from the Network.

K. Initial applicants who possess a DEA certificate in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain the additional DEA. If the applicant has applied for additional DEA the credentialing process may proceed if ALL the following criteria are met:

    1. It can be verified that this application is pending and,

    2. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained,

    3. The applicant agrees to notify HealthLink upon receipt of the required DEA,

    4. HealthLink will verify the appropriate DEA/CDS via standard sources; applicant agrees that failure to provide the appropriate DEA within a ninety (90) calendar day timeframe will result in termination from the Network, AND

    5. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

L. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;

M. No history of or current use of illegal drugs or history of or current alcoholism;

N. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

O. No gap in work history greater than six months in the past five years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty four (6 – 24) months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two years.

P. No history of criminal/felony convictions or a plea of no contest;

Q. A minimum of the past ten years of malpractice case history is reviewed.

R. Meets Credentialing Standards for education/training for specialty/specialties in which practitioner wants to be listed in a HealthLink Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs and oral & maxillofacial surgeons;

S. No involuntary terminations from an HMO or PPO;

T. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:

1. Investment or business interest in ancillary services, equipment or supplies;

2. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;

3. Voluntary surrender of state license related to relocation or nonuse of said license;

4. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.

5. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);

6. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window.

7. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;

8. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner's name and specialty.

III. Currently Participating Applicants (Recredentialing)

A. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;

B. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;

C. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;

D. No evidence of potential material omission(s) on re-credentialing application;

E. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;

F. *No current license probation;

G. *License is unencumbered;

H. No new history of licensing board reprimand since prior credentialing review;

I. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per OIG and OPM Reports or on NPDB report);

J. Current DEA, CDS Certificate and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;

K. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network/Participating Provider of similar specialty at a Network hospital who provides inpatient care to Covered Individuals needing hospitalization;

L. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;

M. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;

N. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;

O. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.

P. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;

Q. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:

1. Investment or business interest in ancillary services, equipment or supplies;

2. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;

3. Voluntary surrender of state license related to relocation or nonuse of said license;

4. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;

5. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);

6. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window;

7. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;

8. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

R. No QI data or other performance data including complaints above the set threshold.

S. Recredentialed at least every three years to assess the practitioner's continued compliance with HealthLink standards.

*It is expected that these findings will be discovered for currently credentialed Providers and Facilities through ongoing sanction monitoring. Providers and Facilities with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Provider or Facility that does not meet one or more of the criteria for recredentialing.

IV. Additional Participation Criteria and Exceptions for Behavioral Health Practitioners (Non Physician) Credentialing.

A. Licensed Clinical Social Workers (LCSW) or other master level social work license type:

1. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).

2. Program must have been accredited within three years of the time the practitioner graduated.

3. Full accreditation is required, candidacy programs will not be considered.

4. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the APA or be regionally accredited by the Council for Higher Education ("CHEA"). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

B. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:

1. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.

2. Master or doctoral degrees in divinity do not meet criteria as a related field of study.

3. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs ("CACREP"), or Commission on Accreditation for Marriage and Family Therapy Education ("COAMFTE") listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.

4. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

C. Clinical nurse specialist/psychiatric and mental health nurse practitioner:

1. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of the time of the practitioner's graduation.

2. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.

3. Certification by the American Nurses Association ("ANA") in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner or Family Psychiatric and Mental Health Nurse Practitioner.

4. Valid, current, unrestricted DEA Certificate, where applicable with appropriate supervision/consultation by a Provider as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate if required. The DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals.

D. Clinical Psychologists:

1. Valid state clinical psychologist license.

2. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner's graduation.

3. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.

4. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

E. Clinical Neuropsychologist:

1. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology ("ABPN") or American Board of Clinical Neuropsychology ("ABCN").

2. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.

3. Clinical neuropsychologists who are neither board-certified nor listed in the National Register will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:

   a. Transcript of applicable pre-doctoral training OR

   b. Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate) OR

   c. Letters from supervisors in clinical neuropsychology (including number of hours per week) OR

   d. Minimum of five years' experience practicing neuropsychology at least ten hours per week

V. Health Delivery Organization (HDO) Eligibility Criteria

All Health Delivery Organizations must be accredited by an appropriate, recognized

accrediting body or in the absence of such accreditation; HealthLink may evaluate the most recent site survey by Medicare or the appropriate state oversight agency. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual access need only when the CC review indicates compliance with HealthLink standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO's continued compliance with HealthLink standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Covered Individuals. The license must be in good standing with no sanctions.

2. Valid and current Medicare certification.

3. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

4. Liability insurance acceptable to HealthLink.

5. If not appropriately accredited, HDO must submit a copy of its CMS or state site survey for review by the CC to determine if HealthLink's quality and certification criteria standards have been met.

B. Additional Participation Criteria for Health Delivery Organizations by Provider Type:

Medical Facilities

1. Acute Care Hospital

   a. Must be accredited by the TJC,HFAP or NIAHO;

2. Ambulatory Surgical Centers

   a. Must be accredited by the TJC,HFAP, AAPSF, AAAHC, AAAASF or IMQ;

3. Free Standing Cardiac Catheterization Facilities

   a. Must be accredited by the TJC or HFAP (may be covered under parent institution);

4. Lithotripsy Centers (Kidney stones)

   a. Must be accredited by the TJC;

5. Home Health Care Agencies

   a. Must be accredited by the TJC, CHAP or ACHC;

6. Skilled Nursing Facilities

   a. Must be accredited by the TJC or CARF;

7. Nursing Homes

   a. Must be accredited by the TJC;

8. Behavioral Health Facilities

   a. The following behavioral health facilities must be accredited by the TJC, HFAP, NIAHO or CARF as indicated:

      i. Acute Care Hospital – Psychiatric Disorders; TJC, HFAP or NIAHO;

      ii. Residential Care – Psychiatric Disorders; TJC, HFAP, NIAHO or CARF;

      iii. Partial Hospitalization/Day Treatment – Psychiatric Disorders; TJC, HFAP, NIAHO or CARF for programs associated with an acute care facility or Residential Treatment Facilities;

      iv. Intensive Structured Outpatient Program – Psychiatric Disorders; TJC, HFAP or NIAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents; CARF if program is a residential treatment center providing psychiatric services;

      v. Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation; TJC, HFAP or NIAHO;

      vi. Acute Inpatient Hospital – Detoxification Only Facilities; TJC, HFAP or NIAHO;

      vii. Residential Care – Chemical Dependency; TJC, HFAP, NIAHO or CARF;

      viii. Partial Hospitalization/Day Treatment – Chemical Dependency;

TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents;

ix. Intensive Structured Outpatient Program – Chemical Dependency; TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.

Provider Record Updates

All providers are responsible for notifying HealthLink with any of the following changes:

- Ownership Changes
- Name Change
- Business Address
- Hospital Staff Association
- Federal EIN/TIN
- National Provider Identifier (NPI)

Physicians, hospitals and other health care professionals can submit the above listed changes:

- On-line at *ProviderInfoSource.HealthLink.com*
- Fax to 314-925-6627, Attention: Network Representative
- Contact your Network Consultant

Coordination of Benefits

HealthLink does not direct how coordination of benefits is performed. Coordination of benefits may vary and procedures are specified in the Payor health plan document. To verify which health plan is primary when a patient has two or more health plans, the physician should contact the claims administrator listed on the enrollee's ID card.

Physician Availability and Accessibility

Ongoing Availability

Primary care physicians (i.e., specialties of Family Practice, General Medicine, Internal Medicine and Pediatrics) participating in the HealthLink network agree to be available or to arrange for medical coverage/consultation to patients enrolled in a HealthLink program 24 hours a day, seven days a week for consultation on medical concerns.

Availability of Services
Participating physicians and hospitals cooperate with HealthLink in working toward timeliness in performing medical services and mental health treatment. HealthLink's guidelines for physician appointments are as follows:

TYPE OF CARE	GUIDELINE
Emergency	Within four hours on the basis of medical need
Urgent	Within 24 hours on the basis of medical need
Routine Care with Symptoms	Within one week on the basis of medical need
TYPE OF CARE	GUIDELINE
Baseline Physical Exams	Within 30 days
Well Child Care (< age one)	Within three weeks
Well Child Care (> age one)	Within six weeks
Prenatal Care First Trimester Second Trimester Third Trimester High Risk Pregnancy	 Within one week Within one week Within three days Within three days or immediately for emergency care
Wait Time in Physician Office Scheduled Unscheduled (worked in)	 Within 30 minutes in waiting room; 15 minutes in exam room Within 60 minutes in waiting room or exam room
Telephone Response After Hours Emergency Urgent Non-Urgent	 Within 30 minutes Immediate Within one hour Same day

Covering Physicians
All participating physicians are required to make arrangements for coverage in their absence, and must disclose this information to patients by telephone or answering service. HealthLink urges physicians to use HealthLink participating physicians for coverage, since patient benefits are typically reduced if patients utilize non-participating practitioners.

Behavioral Health Treatment
Participating behavioral health inpatient facilities are available for individuals who are in acute distress and require the close observation that is only available in an acute inpatient psychiatric setting. Participating behavioral health outpatient providers are available for individuals who can be safely and effectively treated in an office or outpatient hospital setting.

Patient Selection and Transfer of Care

Acceptance of Enrollees as New Patients

A physician must accept a reasonable number of enrollees of health plans accessing HealthLink's programs, as mutually agreeable at the time the physician applies for participation in HealthLink programs, and as notified thereafter. If a primary care physician participating in HealthLink programs is no longer able to accept new enrollees from health plans accessing the HealthLink network programs, the primary care physician must provide written notice to HealthLink 30 days in advance of the effective date so that HealthLink can update its records for health plan enrollees and applicants seeking physician selection. The intent of this provision is to accommodate the participating physician's practice needs and to accurately reflect availability of care within HealthLink's networks.

Physician and Enrollee Transfer Requests

Participating physicians, hospitals and other health care professionals in HealthLink programs should notify HealthLink of a request for the transfer of patient care to another physician. Health plan enrollees electing to transfer from one primary care physician to another may notify HealthLink Customer Service by phone or in writing. The change of physician will be effective on the first day of the month following such notice.

Referrals and Other Requirements

Providers shall admit or arrange for the admission of patients at Participating Hospitals and shall refer patients in need of specialty, ancillary and other health care services to Participating Providers, except in cases of medical emergency.

Confidentiality of Patient Information

Federal and state law as well as generally accepted medical practice standards require that contracted physicians must maintain a medical record for each patient accessing HealthLink's networks and programs. The physician and physician's employees must treat the medical records of enrollees as confidential and comply with all federal and state confidentiality laws. The following is a link to access more information regarding the standard HIPAA-Business Associate guidelines.

HealthLink HIPAA – Business Associate Guidelines

Enrollee Records Inspection

Contracted physicians, hospitals and other health care professionals must document all services provided to health plan enrollees accessing HealthLink's networks and programs. Upon the request of any federal or state governmental agency that has jurisdiction or authority over HealthLink, physicians must permit inspection of the books, records and information regarding the provision of health care services to health plan enrollees. In addition, physicians must comply with requests from HealthLink or its affiliated Payors to provide information contained within the medical record for purposes

related to health care operations and benefit consideration. HealthLink will make reasonable efforts to secure this information. Physicians participating in HealthLink's networks and programs agree to supply necessary information at no copying costs to HealthLink, its affiliated Payors or patients.

HealthLink Network Programs and Services

HealthLink Network Programs and Services Overview

HealthLink Program	Network included in HealthLink Program: HMO Tier I	PPO Tier II	Workers' Compensation	Out-of-Network*
PPO		♦		♦
Workers' Compensation			♦	
Open Access I (OA I)	♦			
Open Access II (OA II)	♦			♦
Open Access III (OA III)	♦	♦		♦

* Please note out-of-network coverage is provided in accordance with the payor's health plan.

HealthLink PPO Network Program

HealthLink provides network access to approximately 200 payors who administer benefits on behalf of contracted HealthLink clients. These clients include:

- Contracted Insurance Carriers
- Self-Funded, Self-Administered Clients
- Third Party Administrators

HealthLink PPO is a non-gatekeeper plan, and certain employer groups may require precertification (please refer to the enrollee's ID card). HealthLink prices PPO claims per the contract and sends the claim along with the pricing to the specified claims administrator for claim adjudication benefit determination and payment for covered services. To verify eligibility, benefit or claims payment information, please contact the health plan benefit administrator identified on the enrollee's ID card.

HealthLink Open Access Network Programs

HealthLink Open Access is a non-gatekeeper plan, and certain employer groups may require precertification (please refer to the enrollee's ID card). Enrollees may self-refer to physicians, hospitals and other health care professionals.

Open Access I (OAI) is a single-tier program: This program has one level of benefit. Enrollees may self-refer to HealthLink HMO providers only. There are no PPO or out-of-network benefits. Only HealthLink HMO contracted physicians, hospitals and other health care professionals participate in the OAI network program.

Open Access II (OAII) is a two-tier program: This program has two levels of benefits. The highest level of benefit is available to enrollees who self-refer to HealthLink HMO participating providers. A second, lower level of benefit is available to enrollees who

self-refer to out-of-network providers. Only HealthLink HMO contracted physicians, hospitals and other health care professionals participate in the OAII network program.

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

If you are contracted as both an HMO and PPO provider, the enrollee's highest level of benefits will be applied at Tier I, which would be your HMO agreement.

HealthLink AWC+ Network Program

AWC+ is a certified Workers' Compensation PPO network program, licensed or registered in the states in which it conducts business. More than two million employees are enrolled in Workers' Compensation plans that access the AWC+ networks. The AWC+ service area includes portions of Missouri, Illinois, Arkansas, Iowa and Indiana. AWC+ objective is to assist employers in managing the financial risk associated with work-related illness and injury by providing access to participating health care professionals, physicians and facilities.

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Contact Us

Phone Numbers and Hours of Operation

Department	Phone Number	Hours of Operation
Customer Service	800-624-2356	8 a.m. to 5 p.m. business days CST
Claims Interactive Voice Response (IVR)	877-660-2472	5 a.m. to 12 a.m. 7 days a week CST
Utilization Management	877-284-0102 phone 800-510-2162 fax	8 a.m. to 5 p.m. business days CST
Utilization Management Interactive Voice Response (IVR)	877-284-0102, option 8	5 a.m. to 12 a.m. 7 days a week CST

HealthLink Addresses

HealthLink	Grievance & Appeals
1831 Chestnut Street St. Louis, MO 63103	P.O. Box 411424 St. Louis, MO 63141
Claims	
PPO/Open Access P.O. Box 419104 St. Louis, MO 63141	**State of Illinois Open Access** P.O. Box 411580 St. Louis, MO 63141
Electronic Payor ID: 90001	**Electronic Payor ID:** 96475

Administrative Manual

HealthLink Member ID Cards & Office Co-payments

Chapter 5

1831 Chestnut Street • St. Louis, MO 63103-2225
www.healthlink.com • 1-877-284-0101

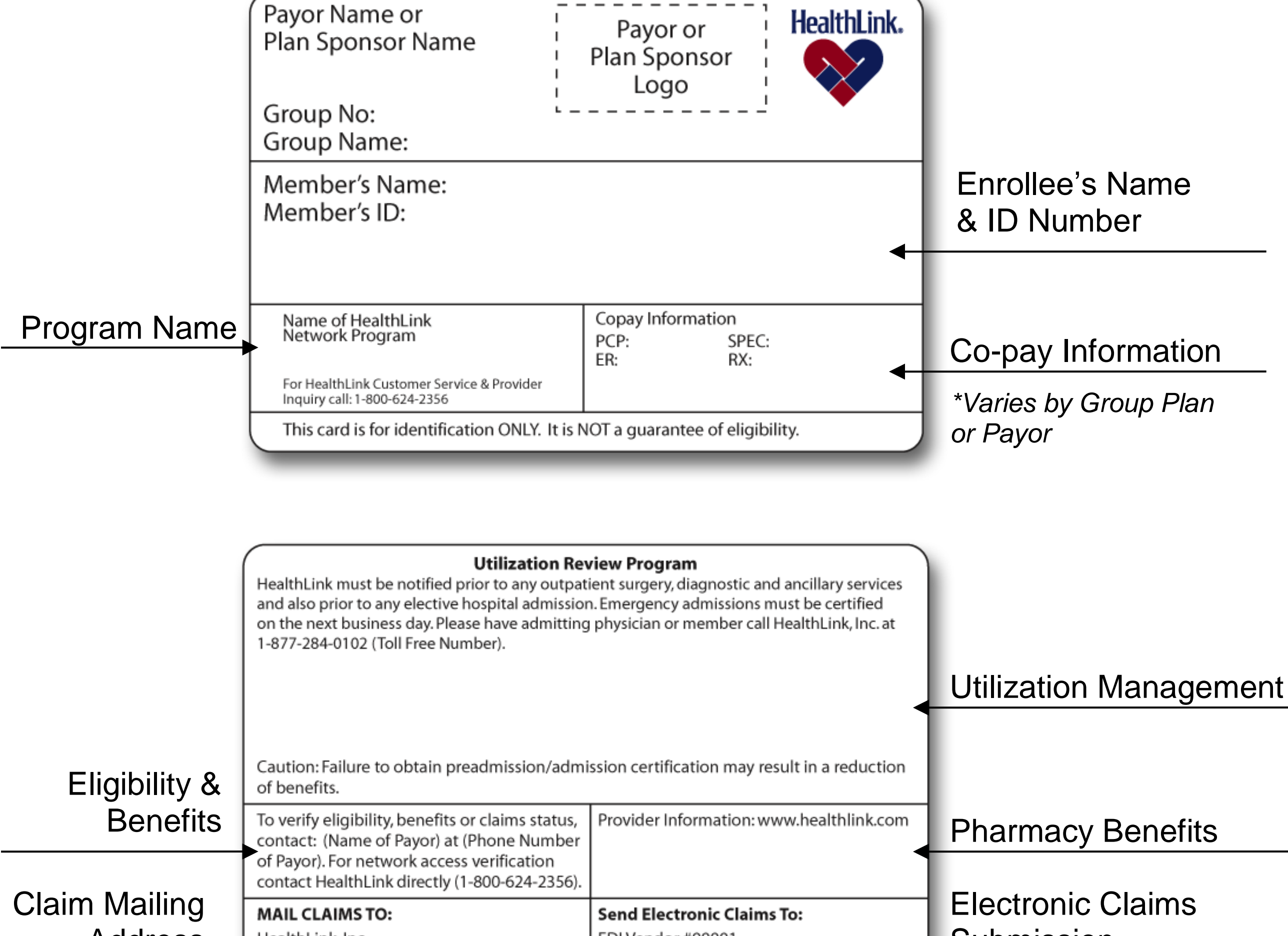
HealthLink Member ID Cards and Office Co-payments

HealthLink ID Card Requirements

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, OAI, etc.)
- Toll-Free Number for Benefit Verification and Eligibility Information
- Subscriber Name
- Subscriber ID Number
- Group Name
- Group Identification Number
- Utilization Management Toll-Free Number
- Customer Service Nationwide Numbers
- Claims Filing Address
- Disclaimer

If an enrollee 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 Co-payment

The office visit co-payment varies by payor health plan. Typically, a specific dollar amount co-payment is indicated on the patient's enrollee ID card if the health plan coverage includes a flat co-payment. Collect this co-payment at the time of service. If the health plan has a co-insurance percentage and/or deductible, the amount payable by the patient may vary as benefits are used during the health plan benefit year. Co-insurance and deductibles usually are not printed on the patient's enrollee ID card.

File your claim as directed on the patient's enrollee ID card. The Explanation of Benefits will advise you and your patient of the expense paid by the health plan and the amount payable by the patient, if any. Practices are responsible for collecting any monies due from patients.

Explanation of Benefits (EOBs)

Explanation of Benefits forms (EOBs) are sent by payors to both enrollees and providers. These EOBs provide necessary information about claim payment and patient responsibility amounts. Patient responsibility amounts are needed for accurate patient balance billing. EOBs are reviewed by HealthLink upon payor implementation and compliance is checked periodically thereafter.

Both enrollee and provider EOBs shall include the following elements:

- Name and address of payor*
- Toll-free number of payor*
- Subscriber's name/address*
- Subscriber's ID number*
- Patient name*
- Provider name*
- Provider tax identification number (TIN)*
- Provider participation status (e.g. PPO, OAII)
- Claim date of service*
- Type of service
- Total billed charges*, allowed amount* and discount amount
- Excluded charges
- Explanation of excluded charges (code and associated key)
- Amount applied to deductible
- Co-payment/co-insurance amount
- Total patient 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*

UniCare Providers seeing HealthLink Members
Since UniCare is a HealthLink affiliate, UniCare providers should recognize the HealthLink logo and identification card in the same manner as the former UniCare logo.

HealthLink will continue to reprice claims in accordance with your UniCare Provider Agreement.

All Explanations of Benefits (EOB) will come from HealthLink. The EOBs will clearly indicate the UniCare contract allowed amount as the “HealthLink (HLK) Allowed Amount” so that your staff can readily identify the UniCare contract as the source for applicable discounts.

Claim Processing Guidelines

Claims Filing Process

For optimum claim processing and payment:

- File claims within 30 days following the date of service or hospital discharge date.
- Complete standard claim forms utilizing current CPT-4/HCPC and Revenue Code guidelines.
- Submit claims electronically through your local vendor or submit paper claims to the appropriate address located on the back of the enrollee's ID card.
- HealthLink prices the claim based upon contractual allowances.
- The Payor determines benefits and eligibility, and then issues a remittance advice report to the participating physician, hospital or health care professional.

HealthLink encourages hospitals and health care professionals to submit electronic claims. Except workers' compensation claims, all claims can be sent electronically to HealthLink resulting in cost efficiencies and faster processing.

To begin sending claims to HealthLink:	
HealthLink P.O. Box 419104 St. Louis, MO 63141	Electronic Payor ID number: 90001

To avoid payments delays, verify the correction Electronic Payor ID numbers and claims addresses.

Exception: State of Illinois claims should be sent to:	
HealthLink P.O. Box 411580 St. Louis, MO 63141	Electronic Payor ID number: 96475

While electronic claim submission is by far the more efficient procedure, HealthLink understands that some providers find it necessary to submit paper claims. Please note the following information to help streamline the process of paper claim submission.

When the scanned data on a paper claim cannot be read by the Optical Character Recognition (OCR) software, the claim has to be handled through a manual process. The transition to the manual process can extend the claim processing time by 150%.

To ensure your claims are handled in the most efficient way possible, please follow these simple steps:

- Submit your paper claim on standard claim forms utilizing current CPT-4/HCPC and Revenue Code guidelines.

- Be sure your toner or ink cartridge is fresh. Use the Claim Print Guide (shown below) to check the shade of the print on the form.
- Check the placement of data on the claim form. Data should print within the fields, not outside the lines.
- Laser and ink jet printers work. The OCR software can misread these characters, causing errors in the electronic data. Handwritten claim data or notes should be avoided as they will cause the claim to be handled manually.

Claim Print Guide

Ideal	Acceptable	Illegible
John Doe	John Doe	John Doe
John Doe	**John Doe**	John Doe

Claim Information

To facilitate prompt processing, please include the following information on the standard claim forms:

Place of Service Codes:

1. Pharmacy
3. School
4. Homeless shelter
5. Indian Health Service – freestanding facility
6. Indian Health Service – provider-based facility
7. Tribal 638 – freestanding facility
8. Tribal 638 – provider-based facility
9. Prison/correctional facility
11. Office
12. Home
13. Assisted living facility
14. Group home
15. Mobile unit
16. Temporary lodging
17. Walk-in retail health clinic
18. Place of employment-worksite
19. Off Campus – Outpatient Hospital
20. Urgent care facility
21. Inpatient hospital
22. On Campus – Outpatient hospital
23. Emergency room – hospital
24. Ambulatory surgical center
25. Birthing center
26. Military treatment facility
31. Skilled nursing facility
32. Nursing facility
33. Custodial care facility
34. Hospice
41. Ambulance – land
42. Ambulance – air or water
49. Independent clinic
50. Federally qualified health center
51. Inpatient psychiatric facility
52. Psychiatric facility – partial hospitalization
53. Community mental health center
54. Intermediate care facility/mentally retarded
55. Residential substance abuse treatment facility
56. Psychiatric residential treatment center
57. Non-residential substance abuse treatment facility
60. Mass immunization center
61. Comprehensive inpatient rehabilitation facility
62. Comprehensive outpatient rehabilitation facility

65. End-stage renal disease treatment facility
71. Public health clinic
72. Rural health clinic
81. Independent laboratory
99. Other place of service

*** Unassigned Codes 2, 10, 27-30, 35-40, 43-48, 58, 59, 63, 64, 66-70, 73-80, 82-98**

Claims Processing Guidelines

HealthLink reprices all claims for contracted payors. All repricing and payor adjudication is in accordance with the Provider Agreements. Payors may be insurance companies or other groups such as self-insured employers, trusts, or governments. Usually, benefits for medical services or supplies that are payable under the terms of a benefit plan are paid directly by the payor. For some payors, HealthLink acting as TPA may make benefit recommendations and payments on behalf of the payor using payor funds.

The administrator of the benefit plan retains 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 and limitations, and to applicable state and/or federal law. Medical claim guidelines neither constitute plan authorization, nor an explanation or guarantee of benefits.

Medical claim pricing and processing services provided by HealthLink are available to a payor. Not all payors purchase such services for the benefit plans they sponsor. For payors who have purchased such services, however, HealthLink processes claims based on its contracts using a proprietary software product licensed from a vendor, *McKesson Claim Check*. The claims processing logic is annually reviewed and updated by McKesson. HealthLink has the ability to customize portions of the Claim Check software and utilize various resources in making customization determinations. These include the National Correct Coding Initiative (NCCI), Medicare guidelines, and physician specialty societies.

HealthLink developed a guide to medical claim pricing for your reference including:

- HealthLink Significant Edits
  - Multiple Surgery Guidelines
  - Modifier Recognition and Reimbursement Methodology
  - Customized Claims Edits

Claim Edits and Modifier Use

An edit that is based on experience with submitted claims will cause, on initial review of submitted claims, the denial or reduction in payment for a particular CPT® code or HCPCS Level II code more than two-hundred and fifty (250) times per year.

When multiple modifiers that apply a percentage amount to the maximum allowance are reported with a procedure, our claims system will multiply the percentage amounts

together to determine a new percentage amount. When the new percentage amount contains a decimal place our claims system will round the new percentage amount up to the next whole percentage and apply this whole percentage amount to the maximum allowance for the procedure the modifiers are reported with.

- For example, modifier 78 (unplanned return to the operating/procedure room) applies a percentage of 70% and modifier 62 (two surgeons) applies a percentage of 63%. When both modifier 78 and 62 are reported on a single procedure, the claims system will multiply 70% x 63% for a new percentage amount of 44.1%. Because the new percentage amount contains a decimal place, the new percentage amount will be rounded up to 45% and applied to the [maximum allowance]. Note: modifier 50 is not part of these calculations and is handled as bilateral only.

Age edit: Age edits occur when the provider assigns an age-specific procedure or diagnosis code to a patient whose age is outside the designated age range.

Allergy: When billing for allergy tests or injections, use the appropriate CPT or HCPCS Codes to indicate the type performed. In the description, identify the number of tests or injections. If billing for multiple dates of service on a single claim form, indicate each date of service, CPT, HCPCS Code and itemized charge on a separate line.

Anesthesia: Should be billed using the anesthesia procedural codes published by the American Medical Association (AMA) in the current edition of CPT as adapted from the American Society of Anesthesiologists (ASA) guidelines:

- Primary anesthesia procedural code – CPT (service descriptor)
- Additional ASA or CPT Codes (e.g., post-operative pain management, arterial catheter, etc.)
- Physical status P3, P4, P5
- Time in minutes (or hours and minutes)
- Charge by service
- Total billed charge

Anesthesia (Modifiers AD, P3, P4, P5, P6, QK, QX, QY)
All anesthesia services are reported by use of the five-digit anesthesia procedure code with the appropriate physical status modifier appended.

- AD – medical supervision by a physician: more than four concurrent anesthesia procedures; 50% of the allowable for the procedure.
- P3 – patient with severe systemic disease; 1 additional unit;
- P4 – patient with severe systemic disease that is life threatening; 2 additional units;
- P5 – a moribund patient who is not expected to survived without the operation; 3 additional units;
- P6 – brain dead patient for organ donation; No additional units.
- QK – medical direct of two, three, or four concurrent anesthesia procedures involving qualified individuals; 50% of the allowable for the procedure.

- QX – CRNA service: with medical direction by a physician; 50% of the allowable for the procedure.
- QY – medical direction of one CRNA by an anesthesiologist; 50% of the allowable for the procedure.

Assistant Surgeons (Modifiers 80, 81, or 82)
Assistant Surgeon recommendations follow the guidelines of CMS and the American College of Surgeons.

- 16% of the allowable for the procedure.
- Assistant surgeons are also subject to multiple surgery reductions.

Assistant Surgeons (Modifier AS)
Assistant Surgeon recommendations follow the guidelines of CMS and the American College of Surgeons.

- 14% of the allowable for the procedure.
- Assistant surgeons are also subject to multiple surgery reductions.

Bilateral Surgical Procedures (Modifier 50)
A bilateral surgery that uses a unilateral code should be reported on a single line with modifier 50, using one unit of service. This line item will be considered as one surgery however will be eligible for reimbursement equal to 150% of the amount applicable to the unilateral code on the date of service.

When a bilateral surgery that uses a unilateral code is reported with other surgical procedures, we will increase the RVU for the applicable unilateral code by 150%. HealthLink will then apply our multiple surgical rules 50%. If bilateral surgery using a unilateral code is not reported on a single line with modifier 50 and one unit, the claims system will treat the following coding scenarios as bilateral:

- A single line, no modifier 50, quantity = 2— HealthLink will apply the policy described above related to bilateral surgeries that use a unilateral code.
- When two claim lines are reported with the same procedure code and one line is reported with modifier 50 and the second line is unmodified, HealthLink will apply the policy described above related to bilateral surgeries that use a unilateral code on the line with modifier 50.
- When two claim lines are reported with the same procedure code and both lines are reported with modifier 50, HealthLink will apply the policy described above related to bilateral surgeries that use a unilateral code on the line with modifier 50 and apply any bilateral or multiple surgery reductions for additional procedures.

When a surgical procedure code contains the terminology “bilateral” or “unilateral or bilateral”, modifier 50 should not be used since the description of the code defines it as a bilateral procedure.

Decision for Surgery (Modifier 57)
An Evaluation and Management (E&M) Service resulting in the initial decision to perform surgery. No additional payment, but use of this modifier will cause an E&M to be allowed when submitted with a procedure code.

Dental: HealthLink requires dental ADA codes & diagnosis codes for all dental/medical service.

Discontinued Procedures (Modifier 53)
Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure.

- 50% of the allowable for the procedure.

Distinct Procedural Service (Modifier 59)
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E&M services performed on the same day.

- 100% of the allowable for the procedure.

Gender Specific: Sex or gender specific edits occur when the providers assigns a gender-specific procedure or diagnosis code to a patient of the opposite sex.

Global Surgery: The global surgery package concept for the reimbursement of surgical services is utilized in the processing of claims related to the surgical service. The global surgical package applies to all surgical procedures. The RBRVS fee schedule from CMS is the source used to determine the pre and postoperative periods associated with each surgical procedure. Services included in the surgical allowance include but are not limited to the pre-operative visits after the decision for surgery, intra-operative services, follow-up visits, anesthesia by the surgeon and other services during the post-operative period.

HealthLink Customized Edits
Custom claim edits differ from the standard claims editing software used by HealthLink. At this time, HealthLink does not have any customized edits.

Incidental: An incidental procedure is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

Increased Procedural Services (Modifier 22)
When the work required to provide a service is substantially greater than typically required.

- 120% of the allowable for the procedure.
- Increased Procedural Services are subject to multiple surgery reductions.

Modifier Use: Certain modifiers are only valid for specific codes (i.e. modifier 25 and 57 are only valid with E&M services, modifier 26 is not valid for surgical procedures as they are inherently professional in nature). As of the date of publication of this manual, HealthLink includes a special coding update section in the HealthLink Provider newsletter, *In Touch.*

Multiple Procedures (Modifier 51)
Multiple procedures performed at the same session by the same provider. Some procedures are exempt from modifier 51 and are listed in CPT guidelines. These guidelines do not apply to modifier 51 exempt procedures or to add-on codes; appropriate reductions are taken regardless if modifier 51 is billed or not.

- 100% of the allowable (or the lesser of the actual charge) for the procedure with the highest allowable. The procedure with the highest allowed amount is considered by HealthLink to be the primary procedure.
- 50% of the allowable (or the lesser of the actual charge) for any additional surgical procedure.

Multiple Surgery Guidelines: Multi-surgery pricing is applied when there are two (2) or greater surgical codes submitted on a claim. The allowed amount (herein referred to as the "allowed amount" or "allowable") is based upon the lesser of either the contracted allowed amount or the physician's actual billed charge. When multiple procedures are involved, the procedure with the highest allowable is considered to be the primary procedure by HealthLink, unless that procedure is an add-on code or modifier 51 exempt. These guidelines only apply to physician services submitted on the current standard professional claim form, as there are different pricing rules that apply to facility claims when contracted for Ambulatory Surgical Center (ASC) groupers and these will not be addressed in this document.

Mutually Exclusive: Mutually exclusive procedures are two or more procedures usually not performed during the same patient encounter on the same date of service.

Postoperative Management Only (Modifier 55)
When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure.

- 20% of the allowable for the service.

Preoperative Management Only (Modifier 56)
When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure.

- 10% of the allowable for the service.

Procedure Performed on Infants less than 4kg (Modifier 63)
Procedures performed on neonates and infants up to a present body weight of 4kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients.

- 120% of the allowable for the procedure.

Professional Component (Modifier 26)
Certain procedures are a combination of a physical or other qualified health care professional component and a technical component.

- Professional fee allowance

Psychiatry: When billing for individual or group therapy, include the duration of time in the descriptions.

Reduced Services (Modifier 52)
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional.

- 50% of the allowable for the procedure.

Significant, Separately Identifiable Service (Modifier 25)
Significant, Separately Identifiable Evaluation and Management (E&M) Service by the same provider or other qualified health care professional on the same day of the procedure or other service. No additional payment, but use of this modifier will cause an E&M to be allowed when submitted with a procedure code.

Surgical Care Only (Modifier 54)
When one physician or other qualified health care professional performs a surgical procedure and other provides preoperative and/or postoperative management.

- 70% of the allowable for the procedure.

Two Surgeons (Modifier 62)
Two (2) surgeons work together performing distinct part(s) of a procedure.

- 63% of the allowable for the procedure.
- Reduction applies only to the common procedure billed by both surgeons.
- In the absence of a common procedure, the reduction is taken on each surgeon's primary procedure.
- Both surgeons are also subject to multiple surgery reductions.

Unbundling: Procedure unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a provider. In this instance, the two codes may be replaced with the more appropriate code by our bundling system.

Unlisted codes: When performing services that do not have a code assigned, be prepared to supply supporting documentation for the service. This may be in the form of operative reports, office notes, radiology reports, etc. If a service is defined by a Category III code as listed in CPT, then use the Category III code instead of an unlisted code.

Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedures for a Related Procedure During the Postoperative Period (Modifier 78)

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedures.

- 70% of the allowable for the procedure.

Venipuncture/Specimen Collection: Drawing blood, specimen collection or conveyance of the specimen is considered to be integral to the performance of a laboratory test, and is not allowed separately.

Preventable Adverse Events

Acute Care General Hospitals

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 HealthLink, a Payor **or** the Member for such events. If acute care general hospital receives any payment from HealthLink, a Payor 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 hospital shall cooperate with HealthLink, to the extent reasonable, in any 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
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.
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.
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 POA indicators (as defined by CMS) must be populated on all inpatient acute care hospital claims.

When a HAC does occur, all inpatient acute care hospitals 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 HealthLink for payment by Payor. In no event shall the charges or days associated with the HAC be billed to HealthLink, a Payor, or the Member.

Participating Provider (excluding 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 Participating Provider shall neither bill, nor seek to collect from, nor accept any payment from HealthLink, a Payor **or** the Member for such events. If Participating Provider receives any payment from HealthLink, a Payor or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Participating Provider shall cooperate with HealthLink, to the extent reasonable, in any 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, Participating Provider 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
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.
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.
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.

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.

Reimbursement/Overpayment Process

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

Refund per Written Request from a Claims Administrator or Health Carrier Accessing the HealthLink Network:
A claims administrator (other than HealthLink) or health carrier may send a letter of explanation and request for return of amounts due to an overpayment. In this event, please send the check or money order along with the patient's name, enrollee identification number, and/or claim number to the claims administrator or health carrier who has requested the information. Do not remit payment to HealthLink because HealthLink is not the claims administrator and does not administer the health plan's benefits or claim payments.

Refund per Written Request from HealthLink:
In the event that HealthLink is the claims administrator and an overpayment has been made to a participating HealthLink physician, hospital or health care professional, HealthLink will deduct the amount from future remittances until the overpayment is reconciled for the health plan.

When this situation arises, it is typically the result of interim billing processes for extended inpatient care. The specific claim and claim information appears on the adjustment code remark on the provider's HealthLink remittance advice.

Discovery of overpayments or questions regarding an offset or recoupment balance may be addressed by calling HealthLink Customer Service at 800-624-2356.

Reimbursement/Underpayment and Verification Process

General Inquiries:
For general inquiries about claims payment and benefit determinations, physicians, hospitals and other health care professionals should contact the plan administrator identified on the remittance advice or explanation of benefits accompanying the payment. The plan administrator can answer questions about applicable coinsurance and deductible amounts, or other service charges that may be the individual's responsibility. The plan administrator's name and telephone number typically appears

on the remittance advice. Also, HealthLink can provide health care providers with the name and telephone number of the plan administrator.

For questions about the HealthLink contract amount, participating providers should contact HealthLink. There are three resources to assist in confirming the HealthLink contract amount:

1. HealthLink Network Service Consultant who works with the practice or facility;

2. HealthLink Customer Call Center Representatives: 1-800-624-2356; or,

3. If the question is specific to a particular claim, access HealthLink ProviderInfoSource: https://providerinfosource.healthlink.com.

If HealthLink determines that a pricing error has occurred in relationship to an underpayment, HealthLink's Customer Service or Network Service staff will forward the claim(s) for adjustment and send the adjustment to the applicable payor with notice of the corrected HealthLink allowed amount. If the service or procedure was priced according to the contract amount, HealthLink's Customer Service or Network Service staff member will confirm this fact and assist the participating provider, as appropriate, with confirming the contract rate with the applicable payor, as appropriate.

Formal Grievance Notice and Review Process:
If a participating provider disputes the finding and believes the claim remains underpaid, he or she may initiate a grievance by sending documentation explaining the nature of the complaint. This request for review of the claim payment and HealthLink contract amount must be filed within 90 calendar days of receipt of payment of the disputed claim or HealthLink contract amount.

Participating providers should:

- Submit a formal written request, or print and complete the form below:
  Participating Provider Request for Review Form
- Include any substantiating documentation that was not previously reviewed;
- Send the document/form to the address noted below:

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

HealthLink will acknowledge receipt of all letters and respond with the resolution or action undertaken to resolve the matter. The resolution letter will follow within 30 calendar days after HealthLink's receipt of the grievance or appeal. As applicable, the payor will be copied on such correspondence and provided necessary information confirming the HealthLink contract amount if a claim adjustment is warranted.

HealthLink offers participating health care providers two levels of internal review. If a participating health care provider remains dissatisfied with the resolution of the issue and 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. The second level review determination is final and binding with respect to the HealthLink contract amount.

Please Note:

- If applicable, contractual provisions that are mutually agreed upon by HealthLink and the participating provider will supersede the processes outlined within these policies.

Workers' Compensation Claims Filing Process

For optimum processing and payment, please submit claims within 60 days following the date of service to the following address or fax:

To submit paper claims send HealthLink claims to the following address:		
Preferred Method: Workers' Compensation Payor (As listed on the Patient Information Card)	*or*	Anthem Workers' Compensation P.O. Box 410980 St. Louis, MO 63141-0980 Fax: (314) 925-6401

The claim filing process is outlined below:

1. Refer to the Workers' Compensation listing of employers covered by this program, and ask the patient for the Patient Information Card that was completed at the time of an injury.

2. Contact the insurance payor/adjuster's office listed on the Patient Information Card to verify eligibility and confirm benefit coverage.

3. Complete standard claim forms utilizing current CPT-4/HCPC and Revenue Code Guidelines. Please include the following information:
   - Employer
   - Patients name and social security number
   - Patients diagnosis or symptoms, using **ICD-9 CM code and/or written description (**ICD10 Procedure and Diagnosis codes will be utilized for Date of Service/Date of Admission/Date of Discharge after mandated compliance date.)
   - 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)
- Tax Identification Number (FEIN) or SSN of the treating physician
- Name, address and signature of the treating physician
- Name of referring physician, if patient was referred for diagnosis or treatment
- Details of accident or occupation-related incident if applicable
- Description and office/operative notes for any "unlisted service"
- A copy of operative notes if any surgical procedure was complicated, requiring more than usual time or care, or the procedure is not currently listed in the Physicians Current Procedural Terminology (CPT-4) text

4. HealthLink reprices claims based on its contracts using coding policies and procedures based on a software product, *McKesson Claim Check*.

5. The claim and repricing worksheets 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. Physicians, facilities and other health care professionals may not balance bill patients in excess of the negotiated discounted fee-for-service amount for services covered by the Workers' Compensation benefit plan.

Claim Status Tools

The following claim status tools are available in the HealthLink Tools/Resources chapter of this Administrative Manual:

- ***ProviderInfoSource®*** enables contracted providers to access secure information about claim status, member eligibility and payor information.
- **Claims Status Research** – if claim problems arise, physicians may submit a representative sample of the problem to their Network Consultant for research.
- **Claims Interactive Voice Response (IVR)** allows convenient access to patient claim information in a secure environment 5:00 am to 12:00 am daily.

Utilization Management

Utilization Management Procedures

For medical necessity pre-certification of inpatient and select outpatient procedures, please call or fax:

HealthLink Utilization Management
Phone: 877-284-0102 Fax: 800-510-2162
Hours: 8:00 am to 5:00 pm CST
Answering Service after 5:00 pm CST

For medical necessity pre-certification, please be prepared to provide the following information:

- Patient Name
- Diagnosis
- Patient ID Number or Social Security Number
- Procedure Required
- Hospital Name
- Date of Admission
- Admitting Physician Name and Tax ID Number

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 standard services requiring pre-certification is located online at https://www.healthlink.com/um.asp.

HealthLink Medical Necessity Certification Process

(For a complete listing of Utilization Management forms see Chapter 10-8)

All certification review is conducted for medical necessity, utilizing clinical criteria specific to the condition or service under review. Clinical criteria review is evaluated at least annually and is subject to approval by the Medical Director and the Advisory Committee. The committee validates current status and appropriateness of criteria. New technologies are reviewed regularly through a medical policy and technology assessment committee.

1. Any case not meeting criteria for the prescribing physician's treatment plan is immediately referred to a HealthLink physician reviewer or the Medical Director for review and appropriate follow-up with the prescribing physician.

2. All notifications of certification and non-certification are issued in compliance with standards for timeliness established by national and state regulatory agencies and accreditation bodies.

3. An adverse certification recommendation is when days or procedures are not certified as medically necessary. If you are notified that our recommendation to the payor is a non-certification, you have the right to reconsideration by HealthLink of any initial adverse certification recommendation, including an appeal process expedited by telephone for ongoing or imminent services under review. An appeal review is provided by licensed clinical peers who were not involved in the initial adverse certification recommendation. If the initial reconsideration upholds the adverse certification recommendation, a further reconsideration or appeal regarding the recommendation should be directed to the health plan claims administrator listed on the enrollee ID card. The appeal process is outlined in the Inquires, Complaints, Grievance & Appeals chapter.

4. Letters of non-certification will include the following information:

    a. The principal reason(s) for the determination

    b. The instructions for initiating an appeal

    c. The instructions for requesting a written statement of the clinical rationale, including the clinical criteria used to make the determination. The physician, facility, patient or patient's representative may request clinical rationale and/or appeal.

Note to admitting physicians, hospitals and outpatient/ancillary care professionals: Noncompliance with Utilization Management protocols may result in the loss of a portion of your reimbursement for services (e.g., a fixed fee or percentage reduction) that may not be recovered from the health plan or patient. Please contact HealthLink, the health plan claims administrator or the Utilization Management firm listed on the health plan enrollee identification card if you have any questions about a patient's Utilization Management requirements (or the effect of noncompliance) prior to the delivery of service.

Utilization Management Appeals Process

The Appeals Process is available for all of the aforementioned Utilization Management components. Please refer to the Clinical Appeals portion of the Inquiries, Complaints, Grievance and Appeals Chapter for further information.

Utilization Management Tools

The following claim status tools are available in the HealthLink Tools/Resources chapter of this Administrative Manual:

- **Utilization Management Fax Forms** streamline the precertification/certification process for health care providers.
- **Utilization Management Contact Information** – on-line UM Contact Information is a time-saving alternative to the telephone procedures and voicemail messaging associated with telephonic pre-certification/certification.
- **Utilization Management Interactive Voice Response (IVR)** is your route to patient precertification information.

Anthem Workers' Compensation

About Anthem Workers' Compensation

Anthem Workers' Compensation (AWC) PPO is a specialty Preferred Provider Organization network program that offers contracted Workers' Compensation payors access to a network of participating physicians, hospitals, occupational medicine facilities/professionals and other health care professionals 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.

Multi-Payor System
AWC is not tied to one payor organization. Rather, AWC provides network access and administrative services to contracted insurance carriers, self-funded self-administered payor plans and third party administrators who administer benefits on behalf of self-funded employers. These payors have contracted with AWC to use the HealthLink network and services.

Neither HealthLink nor AWC are insurance carriers or claims administrators in these arrangements. In exchange for access to HealthLink's networks and certain related administrative services, contracted payors agree to guide plan participants to the HealthLink network of participating physicians, facilities and health care professionals for treatment of work-related injuries and illnesses. They also agree to administer claims promptly and to make payments to participating network physicians and facilities in accordance with HealthLink's negotiated rates.

Reimbursement Model
HealthLink's negotiated rates with physicians and facilities are based on an agreed discounted PPO fee-for-service arrangement. Participating physicians, hospitals and other health care professionals may not balance bill patients for services funded by Workers' Compensation plans.

Focused Comp Network
HealthLink participating physicians, health care professionals and facilities are experienced in treating work-related injury and illness. Should an illness or injury require services beyond the scope of the initial treating physician's area of expertise, the injured employee should be guided to appropriate specialists for treatment.

The HealthLink network includes participating local physical therapy, rehabilitation centers, work-hardening centers, and hospitals for treatment of severe and second/third shift work injuries.

Telephonic Case Management

AWC case managers help communicate an injured worker's course of treatment – and his/her timely return to work. AWC's staff of medical and administrative specialists communicates with the patient, physician or facility and Workers' Compensation plan adjusters during the various stages of recovery, with full documentation of each case.

The process for Telephonic Case Management is as follows:

1. The client contacts AWC case managers and identifies the professional care needs of the injured worker.
2. AWC's case manager will advise the attending physician if the patient's care meets the medical necessity criteria for case management.
3. If the case does not meet medical necessity criteria, the case manager refers the information to the Medical Director or Physician Advisor to discuss the case with the prescribing/attending physician.
4. The medical recommendation is communicated to the Workers' Compensation plan adjuster for final determination and benefit authorization.
5. The Workers' Compensation plan adjuster communicates the decision to the AWC case manager, who reports the decision to the prescribing physician.

Guided Referral Program
The AWC case manager reviews the patient information to determine if a referral to a specialist is indicated. Referral recommendations are made to the Workers' Compensation plan adjuster to physicians within the HealthLink Network.

Please note: authorization is required from the employer or adjuster prior to services rendered. AWC will be responsible for contacting the adjuster and the treating physician and determination by the adjuster for requested treatment.

Prior Authorization Process and Medical Necessity Recommendations
All prior authorization is conducted for medical necessity utilizing clinical criteria specific to the condition or service under review. Clinical criteria are evaluated at least annually and are subject to approval by the Medical Director and the Advisory Committee. The committee validates current status and appropriateness of criteria.

Any case not meeting medical necessity criteria for the prescribing physician's treatment plan is referred to a HealthLink physician reviewer or the Medical Director for review and appropriate follow-up with the prescribing physician.

Staff Qualifications
HealthLink's staff includes licensed physicians, registered nurses and administrative personnel. All physician reviewers and case managers undergo a formal orientation and training program.

Eligibility and Verification Disclosure

The physician or clinic will be 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 physician or clinic on the initial visit. You may use your own form if it includes the requested information. If you are unsure about eligibility, you can verify the existence and extent of coverage by contacting the employer's Workers' Compensation payor as listed on the Patient Information Card.

Please be prepared to:

- Identify yourself as a physician participating in the HealthLink network.
- Provide patient name and the name of the employer.
- Obtain the name and extension number of the person providing you with this information for your records.
- Identify if you have any financial interest in an Institution or Facility in which you are referring.

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 the employer's Workers' Compensation plan.

AWC Claims Filing Process

Providers may submit claims by mail to HealthLink for services rendered to patients enrolled in the AWC program. HealthLink will reprice and forward the claims to the appropriate payor along with copies of all reports, which are provided to the payor, employer and primary care physician. The payor will send claim payment checks 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, please submit claims within 60 days following the date of service to the following address or fax:

To submit paper claims send HealthLink claims to the following address:		
Preferred Method: Workers' Compensation Payor (As listed on the Patient Information Card)	or	Anthem Workers' Compensation P.O. Box 410980 St. Louis, MO 63141-0980 Fax: (314) 925-6401

The claim filing process is outlined below:

1. Refer to the AWC listing of employers covered by this program, and ask the patient for the Patient Information Card that was completed at the time of an injury.

2. Contact the insurance payor/adjuster's office listed on the Patient Information Card to verify eligibility and confirm benefit coverage.

3. Complete standard claim forms utilizing current CPT-4/HCPC and Revenue Code Guidelines. Please include the following information:
   - Employer
   - Patient name and social security number
   - Patient diagnosis or symptoms, using **ICD-9 CM code and/or written description (**ICD10 Procedure and Diagnosis codes will be utilized for Date of Service/Date of Admission/Date of Discharge after 10/01/2014 compliance date.)
   - 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)
   - Tax Identification Number (FEIN) or SSN of the treating physician
   - Name, address and signature of the treating physician
   - Name of referring physician if patient was referred for diagnosis or treatment
   - 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, *McKesson Claim Check*.

5. The claim and repricing worksheets 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. Participating physicians, facilities and other health care professionals may not balance bill patients in excess of the negotiated discounted fee-for-service amount for services covered by the Workers' Compensation benefit plan.

Claim Coordination and 24-Hour Preprocessing
Many of HealthLink's clients choose HealthLink programs for their group health plan and also utilize the Workers' Compensation network program. One of the advantages is "24-hour pre-processing," which automatically identifies any claims duplicated between HealthLink's group medical and Workers' Compensation pricing systems. This electronic interface reduces the possibility of paying twice for the same episode of medical care by directing the claim to the proper source of funding – i.e., either medical or Workers' Compensation funds. The system helps reduce error and promotes timely resolution of payment disputes.

Procedures for Primary Care Physicians and Occupational Medicine Clinics

Patient Information Cards
AWC provides employers accessing the program with Patient Information Cards to be completed at the time of an injury. The employee should bring the card to the physician/clinic on the initial visit.

Physician as Initial Caregiver
On the first notification of an injury, the health care professional or facility will be the initial caregiver. The health care professional will evaluate the injured worker and direct his/her necessary treatment to specialists, hospitals and other health care professionals in the HealthLink Workers' Compensation Network.

During each visit, the health care professional completes the AWC Physical Capability Form. For additional visits or a referral to a specialist, please notify AWC or the payor prior to making the appointment for the referral. To obtain an Anthem Workers' Compensation Directory you may access our website at www.Anthemwc.com or contact AWC's Customer Service Department.

Treatment Procedures
Please comply with the following treatment procedures:

1. Complete an AWC Physical Capability Form or your work status form for each injured worker when he/she arrives for initial treatment. If a worker has subsequent appointments, injuries or accidents, you must complete a new form for each new episode. You may use your own form if it includes the requested information.

2. Examine and treat the injured worker.

    a. If the injured worker is treated and released the same day, you need not provide verbal notification to AWC. Please 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 listed on the Patient Information Card.

b. If the injured worker has follow-up appointments, please notify AWC or 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.

3. If a referral to a specialist is necessary, please contact AWC or the payor by phone for medical necessity and the payor's benefit determination prior to making the appointment for the referral. See Guided Referral Program

4. After the medical necessity and payor's benefit determination are obtained, you may schedule an appointment 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 as listed on the Patient Information Card.

Procedures for Specialists
The specialist physician may receive a referral from the primary care physician.

1. A representative of AWC or the payor will contact the specialist physician after the initial appointment for the physician's assessment and treatment recommendations.

2. The specialist physician should contact AWC or the payor prior to the delivery of additional services, including additional referrals to other specialist physicians. Please note: If medical necessity and the payor's benefit determination are required from the employer or adjuster in order for benefits to be available, AWC will be responsible for contacting the adjuster for authorization and advising the specialist.

3. Periodically, the case manager may request that the specialist physician be available for consultation.

4. The specialist physician should refer patients enrolled in Workers' Compensation plans using the AWC program to hospitals, physicians and health professionals who participate in HealthLink's Network whenever medically appropriate.

5. The specialist physician should mail or fax all reports directly to:

AWC
P.O. Box 410980
St. Louis, MO 63141-0980
Fax: (314) 925-6642

6. Claims should include the Social Security Number and birth date of the injured employee.

7. HealthLink will price and forward claims to the Workers' Compensation payor in accordance with the HealthLink Agreement.

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, please follow these procedures:

- The employer will notify AWC that a seriously injured employee was directed to the hospital.
- An AWC telephonic case manager will contact the hospital on the next business day to provide any information needed to appropriately manage the referral or rehabilitation process from that point to facilitate benefit availability for covered services.
- The physician and/or facility should send all bills, copies of emergency room reports and physician notes to HealthLink or to the payor as listed on the Patient Information Card.

HealthLink Appeals Process

The Appeals Process is available for all of the aforementioned HealthLink components. Please refer to the Inquires, Complaints, Grievance, & Appeals Chapter for further information.

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.

HealthLink Tools/Resources

On-line Tools

ProviderInfoSource®

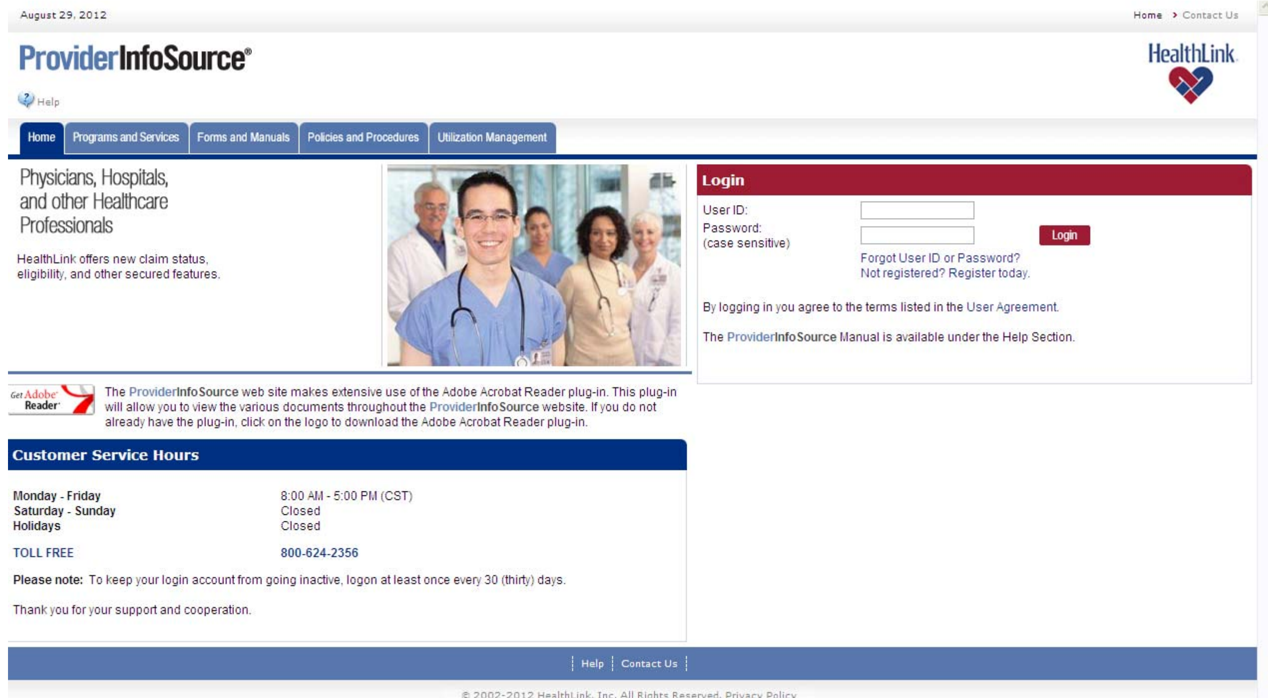
HealthLink's *ProviderInfoSource®* is an online tool that gives you and your staff immediate access to information pertinent to your practice. Throughout the development of *ProviderInfoSource*, HealthLink has worked closely with several physician groups and hospitals to obtain valuable feedback.

ProviderInfoSource allows your practice to obtain patient eligibility and claim information. You can utilize the *My HealthLink* messages feature allowing secure messaging between you and HealthLink, and you can access a wealth of information including HealthLink's In-Touch newsletter, Provider Manual, online forms and much more.

The *ProviderInfoSource* User Guide, located in the "Help" section and "Forms and Manuals", is designed to help you and your staff understand HealthLink's *ProviderInfoSource* and all of the features it has to offer. We encourage you to contact us if you have any questions or comments regarding *ProviderInfoSource*. Your suggestions will help us keep the website efficient and effective.

***ProviderInfoSource®* Public Home Page**

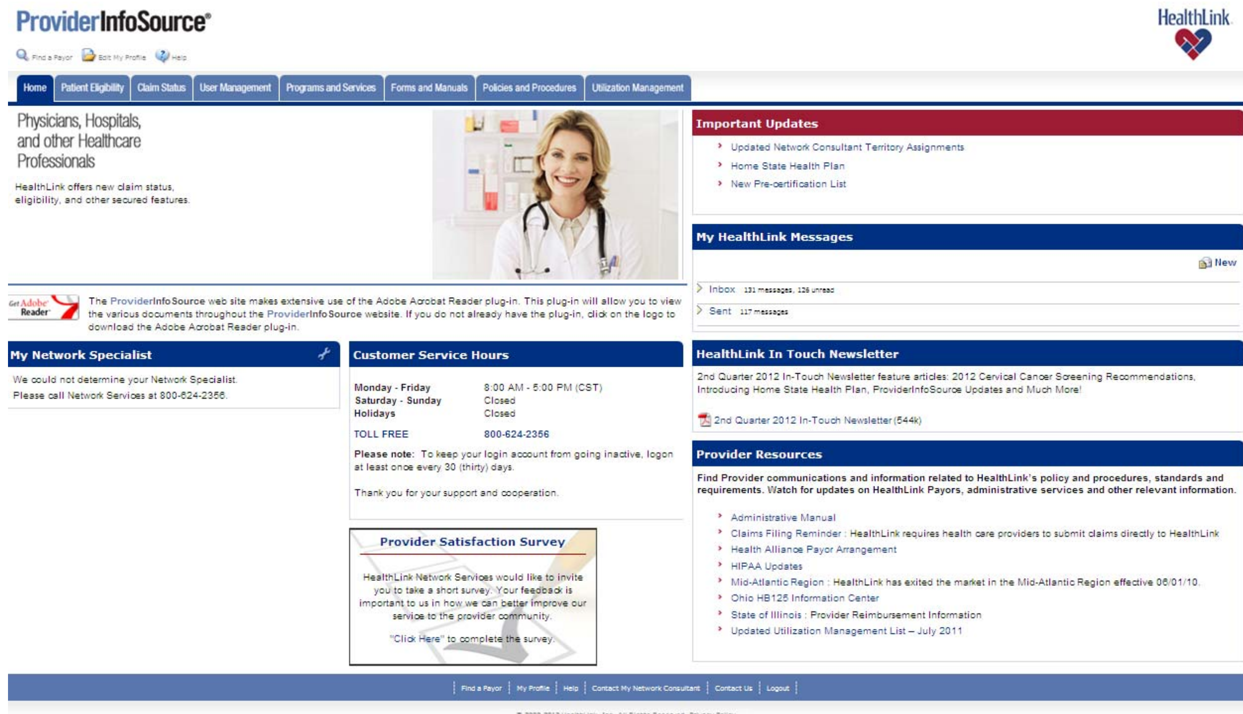
The Public Home Page is the first page you see when you navigate to *ProviderInfoSource*. The Public Home Page does not require you to login and contains access to policies, forms and HealthLink network program information



ProviderInfoSource® Secured Home Page

The Secured Home Page is the private, restricted home page that only HealthLink participating physicians, hospitals and other health care professionals can utilize with a valid, registered account.

Once you log into the secured area ProviderInfoSource provides additional secured information including Patient Eligibility, Claim Status and various User Management options as illustrated below:



How to Self-Register as an Administrator

As an **Administrator** you are able to customize and manage access to your information, create new users, manage your users and reset passwords. You also may assign other users as administrators and delegate the appropriate access for each user.

1. Use the Internet browser to navigate to *ProviderInfoSource's* Public Home Page located at the following web address: *https://providerinfosource.healthlink.com*
2. When the Public Home Page opens, go to the Provider Login window and click Not registered? Register today.
3. This will display the **Administrator Self-Registration** window
   a. Step 1 – Enter Tax ID Number & National Provider Identifier
   b. Step 2 – Verify Providers
   c. Step 3 – Complete My User Profile
   d. Step 4 – After all the required fields have been entered, click the **Submit** button or press **Enter**.
   e. Step 5 – View your "Welcome to *ProviderInfoSource*" email message.

HealthLink Web Site

The enhanced HealthLink web site www.healthlink.com includes online forms, educational documents and a Physician/Hospital Locator.

Partnering with health care professionals to deliver value in medical services.

| Privacy Statement | Terms of Use | Careers | Press Room | HIPAA | Legal | Glossary |

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Create a Customized Directory - Physician/Hospital Locator
Find the results you need by searching HealthLink networks of participating physicians, hospitals and other health care professionals. Log onto HealthLink's website at www.healthlink.com click on Find a Doctor.

1. Select a HealthLink network from the drop down menu.

2. Select a Provider Type – choose one of four options:
   a. Physician
   b. Group of Physicians
   c. Hospital or
   d. Ancillaries

   If you choose "Physicians" you are able to:
   - Choose the specialty of the physician from the drop down menu.
   - Enter the last name of the physician. If you are not sure how to spell the physician's name, enter the first letter of the last name to view an alphabetical listing of ALL physicians.
   - You may also enter a gender preference, a group name or a hospital affiliation of the specified physician.

   If you choose "Group of Physicians," you are able to:
   - Enter the name of the group in the "With the Name" field.

   If you choose "Hospital," you are able to:
   - Enter the name of the hospital in the "With the Name" field. If you do not know the name of the hospital move to Step 3 and further define your search by entering your specified location.

   If you choose "Ancillary Facility" you are able to:
   - Choose the type of ancillary facility from the drop down menu.

3. Select one of the three options:
   a. State and City
   b. State and County
   c. Zip Code with Mile Radius from Zip Code

Reading Your Search Results
Once you have entered your search criteria, you are ready to view results. Here are tips to help you read the search results that are generated.

1. Search Specifications – This is a brief description of the search criteria you entered.

2. Display Results – This displays the number of results and the total number of pages you are able to view. There are 20 result items listed per page.

3. New Search – Need to start over? This feature will take you back to the original search page.

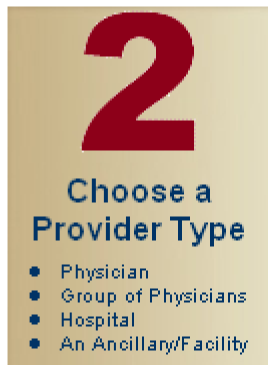
4. Create Customized Directory – Once your results are listed, you are able to create a customized directory by clicking on the “Create Customized Directory” button.

5. Result Listing – Each result listed will include the name, address, state, zip phone, gender, provider ID number and panel status.

6. Map It – You are able to access a map with directions to the location you searched.

7. Result Display Pages – You are able to move easily through the result display pages.

Customized Directories
Click on Create Customized Directory to automatically generate a PDF that includes information from your search results. The PDF may be printed or saved to your computer.



Claim Status Research

If claim problems arise, physicians may submit a representative sample of the problem for research. HealthLink investigates claim status (paid, resolved, delayed), date of payment, payor name etc. HealthLink also supplies full reporting to physician offices of claims research results.

Claims Interactive Voice Response (IVR)

The HealthLink's Interactive Voice Response system allows convenient access to patient claim information in a secure environment 5:00 am to 12:00 am daily. The IVR system is your route to patient claim information. This resource will provide the following claim status information:

- Amount Billed
- Date of Service
- Date Processed
- Amount Allowed or Paid if Applicable
- Name and Phone Number of Claims Administrator

To protect the confidentiality of patient accounts, you and your staff are required to enter your Federal Tax ID number (TIN) and NPI number to use the system.

To begin using the IVR call 1-877-660-2472:

1. Enter your 9-digit tax identification number.
2. Enter your NPI or unique 6-digit HealthLink provider number.
3. Enter subscriber's Privacy ID or Social Security Number.
4. Select patient from list.
5. Enter mm/dd/yy for date of service (must be within the last 9 months).

To select another subscriber:

1. Enter 4.
2. Enter subscriber's Privacy ID or Social Security Number.
3. Select patient from list.
4. Enter mm/dd/yy for date of service (must be within the last 9 months).

To select another Tax Identification Number:

1. Enter 5.
2. Enter the 9-digit tax identification number.
3. Enter your NPI or unique 6-digit HealthLink provider number.
4. Enter subscriber's Privacy ID or Social Security Number.
5. Select patient from list.
6. Enter mm/dd/yy for date of service (must be within the last 9 months).

To select another patient's claim status:

1. Enter 6.
2. Enter your NPI or unique 6-digit HealthLink provider number.

3. Enter subscriber's Privacy ID or Social Security Number.
4. Select patient from list.
5. Enter mm/dd/yy for date of service (must be within the last 9 months).

Claims Interactive Voice Response (IVR) (continued)
IVR - Instructions for entering alpha characters in the member's ID
Voice: "Please enter the Subscriber's ID number. If the identifier contains an alpha character, press the * (star) key and then press the corresponding number on the keypad followed by the placement in which the alpha character appears. For example, if the ID is 378C24, enter 3 7 8 * (star) 2 3 2 4. If the letters "Q" or "Z" do not appear on your keypad, use * (star) 1 1 for the letter "Q" or * (star) 1 2 for the letter "Z"."

IVR – Instructions for entering last name / first name
Voice: "To enter alpha characters, press the * (star) key, then the alpha character, followed by the placement in which the alpha character appears. For example, if the last name is Smith, enter * 7 4 for S (S is the fourth letter on the number 7 button) * 6 1 (for M) and * 4 3 (for I)"

Utilization Management (UM) Tools

Utilization Management Fax Forms

The UM Fax forms streamline the precertification/certification process for health care providers. The fax-back form requests information pertinent only to the current admission or service requested, and to relevant discharge planning needs. The fax number for HealthLink's Medical Management Department is **800-510-2162**. The fax forms are available on https://providerinfosource.healthlink.com.

Utilization Management Contact Information

On-line UM Contact Information is a time-saving alternative to the telephone procedures and voicemail messaging associated with telephonic pre-certification/certification.

1. Log onto HealthLink's web site at https://providerinfosource.healthlink.com.
2. Click on the "Find UM Contact Information" button.
3. Enter the member's ID number or subscriber's social security number and select "Perform Lookup"
4. View the UM contact information. If contact information cannot be found, please contact 800-624-2356.

Utilization Management Interactive Voice Response (IVR) System

The UM IVR system is your route to patient precertification information. The IVR system is a secure environment and provides the following information:

- Utilization Management Contact Information
- Phone Number

Toll-free phone lines are open every business day from 5:00 a.m. to 12:00 a.m.

To get started:

1. Dial **877-284-0102**
2. Enter option “8” to access the system
3. Enter Member’s ID or Subscriber’s SSN
4. Verify Member’s ID or Subscriber’s SSN

To Select another Utilization Contact

1. At the end of the initial look-up Enter Option “2”
2. Enter Member’s ID or Subscriber’s SSN
3. Verify Member’s ID or Subscriber’s SSN

IVR – instructions for entering alpha characters in the member’s ID

Voice: “Please enter the Subscriber’s ID number. If the identifier contains an alpha character, press the * (star) key and then press the corresponding number on the keypad followed by the placement in which the alpha character appears. For example, if the ID is 378C24, enter 3 7 8 * (star) 2 3 (C is the third letter on the number 2 button) 2 4. If the letters “Q” or “Z” do not appear on your keypad, use * (star) 1 1 for the letter “Q” or * (star) 1 2 for the letter “Z”.”