Payor Administrative Manual

HealthLink

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ABOUT THE PAYOR ADMINISTRATIVE MANUAL

The **Payor Administrative Manual** is a reference source for insurance companies and TPAs regarding HealthLink, its networks, products and administrative procedures.

The payor administrative manual documents HealthLink processes, procedures and standard specifications.

One of our key objectives at HealthLink is to provide our payors with the best possible service. Your company's cooperation with these administrative guidelines will help us meet that objective.

HealthLink is a PPO and Workers' Compensation network based in St. Louis, Missouri, servicing such areas as Missouri, Illinois and Arkansas.

ABOUT HEALTHLINK, INC.

HealthLink builds regional provider networks and makes them available by contract to multiple payors of health benefits, including insurers, third party administrators, union trust funds and employers. HealthLink operates PPO, HMO and Open Access networks in Missouri, Illinois, Arkansas, Indiana and Kentucky.

Across our service area, the PPO currently has more than 48,500 participating providers, including 20,300 specialists, 10,800 PCPs and 291 hospitals. HealthLink HMO has more than 40,700 participating providers, including approximately 17,200 specialists, 8,200 Primary Care Physicians and 274 hospitals.

HealthLink was created in 1985 by a consortium of St. Louis area hospitals in response to a growing trend toward managed care. A for-profit managed care organization; HealthLink is currently registered to do business in multiple states, including Missouri, Illinois, and Arkansas.

In 1992, Blue Cross Blue Shield of Kansas City purchased 21% of HealthLink stock, resulting in the company co-venturing HealthLink HMO. In August 1995, RightCHOICE Managed Care acquired HealthLink, Inc.

On January 31, 2002, WellPoint Health Networks located in Thousand Oaks, California, acquired RightCHOICE Managed Care, Inc. As a result of this merger, a new organization, *WellPoint Central Region*, was formed. The companies comprising the *WellPoint Central Region* include: HealthLink and its subsidiary, HealthLink HMO, Inc.; Blue Cross Blue Shield of Missouri and UNICARE.

In 2003, Anthem, Inc. and WellPoint announced the acquisition of WellPoint by Anthem Holding Corp., a wholly owned subsidiary of Anthem, Inc. The merger closed on November 30, 2004. The WellPoint-Anthem Company was called "WellPoint".

In December 2014, HealthLink's parent company, WellPoint, Inc., changed its name to Anthem, Inc.

PURPOSE, VISION AND VALUES

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 PPO OVERVIEW

HealthLink Preferred Provider Organization (PPO) provides access to high quality health care services – and freedom of choice – at competitive managed care costs.

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KEY FEATURES

- **Freedom of Choice**

- **Broad Network with Discounted Fee-for-Service Negotiated Rates**

- **Claims Coordination and Repricing**

- **Responsive Customer Service**

- **Integration with HealthLink Managed Care Programs**

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Broad PPO Provider Network

HealthLink's PPO provider network is geographically and specialty balanced to ensure convenient access to contracted health care services.

PPO enrollees have the freedom to choose any participating physician or facility in any state in which we do business. Network providers have agreed to accept special or discounted rates of reimbursement for treatment, so enrollees who receive medical care within the PPO network have lower out-of-pocket costs and may receive higher benefit coverage for covered services. The HealthLink ID card is the key to using the HealthLink PPOs. Enrollees with HealthLink ID cards are welcome to

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use network providers throughout the HealthLink service area.

Insurance companies and TPAs may produce their own ID cards in accordance with HealthLink specification guidelines, in order for enrollees to access network providers.

Insurance companies usually provide their own medical management services for the PPO business block (using an URAC accredited Medical Management vendor or in-house program). HealthLink will provide medical management services for payors upon request and for an additional fee. HealthLink's Medical Management program, under the auspices of AUMSI, the utilization review agency of our parent corporation (Anthem, Inc.), is fully accredited URAC.

ENROLLEE RIGHTS

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.

- To expect and receive considerate and respectful care and services from our staff and participating providers.

- To receive from the physician, (or the hospital/office personnel) complete and understandable information about illness, possible treatments and likely outcomes. No restriction shall be placed in the dialogue between practitioner and patient.

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

- To know the names and roles of the people providing care.

- To consent or to refuse a treatment, as permitted by law. If a recommended treatment is refused, alternatives are recommended.

- To every consideration of privacy concerning medical care. Case discussion, consultations and treatments should be conducted discreetly, with only necessary individuals present.

- To have all communications and records pertaining to care treated as confidential, released only with permission, or as required by law.

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

- To be informed of complaint and grievance procedures, and to be allowed to file a complaint when dissatisfied with the care the enrollee receives.

- To receive information about our PPO Network, its services and participating health care providers in a clear and concise manner.

ENROLLEE RESPONSIBILITIES

- To select a medical practitioner and establish a relationship with him/her.

- To seek medical care at the earliest possible time when experiencing symptoms that may indicate illness/injury.

- To provide, to the best of the enrollee's knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications or other matters concerning health.

- To communicate to medical personnel if the enrollee does not clearly understand what is expected or how to take prescribed medication.

- To follow the treatment plan recommended by the practitioner primarily responsible for the care. Keep scheduled appointments. Take medications as prescribed, or communicate reason for not doing so to the doctor. Adhere to any prescribed diet or exercise regimen or consult with prescribing practitioner to adjust the requirements or resolve problems.

- To recognize the effect of lifestyle and preventive care in personal health.

- To read the benefits plan information provided.

- To carry health ID card and identify oneself as a HealthLink enrollee when seeking health care services.

- To provide, to the best of the enrollee's knowledge, accurate and complete information about current health coverage to health care providers of service.

- To contact HealthLink for questions or concerns about the managed care plan or the health care service received.

- To arrange payment of applicable co-payments/co-insurance to health care providers for services received.

HEALTHLINK'S URAC ACCREDITATION

HealthLink's Medical Management program is fully accredited by the American Accreditation HealthCare Commission/URAC, the preeminent accrediting board for managed care organizations. HealthLink is in the minority of managed care organizations across the nation to embrace and achieve the rigorous standards of AAHC/URAC accreditation for its medical management program.

HealthLink's AAHC/URAC accreditation is a testament to the quality of its operational standards and its commitment to superior service in the delivery of access to health care for its enrollees. The accreditation is also evidence of its accountability to enrollees, providers, regulators and insurance carriers.

In maintaining its AAHC/URAC endorsement, HealthLink holds itself to the highest standards in its execution of work in medical management.

HealthLink's accreditation is the result of URAC's thorough review of HealthLink policies and procedures in Medical Management.

HEALTHLINK PROGRAMS & SERVICES

HealthLink's goal is to provide comprehensive health care services, offering the following products and services through our contracted network models and supporting administrative systems:

- PPO (Preferred Provider Organization)

- Open Access Plans (for Self-Funded and Fully-Insured Clients)

- Workers' Compensation

- Medical Management

Programs and Services

	PPO	OAIII OR OAII FOR SF	Workers' Comp
Network Service Area By State			
Missouri	♦	♦	♦
Illinois	♦	♦	♦
Indiana	♦		♦
Iowa	♦		
Arkansas	♦	♦	●
Kentucky	♦		●
West Virginia	♦		
Provider Networks			
PCP-Directed Care			♦
Self-Referral	♦	♦	■
Pharmacy Network	■	■	■
Medical Management			
Inpatient Certification	♦	♦	
Continued Stay Review	♦	♦	
Discharge Planning	♦	♦	
Major Case Management	♦	♦	♦
Specialty Referral Authorization			♦
Outpatient Review	♦	♦	
Administrative Services			
Claim Repricing	♦	♦	♦
Management Reports	♦	♦	♦
Enrollee ID Card/ Directories	■	■	♦
Toll-Free Customer Service	♦	♦	♦
Condition Management	■	■	
Worksite Wellness	■	■	

♦ *Included in Program*   ● *In Development*   ■ *Optional Service*

OTHER HEALTHLINK PROGRAMS & SERVICES

Payors or groups must have a signed agreement with HealthLink for access to each network – PPO, HMO, Open Access and Workers' Compensation – in order to market insured or self-funded products affiliated with the network. Select services are available upon request, special agreement and with additional fees.

Open Access III
- Three-tier Benefit Design
  - HMO Network Access
  - PPO Network Access
  - Out-of-Network
- Self-Referral/No PCP requirement
- Claims repricing provided by HealthLink (requires special processing).
- Medical management services optional.

Open Access II
- Two-tier Benefit Design
  - HMO Network Access
  - Out-of-Network
- Self-Referral/No PCP requirement
- Claims repricing provided by HealthLink
- Medical management services optional.

Open Access I
- Single-tier Benefit Design
- HMO Network Access
- No Out-of-Network
- Self-Referral/No PCP requirement
- Claims repricing provided by HealthLink
- Medical management services optional.

Workers' Compensation
- PPO network for workers' compensation insurance.
- Features network of providers experienced in occupational medicine and treatment of work-related injuries.
- Uses a discounted fee for service (FFS) provider reimbursement schedule, case management and reporting.

OTHER HEALTHLINK PROGRAMS & SERVICES *(Continued)*

24 Hour Nurse Line
- For special programs only.
- 24-hour operation.
- Toll-free phone program for enrollee's access to nurse for symptoms and care advice.

Maternity Management
- Designed to increase prenatal care services.
- Directs patients to HealthLink network participating providers.
- Risk assessment via telephone survey with prenatal nurse case manager.
- Follow-up with attending network OB-GYN and patient.
- Case management for high-risk mothers, including home monitoring as necessary.

NCN – Network Fee Negotiation and Savings-Based PPO Services
- Professional fee negotiation services for non-par claims.
- Fee based upon a percent of savings.

Medical Management Program
- Utilization Management (focused review)
- Case Management
- Condition Management (formerly Disease Management)

PROVIDER NETWORK OVERVIEW

HealthLink provides its insurance company partners access to a broad and diverse network of participating physicians and hospitals in the Midwest. The size and scope of our network, coupled with a sound reputation among its purchaser groups, gives HealthLink an advantage that is passed on to insurance companies in the form of competitive discounts, administrative flexibility and customer satisfaction.

HealthLink maintains a policy for network access and availability. HealthLink's credentialing area performs primary source verification and monitors provider licensing. The Anthem credentialing program is URAC accredited.

HEALTHLINK SERVICE AREA

HealthLink maintains a Midwest service area. HealthLink continually builds upon its network in order to provide enrollees in all communities' access to quality physicians and hospitals.

Areas
- Missouri
- Illinois
- Arkansas

	PPO	HMO
Hospitals	291	274
PCPs	10,876	8,208
Specialists	20,339	17,243
Ancillary Providers	17,053	15,001
Total Providers	**48,559**	**40,726**

Composition

	PPO	HMO
Inpatient	29%	46%
Outpatient Hospital	23%	41%
Physician	37%	45%
Ancillary Provider	34%	56%
Overall Network Discount	**31%**	**45%**

NETWORK ADEQUACY STANDARDS

It is HealthLink's goal that enrollees have access to qualified, diverse care that offers an appropriate amount of choice. Toward meeting this goal, HealthLink has established network standards regarding provider availability and accessibility.

Specifically, the purposes of HealthLink's participating provider availability and accessibility standards are to offer a network of participating providers that are geographically accessible to HealthLink enrollees and offer an adequate number and type of contracted or participating providers to meet the health needs of HealthLink enrollees.

Provider Network Adequacy Goals
The number of network providers of different types will vary from one service region/county to another. HealthLink will recruit and contract with sufficient providers of all types necessary to provide a full range of covered services. In general, the HealthLink provider network will:

- Be adequate in numbers and types of providers to meet the full range of health care service needs of the enrolled population.
- Include at least one community hospital; where one is available.
- Include within each county or multi-county region, enough primary care and specialty care physicians to provide HealthLink enrollees a choice of physicians.

HealthLink's evaluation of our network adequacy standards takes into account that the population density of a county tends to mirror the number of providers available in that same county. Urban counties have greater population and therefore a greater number of providers. Rural counties have less population and therefore fewer providers. Suburban counties fall between Urban and Rural counties. Based on the U.S. Census, counties are defined as being Urban, Suburban or Rural. Our network adequacy standards are different for each type of county.

Categories of County By Population	PCP Accessibility Standard	Specialty Accessibility Standard
Urban Counties Population of 200,000 or more	1 Family Practitioner/Internal Medicine within 10 miles. 1 OB/GYN within 15 miles. 1 Pediatrician within 25 miles.	1 Specialist within 25 miles
Suburban Counties Population of 50,000 to 199,999	1 Family Practitioner/Internal Medicine within 20 miles. 1 OB/GYN within 30 miles. 1 Pediatrician within 40 miles.	1 Specialist within 40 miles
Rural Counties Population of less than 50,000	1 Family Practitioner/Internal Medicine within 30 miles. 1 OB/GYN within 60 miles. 1 Pediatrician within 60 miles.	1 Specialist within 60 miles

Facility and Ancillary Provider Accessibility Standards are also available. Please contact your HealthLink representative if standards are required.

PROVIDER CLAIM FILING AND PAYMENT GUIDELINES

Participating providers submit claims electronically (preferred) or by mail to HealthLink for services rendered to enrollees accessing the HealthLink network. Providers agree to defer collecting any professional fee in excess of the office visit co-payment amount for covered services until they have received benefit information from HealthLink's affiliated payors. The provider is extending credit until payment amounts are processed. In return, both HealthLink and its affiliated payors shall process claims in a timely manner.

Provider Billing Procedures

- Submit claims to HealthLink on UB-04 (Hospital) or CMS-1500 (Physician) forms.
- Submit claims electronically, if possible.
- Submit claims timely and accurately.
- Do not resubmit claims unnecessarily.
- Utilize standard CPT code billing procedures.

Provider Claims Payment Guidelines

- **Claims Reimbursement.** Physician is reimbursed in accordance with the terms of the agreement and the benefit plan provisions. This is usually the allowed amount determined by the appropriate fee schedule, or the billed charges if lower than the allowable.

- **No Direct Billing to Enrollees.** Physician agrees not to bill the enrollee directly for any amount except for deductibles, co-insurance amounts, unauthorized services, or services not covered under the health care plan. HealthLink requires payors to clearly indicate patient responsibility amounts on explanation of benefits (EOBs).

- **HealthLink Enrollees are Responsible** for any applicable co-payments and/or co-insurance and non-covered services, depending on their contracted health care plan.

  It is the provider's responsibility to collect applicable co-insurance, co-payments, or deductibles from enrollees. Providers are prohibited from collecting the difference between the maximum allowed amount and billed charge for covered services.

- **Mistakes or Discrepancies**. If there is a concern about mistakes or discrepancies in allowed amounts, the physician or physician's staff must notify HealthLink in a timely manner.

- **Anesthesia Claims.** HealthLink accepts anesthesia claims using the anesthesia procedural code published by the American Medical Association in the current edition of the CPT. HealthLink's repricing sheet reports the CPT anesthesia procedural code (as billed by the provider), the total billed charge and HealthLink's re-priced amount.

Claims from participating providers are "repriced" by the network. Non-participating provider claims are processed by the network and forwarded to the payor with the repriced amount equal to the billed amount for the payor to process.

PROVIDER CLAIM FILING AND PAYMENT GUIDELINES *(Continued)*

Coordination of Benefits (COB) Responsibilities

Participating physicians must make all reasonable efforts to assist in coordinating benefits with HealthLink's partnering insurance companies and other payors. The physician's reimbursement, including the amount payable by plan and by enrollee, will be based on the specific physician agreement.

Participating physicians and hospitals are prohibited from balance billing patients in excess of the HealthLink allowed amount for covered, eligible services.

When a patient is covered by more than one insurance plan, benefits are usually coordinated so that no more than 100% of the eligible expenses are paid under the combined benefits of all plans.

The basic insurance guidelines are:

- The enrollee's own insurance is primary.
- Dependents are primary under the insurance determined by the "birthday rule" which states that of two spouses, the one with the earlier birthday in the calendar year shall be designated as the "primary" subscriber.
- If an enrollee is older than age 65, still employed and has benefit coverage, HealthLink is primary and Medicare is secondary.

Standard Multiple Surgery Reimbursement

Standard multiple surgery reimbursement is 100% of the maximum allowance for the procedure with the highest Relative Value Unit (RVU) maximum allowance for the place of service and date of service and 50% of the maximum allowance for each subsequent procedure eligible for separate reimbursement. Standard multiple surgery reimbursement will also apply when a single procedure code is reported with multiple units on a single line.

When multiple modifiers (that apply a percentage amount to the maximum allowance) are reported with a procedure, the system will multiply the percentage amounts together to determine a new percentage amount. If the new percentage amount contains a decimal place, the system will round up to the next whole percentage and apply it to the maximum allowance. 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 system will multiply 70% and 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. Modifier 50 is not part of these calculations and is handled as bilateral only.

Bilateral Surgical Procedure Reimbursement

A bilateral surgery that uses a unilateral code should be reported <u>on a single line</u> 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, the RVU will increase for the applicable unilateral code by 150%. Standard multiple surgery reimbursement will then apply (50%).

Other bilateral surgical coding scenarios:
1. A bilateral surgery that uses a unilateral code reported on a single claim line using 2 units of service (<u>without</u> modifier 50): the line item will be considered as one surgery and eligible for reimbursement equal to 150% of the amount applicable to the surgical code on the date of service.
2. A bilateral surgery reported on two separate claim lines (using the same procedure code) where one line is reported with modifier 50 and the second line is unmodified: the claim line with the 50 modifier will be considered as one surgery and eligible for reimbursement equal to 150% of the amount applicable to the code on the date of service. The unmodified claim line will be given a zero allowance.
3. A bilateral surgery reported on two separate claim lines (using the same procedure code) and both lines are reported with modifiers 50: the first bilateral procedure will be considered as one surgery and the eligible for reimbursement equal to 150% of the amount applicable to the code on the date of service. The secondary bilateral procedure will be considered as one surgery and eligible for reimbursement equal to 150% and multiple surgery reimbursement will apply (50%).

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.

Co-Surgeons and Assistant Surgeons

HealthLink applies a 63% allowable for co-surgeons and a 16% allowable for assistant surgeons billed with modifiers -80, -81 and -82 on common or primary procedures. Modifier AS is allowed with 14% allowable.

Anesthesia – CRNA and Anesthesiologist Bills

Occasionally anesthesia charges will include a charge by the anesthesiologist and a charge by the CRNA and are billed with the appropriate modifiers. The modifiers help us to recognize that the claim has two or more parts and is not a duplicate claim. If both providers participate in the network and bill their services under different TIN, both claims will be repriced.

PROVIDER CLAIM FILING AND CLAIMS GUIDELINES *(Continued)*

HealthLink applies modifier QX as 50% of the allowable. AD, QK and QY also receive a 50% allowed repricing process.

Automated Claims Code Review

We use an automated software program to review claims submitted by network providers for professional services. The program checks codes for accuracy with current CPT-4 and ICD-9 usage. ICD-10 procedure and diagnosis codes are utilized for date of service /date of admission/date of discharge after 10/1/2015.

HealthLink's coding system is called "Claim Check." Claim Check clinical logic is based on CPT, HCPCS, ICD-9-CM, ICD-10-CM, AMA and CMS guidelines for professional claims and adjustments. Claim Check ensures the correct application of CPT coding rules and will generate recommended denials for the following edits: Re-bundling, Mutually Exclusive, Incidental, CCI Incidental, Duplicate, Pre and Post Op, and Age edits.

There are instances in which the network's claims code review (for professional claims only) is disabled for payors upon request. If disabled, the multiple surgery, co-surgeon/assistant surgeon and modifier cutbacks are not disabled. Payors request code review disabled when they use their own code review software/services.

CLAIMS DEPARTMENT AND CCRU (FOR PAYOR PROBLEM CLAIMS)

PPO Claims

The HealthLink Claims department provides efficient and accurate claim pricing for Preferred Provider Organization (PPO) provider claims. HealthLink requests any pertinent data missing from claims submitted by providers.

Provider claims are received via electronic transmissions daily (via clearinghouses) or delivered to HealthLink twice daily by U.S. mail. Mail received is opened and prepared on the date of receipt by our "front end" vendor. Those claims that can be scanned are scanned and converted to EDI claims using optical character recognition (OCR) by the front-end vendor. Inbound electronic claims are also processed each business day.

For manual claims, the processors enter all pertinent information from the claim into the HealthLink computer system. If the information on the claim is incomplete, HealthLink makes every effort to obtain the missing information before forwarding the information to the payor. During the nightly batch run, the system checks for exact duplicates, UR authorizations, correct coding and assigning the appropriate repriced amount, which corresponds to the specific provider contract. For the most part, application of repriced amounts is fully automated. Most inbound electronic claims are automatically repriced by the computer system.

Once repriced, the EDI claims are sent outbound to corresponding payors (either directly or through a clearinghouse). For manual claims, the repricing sheets are matched with the corresponding claims and are generally mailed to payors the same day they are completed.

Claims must meet quality (audit) and production standards. Claims turnaround is extremely important to the department as well as the entire company. Our payors and clients can expect all clean claims to be turned around in an average of seven business days. This time frame not only includes the day the mail is received, but includes the day the claims are forwarded to the payor. Electronic transmission is the most efficient method to receive network claims.

Customer Claims Research Unit (CCRU) (For Payor Problem Claims)

HealthLink's Customer Claims Resolution Unit (CCRU) focuses on special handling of claims needing researched for corrected pricing, updated eligibility, provider "par" status, etc. Only claims received by affiliated HealthLink payors that require special handling by HealthLink should be emailed to HealthLink's CCRU at CCRU@HealthLink.com. Each claim should be scanned/emailed with instructions as to what is needed for the claim in question as well as instructions for return of the claim to the payor. All claims will be sent by the outbound EDI methodology in place of mailed back, unless return by fax is specifically requested. Eligibility issues for claims may be sent through the CCRU for logging and tracking purposes. Misdirected claims (claims sent directly to the payor from the provider) should be sent back to the provider to be redirected to HealthLink. The CCRU averages a 7-day turnaround time for claims received from payors.

HEALTHLINK CLAIMS REPRICING STANDARDS

HealthLink Claims Standards

HealthLink receives more than 800,000 claims each month. HealthLink strives to maintain an average of 96% of clean claims received to be processed and forwarded to the payor within four business days. Additionally, 98% of all claims are to be processed and forwarded in seven business days.

HealthLink has enlisted the following measures to promote claims efficiency:

- Provisions are included in all HealthLink contracts with carriers requiring "all payments due to the participating providers within 30 days following receipt of complete and proper repriced claims" unless otherwise indicated by state law.
- Insurance carriers shall deliver to enrollees and providers an explanation of benefits for each claim whether or not any payment is made (usually via an EOB).
- In the event of a dispute, the payor shall notify the participating provider and assist in the provider's (or HealthLink's) collection effort to resolve open issues.

ELECTRONIC MEDIA CLAIMS (EMC) CAPABILITIES

There are financial benefits to receiving and sending claims utilizing electronic methods. HealthLink encourages providers to submit claims electronically using clearinghouses. HealthLink will submit claim and repricing data outbound to payors electronically, either directly or through a clearinghouse (such as Emdeon (WebMD)).

Inbound Claims (from Providers)

We continually work with our providers to increase the percentage of electronic claims received.

The following companies submit electronic claim submissions directly to HealthLink from HealthLink providers:

- Availity

Outbound Claims (to Payors)

We offer several ways for payors to receive repriced claims electronically. We send them through a clearinghouse (usually Emdeon (WebMD)) or directly, if the claim volume warrants doing so. We support a number of transmission methods including FTP with PGP encryption (HIPAA compliant transmission method).

Electronic Claim Formats

Electronic claims sent to HealthLink should be in the HIPAA compliant format. The electronic claims that we receive are processed and sent out electronically in the HIPAA compliant 837 Version 5010 Addenda format. For payors who are only able to receive non-standard electronic or paper claims, HealthLink will require that they contract with our outbound clearinghouse, Availity.

The ANSI 837 Version 5010 format specifications can be downloaded from www.wpc-edi.com.

Optical Character Recognition (OCR) Technology

OCR technology is used to scan paper claims and place them into an electronic, outbound claim format, by populating the electronic claims parameters. HealthLink is able to scan professional claims and institutional claims and subsequently send these outbound electronically to payors.

EDI Vendor Number

We require the use of our EDI vendor identification number for all claims submitted electronically. 90001 is the PPO number used for patient ID cards for HealthLink affiliated payors.

ELECTRONIC MEDIA CLAIMS (EMC) CAPABILITIES (*Continued*)

Route of Claims and Confirmations

Providers decide which clearinghouse best suits their needs. Clearinghouses furnish the providers with data requirements and the software necessary to communicate claim information. They may supply PC based software or other ways to submit files from the provider to their system. In turn, clearinghouses transmit the data to HealthLink electronically.

Clearinghouses usually send providers confirmation of receipt of the incoming electronic claims files and acknowledgement that they are relaying the claims to HealthLink. We send a receipt confirmation to the clearinghouse. The clearinghouse should relay HealthLink's confirmation to the provider. Results of using other or additional, secondary clearinghouses may delay our receipt of the claim, and may impede the confirmation process. Some clearinghouses do not support a tracking mechanism to display the path a claim or confirmation has taken from the provider to and from HealthLink. Therefore, HealthLink cannot explain what interim clearinghouse(s) transmitted claims to us or if a provider will receive confirmation of claims received from the clearinghouse(s).

HealthLink accepts 997 or 999 acknowledgements to track/confirm outbound claims sent to payors. Other options are used to confirm EDI claim file receipt between payors, clearinghouses and HealthLink.

Outbound EDI Claims Companion Guide

HealthLink provides payors with an outbound EDI Claims Companion Guide to supplement the HIPAA standards and to explain the business rules specific to HealthLink. The latest version of the Outbound EDI Claims Companion Guide is found on our website.

27X Transactions

ProviderInfoSource enables HealthLink contracted providers to access secure information about claim status and member eligibility from payors using 27X transactions. Our Companion Guide is available for 270, 271, 276, and 277 transactions. For HealthLink's EDI Companion Guides, go to www.healthlink.com (Standards & Requirements).

HEALTHLINK REPRICING SHEET
(FOR CMS 1500 OR PROFESSIONAL CLAIMS)

HEALTHLINK PRICING SHEET

****This is a REPRINT of an original adjudication****   PRINT DATE:
                                                                          ADJUDICATION DATE:
                                                                          PROCESSOR:

CARRIER/TPA. |EMPLOYER INFORMATION:
Address: |Group Number:
                                                    |Group Name:

CLAIM INFORMATION: |EMPLOYEE INFORMATION:
Claim Number: |Employee Social Security #:   Plan:
Remit To: |Policy #:
Provider Name: |Member ID:
Provider Network: Participating Status: |Employee Name:
Taxonomy/Specialty Code:
Effective Date: Tax Id#: |Patient Name:
Termination Date: Fee Schedule: |Relationship: Date of Birth:
NPI:
Patient Account #:   Patient Eligibility Status: Date:
                                                    |Provider Plan:

                              UTILIZATION REVIEW INFORMATION
Diagnoses:
Diagnoses:
Diagnoses:
Diagnoses :

Place of Serv.	Date of Service	Revenue/ RVS Code	Description	Charge	HEALTHLINK Contracted Amount	Code
11	07/05/00	99213	OFFICE VISIT EST PATIENT			

--TOTALS:

CODE(S):

HEALTHLINK REPRICING SHEET
(FOR UB 04 OR INSTITUTIONAL CLAIMS)

HEALTHLINK PRICING SHEET

PRINT DATE:
PRICING DATE:
PROCESSOR:

****This is a REPRINT of an original adjudication****

CARRIER/TPA:
ADDRESS:

| EMPLOYER INFORMATION:
| Group Number:
| Group Name:

_____

CLAIM INFORMATION:
Claim Number:
Remit To:
Provider Name:
Provider Network: Participating Status:
Taxonomy/Specialty Code:
Effective Date: Tax ID #:
Termination Date:
NPI:
Patient Account #:

| EMPLOYEE INFORMATION:
| Employee Social Security #:   Plan:
| Policy #:
| Member ID:
| Employee Name:

| Patient Name :
| Relationship: Date of Birth:

| Patient Elg. Status: Date:
| Provider Plan:

_____

UTILIZATION REVIEW INFORMATION

UR CASE NUMBER:

PRECERTIFICATION/CERTIFICATION: UR NOTIFICATIONS: DATE:

Obtained:
Approved:
Final LOS: Days not
Days Cert.:   Denied: Reviewed:
Final DRG: Diagnosis: Procedure:

SECOND OPINION:
Required:
Obtained: Concurring:
Waived:

_____

Place of Serv.	Date of Service	Revenue/ RVS Code	Description	Charge	HealthLink Contracted Amount	Code
21	09/14/01	122	R&B-Semi-Private			
21	09/14/01	251	Pharmacy-Generic Drugs			
21	09/14/01	252	Pharmacy-NonGeneric Drugs			
21	09/14/01	258	Pharmacy-IV Solutions			
21	09/14/01	270	Medical Surgical Central-General Class			
21	09/14/01	272	Medical-Surgical Central-Central Steri			
21	09/14/01	300	Laboratory-Clinic-General Classificati			
21	09/14/01	301	Laboratory-Clinic-Chemistry			
21	09/14/01	305	Laboratory Clinic-Hematology			
21	09/14/01	306	Laboratory-Clinic-Bacteriology and Mic			
21	09/14/01	320	Radiology-Diagnostic-General Classify			
21	09/14/01	324	Radiology-Diagnostic-Chest X-Ray			
21	09/14/01	402	Other Imaging Services Ultrasound			
21	09/14/01	410	Respiratory-General Classification			
21	09/14/01	412	Respiratory-Hyperbaric Oxygen Therapy			
21	09/14/01	730	EKG (ECG)-General Classification			
21	09/14/01	740	EEG-General Classification			

-- TOTALS:
CODE(S)

HEALTHLINK REPRICING SHEET EXPLANATION

<u>**Carrier/TPA:**</u>

1.	**Name and address** of the appropriate claim payor

<u>**Employer Information**</u>:

2.	**Group number (payor's client group number)**

3.	**Name of the employer group**

<u>**Claim Information:**</u>

4.	**Claim Number** is the number HealthLink assigns to each claim. This number incorporates the Julian date the claim was received. We refer to it as our "DCN" number.

5.	**Remit To** provides payee information for the claim payor. All benefits issued must be made payable to the provider named in this field.

6.	**Provider Name** indicates the provider who rendered the services. Claims from participating physicians will usually show the individual provider of service. Non-participating physician claims may show individual or corporation. Only one provider is listed per claim.

7.	The **Provider Network** field indicates the provider's association within the HealthLink provider networks.

> ***Open Access Plans*:** Open Access plan participants may access HealthLink's PPO and HMO provider networks. When the adjudication is for Open Access then "OA" will be displayed in the Provider Network field.
>
> The Participating Status field will display **"H"** for HMO, **"P"** for PPO or **"N"** for non-participating.
>
> **Participating Status:** This field indicates "P" for participating in HealthLink's provider network and "N" for non-participating provider.

Adjudication forms may also indicate "SPC" or "PCP" in this field for participating physicians. This is account specific only, and will not display for all groups.

> **"SPC"** means the provider practices a sub-specialty (i.e., Allergy Immunology, Cardiothoracic Surgery, Cardiovascular Surgery, Dermatology, etc.).
> **"PCP"** means the provider practices a primary specialty (General Practice, Family Practice, Internal Medicine, Obstetrics / Gynecology and Pediatrics).

HEALTHLINK REPRICING SHEET EXPLANATION *(Continued)*

8. **Effective Date** shows the date the provider became active in one or more of the HealthLink networks. If the provider is not an enrollee of HealthLink's network, "N/A" will appear.

9. **Tax ID Number** is the primary employer tax ID number for which the provider bills.

10. **Termination Date** shows the date the provider terminated participation with HealthLink. If the provider is still an active HealthLink provider, or is not a participant of HealthLink, "N/A" will appear.

11. **Fee Schedule** is the participating provider's fee schedule designation.

12. **NPI (National Provider Identifier)** is the provider's unique identifier.

13. **Patient Account #** information for professional claims can be found in field #26 and the control number on institutional claims can be found in field #3 or #3a.

Employee Information:

14. **Employee Social Security Number** is the social security number or unique identifier of the insured or participant.

15. **Employee Name** is the name of the insured or participant.

16. **Patient Name** is the name of the person for whom the claim is filed.

17. **Relationship** is that of the patient to the employee. Options include "EMP" if the patient is the employee, "SP" if the patient is the spouse and "DEP" if the patient is a child or other dependent.

18. **Date of Birth** is that of the patient.

19. **Patient Eligibility Status** is indicated as in HealthLink's files. The options are "ACT" if they are active and "TERM" if they are terminated for HealthLink network access.

    NOTE: HealthLink does not certify eligibility.

20. **Date** is either the effective date or termination date of coverage according to the information in our files. HealthLink network access effective and termination dates are updated as we receive information from the employer or payor.

Utilization Review Information: (On Inpatient Claims)

These items are pulled over from the Utilization Management information contained within the HealthLink system. Certifications of hospital stays and reviews of bills are completed by Utilization Management RNs and MDs.

HEALTHLINK REPRICING SHEET EXPLANATION *(Continued)*

Precertification/Certification:

21.   **Obtained** indicates if the precertification process was followed. Options are "Y" if precertification was obtained or "N" if precertification was not obtained.

22.   **Approved** indicates whether the admission was certified. Options are "Y" if admission was certified, "N" if admission was not certified or "N/A" if admission certification is not applicable.

23.   **Final LOS** (Length of Stay) is the total number of days that the patient was confined.

24.   **Days CERT** indicates the number of days certified by Utilization Management as medically necessary.

25.   **Denied Days** are those, which are denied by Utilization Management as not medically necessary.

26.   **Days Not Reviewed** are days which required review but which occurred prior to HealthLink's knowledge of the admission; or did not require review due to plan provisions.

   NOTE: **DAYS APPROVED plus DAYS DENIED plus DAYS NOT REVIEWED will always equal the Final Length of Stay. Assessment of any penalties or reduction of benefits is determined by the payor, not HealthLink.**

27.   **Final DRG** is the DRG assigned to the confinement upon retrospective review.

Utilization Management Notifications:

28.   Will indicate if the notification to Utilization Management was done according to the plan provisions. Notifications will include; ADMISSION CERTIFICATION APPROVAL, PRE-ADMISSION CERTIFICATION APPROVAL, HOSPITALIZATION NOT REVIEWED (HealthLink became aware of the admission when claim was received).

Second Opinion:

29.   **Second Opinion** will only be indicated on inpatient related confinements. This section will not be applicable to outpatient related confinements.

HEALTHLINK REPRICING SHEET EXPLANATION *(Continued)*

30. **Diagnosis** is the principal or first diagnosis given for the claims.

31. "**Apply Preferred Rates"** will appear for those situations which required out-of-network services which were authorized by HealthLink's Utilization Management Department. This is HealthLink's recommendation to the payor to pay benefits at the preferred level if applicable.

32. **Place of Service** is where the service was rendered. Options include "21" for inpatient hospital, "22" for outpatient hospital, "11" for doctor office, "23" for emergency room and "12" for home.

33. **Date of Service** is the calendar date on which a particular service was provided.

34. **Revenue/RVS Code** is either the hospital revenue code or the CPT code for the particular procedure.

35. **Description** is the written definition of the preceding Revenue or CPT code.

36. **Charge** is the provider's actual billed charge for the service provided.

37. **HealthLink Contracted Amount** is the contracted rate for this service based on the location and fee schedule, which is applicable, if a HealthLink provider provides the services. If a non-HealthLink provider renders the services, this amount will equal the billed charge.

38. **Code** is a three-digit number, which indicates something is unusual about this claim. An explanation will print at the bottom of the adjudication form.

39. **Code(s)** is a description of the three-digit code explained above. This will indicate such things as duplicate claims, charges incurred after the enrollee's termination date, etc.

40. **Adjustment Code(s)** indicates that we are adjusting this claim that had been previously processed by HealthLink and will indicate the reason for the adjustment.

41. If the **new claim is a duplicate of a previously processed claim**, a copy of the information printed on the original adjudication will be attached. The copy will indicate the original claim number processed. This applies to manual claims only.

ELIGIBILITY AND GROUP NOTIFICATION

We depend on accurate eligibility information from payor partners. Timely and accurate eligibility are the essential ingredients for the efficient distribution of claims after network repricing.

The regular transfer of accurate eligibility information results in significantly fewer customer service issues. Providers may send claims without full payor identification or with outdated payor information. We rely upon payors to provide accurate eligibility information to enhance our claims routing processes.

New Group Implementation - Payors should notify us regarding the implementation of a new client group in advance of the effective date (whenever possible). Group information is submitted by email to Sales-AcctMgmt@healthlink.com. Group changes, updates or terminations are presented in the same manner. Accurate payor group records are necessary for optimum functioning of our claims system. The group file is designed to point our processes to the correct network repricing type. Therefore, payors with multiple products, such as PPO and Open Access/HMO need to notify us in advance of effective dates of product changes for specific groups. A group notification form is available on our website. The contracted payor's own form is also acceptable.

Submitting Membership Information - Submission of electronic membership (eligibility) information is also a crucial step in the network operation. We offer various methods to our payor partners for submitting membership information.

Frequency of Eligibility Transmissions - Payors are required to submit full eligibility files on active subscribers and dependents at least monthly (and sometimes more frequently), with recent terminations also shown, in order to update our files in an automated manner (Excel files are <u>not</u> acceptable transmission methods).

Transfer process - We prefer to receive files electronically via:

- FTP
- Encrypted email to
  Eligibility@healthlink.com

Information required - Eligibility files must include all pertinent membership information:

- Group names and the payor's group numbers;
- Network effective dates;
- Subscriber/dependent information (full name, subscriber social security number, address, gender, birth date and relationship code).
- Client ID (pre-assigned by HealthLink)

For a copy of eligibility specifications, visit our web site at www.healthlink.com then click on TPAs > Forms & Guidelines > Eligibility Requirements.

Web site: www.healthlink.com
Email: eligibility@healthlink.com

HealthLink Electronic Eligibility Format Specifications

Version TDC.7.003

Purpose of Document

This document describes **HealthLink's Eligibility Format Specifications** for receiving eligibility information electronically for subscribers accessing HealthLink networks or products.

Eligibility Format – New Client/Change Request Sheet

HealthLink requires industry standard file types and specific information to correctly set up the HealthLink system and manage membership information, which is used to comply with privacy standards to appropriately identify, reprice and route claims to payors.

The submitter (usually the payor) must complete the accompanying **"Eligibility Format – New Client/Change Request Sheet"** and return it to HealthLink. This form is also available on HealthLink's Web page (www.healthlink.com) or by contacting the Enrollment Department.

A new submitter (e.g. a new payor) is required to send a **test file** with the New Client form, and a copy of the file layout to our Enrollment department, during the implementation process to allow adequate programming and testing time if needed. Usually, this is 30 – 60 days prior to the group's effective date with the HealthLink network. The Enrollment department reviews and loads the test file to ensure the format and methods of transmission are functioning properly. The FTP transmission methodology is established during the implementation process to be used for testing.

The "Eligibility Format – New Client/Change Request Sheet" is used to communicate changes in the eligibility format such as media type, file format, or file frequency. Payors may send their file layout document with the notification sheet.

Eligibility File Media and Transmission Types
HealthLink receives eligibility files in one of the following ways from payors or the payor's vendor:

- FTP (File Transfer Protocol) with PGP encryption
- SFTP (Secure File Transfer Protocol)
- Email to eligibility@healthlink.com

FTP or SFTP is our preferred file submission methodology. The definition of FTP and frequently asked questions about FTP are found in the Payor Manual on our web site under TPA>Forms and Guidelines>Administrative Manual.

The record for an employee (or primary member) and his/her dependents on the eligibility file must be in the same format or layout.

HealthLink is able to accommodate the electronic receipt of full eligibility files from each payor, which is used to automatically update the records following each submission. Eligibility files are submitted in the standard eligibility format described in this document. If a submitter (payor) must use another format, we request that a copy be forwarded to HealthLink, in advance. HealthLink's IT programming staff will review the request and notify the submitter whether the format can be accommodated, with a time estimate to set-up the format. Sending files in the standard format reduces errors, and greatly expedites the loading process. **Use ASCII for all files**.

Full eligibility files include all members who are active, as well as **terminated members**. Once a member's access to HealthLink networks has been terminated the member record should remain on the full file for three consecutive months.

After loading the full eligibility file, HealthLink will email an **eligibility confirmation report**, which includes a summary of the client's electronic eligibility file loading status. A sample confirmation report is found at the end of this document.

HealthLink accepts **ANSI 834 files**. More information on submitting in the 834 format can be found on the HealthLink web page (www.healthlink.com), or by contacting the Enrollment Department. The ANSI 834 file format is designed for client groups to submit enrollment information to a health plan. 834 may be used for the network business, but care should be taken to include network access effective and termination dates, and specific network designations (as applicable).

Files are usually submitted on a monthly basis. For large blocks of business (over 10,000 member records/file) more frequent transmissions are recommended.

- New clients are contacted to establish a mutually agreeable "standard" submission date.
- For established payors/clients, it is only necessary to complete a new sheet upon intent to make schedule changes or format changes from the current submission methodology.

It is imperative that the submitter (payor) **send only HealthLink membership data** on the files indicating the appropriate product and network access. Ancillary services sold through HealthLink may require modifications to the file data, and will be handled in a separate implementation process. Any membership information pertaining to business for which HealthLink is not responsible should not be submitted on eligibility files. Effective dates are those related to the HealthLink network access only.

Multiple Groups, Networks and Products

Multiple Groups

"Payor Group Numbers" are unique identifiers assigned by the submitter (payor) to identify each client group. HealthLink uses **"payor group numbers"** to load group records into our system.

- The submitter (payor) needs to complete the "Payor Group Number" field (positions 1 – 15).
- All groups are submitted on one file, identifying the different groups with unique group numbers. For example, a TPA should submit one file containing all groups' membership records, not a separate file for each group.
- The submitter (payor) must notify HealthLink of their group number configuration in advance of submitting the membership for a specific client group. HealthLink's Enrollment Department adds payor group numbers into the HealthLink system, before eligibility data for the group can be loaded.
- Without payor group number notification to Enrollment and the payor indicating the group information in the exact same configuration as the file (examples: leading digits or dashes between numbers), HealthLink is unable to identify the group and unable to load the membership, which delays the process and may result in claims service problems.

Multiple Networks

"Network ID's" are unique identifiers assigned by submitter (payor) to identify payors or groups that have access to more than one network. For example, if a payor or group has membership that has access to the HealthLink PPO network and membership that will access the HealthLink HMO (Open Access) network, a **Network ID** will need to be added to positions 20-24 to identify which network each member accesses.

Multiple Network Products

"Product Codes" are unique identifiers assigned by the submitter (payor) to identify payors or groups that have access to more than one network product. For example if a payor or group has membership that accesses the PPO network product and other membership that has access to the Open Access II network product, a **product code** will need to be added to positions 25-27 to identify the network product for which each member accesses.

HealthLink Electronic Eligibility File Specifications

Character set: ASCII
Format: Fixed Width
File Name: (see File Naming Convention)

File Naming Conventions:

File naming conventions apply to the file ID for FTP files, and email files.

For **email files**, the **Client ID** should be included in the email subject and body of email, using the following naming convention.

The file name should appear similar to "**H12340501**".
   (1) The file name is a nine character ID with first character being either an H or T.
               (a) "H" meaning production file
               (b) "T" meaning test file
   (2) Character positions 2 – 5 contain the Client's ID number assigned to each unique electronic file received. In our example the client ID is "1234"
   (3) Character positions 6 – 7 indicate the 2-digit month the file was generated. In above example, the month is "05" for the month of May.
   (4) Character positions 8 – 9 contain the 2-digit day the file was generated. In the above example, the day is "01" for the first day of the month.

For **FTP Files**, the file name should appear similar to "ELIG_20040702_001.PGP.

   (1) The file name is a twenty-two character ID with the first four characters being ELIG
   (2) Character positions 6 – 9 contain the 4-digit year the file was generated. In our example the year is 2004.
   (3) Character positions 10 – 11 contain the 2-digit month the file was generated. In our example the month is "07" for the month of July.
   (4) Character positions 12 – 13 contain the 2-digit day the file was generated. In our example, the day is "02" for the second day of the month.
   (5) Character positions 15 – 17 contain the sequence number if multiple files are being sent on the same day. The sequence number will always be 001 for the first file submitted; any additional files submitted on the same day will follow the same sequence pattern. In our example the sequence number is 001.
   (6) Character positions 19 – 21 contain the PGP extensions as all files submitted to HealthLink FTP server are required to be encrypted with the HealthLink PGP key.

Clarification About Member Terminations:

For the purposes of this document:

- "Insured", "Subscriber" and "Employee" have the same meaning, and represent the primary party with coverage under the payor's health benefit plan.
- "Member", "Covered Person" and "Dependent" denote any person covered under the payor's health benefit plan that can be either an employee or a member of their family (spouse or children).
- "Insured" = Subscriber or Employee or Primary Member
- "Member" = Covered Person, Dependent, Employee, Insured or Subscriber

File Layout Specifications with Field Descriptions

Key:

Position: Placement in the field
Length: Number of characters allowed for the field
Type: "AN" = Alpha-numeric (left justified in a field of spaces); "N" = Numeric (Right justified in a field of zeros)
Required: Y (Yes); N (No)

Field Name	Position	Length	Type	Required?
Payor Group Number	1 – 15	15	AN	Y

Payor group numbers are unique identifiers assigned by the submitter (payor) to each group.

Eligibility information is included for all client groups on the same electronic eligibility file with the "Payor's Group Number" field populated.

HealthLink uses the payor's group numbers to load groups into the HealthLink system. The submitter (payor) must provide HealthLink with their group numbers for HealthLink's Enrollment Department to add these records into the system for identification **prior to submission of the membership records**. Without these group records and numbers, a significant delay will occur to the load of the membership, since HealthLink will not be able to identify the group without calling the payor for the information and re-loading the eligibility file.

The group notification forms is available on the HealthLink web site.

Field Name	Position	Length	Type	Required?
Location Code	16 – 19	4	AN	N

Segregation of a group's eligibility due to specific locations, branch numbers, benefit levels, account codes, unit, numbers, etc., requires a **location code** added to the group number. It is a best practice to combine the location code with the payor's group number, as a suffix, appearing at the end of the payor's group number.

Example: A group has three branch locations. The group's number is "12345"; the office locations are 01, 02 and 03. The group number field would be:

- 1234501 for a record indicating location 01
- 1234502 for a record indicating location 02
- 1234503 for a record indicating location 03

Note: This only applies to a specific group requiring a separation of their eligibility due to reporting requirements, affiliated networks use or special products usage for subdivisions of a client group.

| **Network ID** | 20 – 24 | 5 | AN | N |

Network ID's are used to identify which network the member will access. These are only required for files that contain membership for more than one network.

| **Product Code** | 25 – 27 | 3 | AN | N |

The product code is a unique identifier assigned by the submitter (payor) to note groups using more than one of HealthLink's network products. An example is for segregating member records with PPO network access from those with Open Access II network access.

| **Name of Group** | 28 – 57 | 30 | AN | Y |

This field is for the payor's group name associated with the specific payor's group number. If the file contains multiple groups, each group should have a different group name.

| **Insured's Social Security Number** | 58 – 66 | 9 | N | Y |

Use the Social Security Number of the insured to identify the insured, as well as associate all his/her dependent records with this master record.

| **Insured's Policy Number** | 67 – 96 | 30 | AN | N |

If Social Security Numbers are not used to identify the insured, then use this field for the payor's policy number.

In many instances, the Social Security Number of the insured is the policy number, in which case, this field is not used. Use this field for the **payor's Privacy ID number**.

Provide **both the Insured's SSN (see field above) and the Policy or Privacy ID numbers** when used. This facilitates cross-referencing with our records. Many providers utilize the insured's SSN, even when payors use special policy or privacy numbers.

| **Member's Number** | 97 – 98 | 2 | N | Y |

"00" = Insured
"01" = Spouse
"02" = Dependent
"03" = Dependent, increased sequentially for additional dependents

Member's Last Name	99 – 123	25	AN	Y
Members First Name	124 – 138	15	AN	Y
Member's Middle Initial	139	1	AN	N
Member's Address – line one	140 – 169	30	AN	Y
Member's Address – line two	170 – 199	30	AN	N
Member's City	200 – 214	15	AN	Y
Member's State	215 – 216	2	AN	Y
Member's Zip Code	217 – 225	9	N	Y
Member's Phone Number*	226 – 235	10	N	Y

*Include area code. Do not use any punctuation.

Member's Birth Date	236 – 243	8	AN	Y

Format: MMDDYYYY
For example, January 1, 2000 would be entered as "01012000", designating a 4-digit year.

Member's Gender	244	1	AN	Y

"M" = Male
"F" = Female

Member's Relationship to Insured	245	1	AN	Y

"1" = Insured
"2" = Spouse
"3" = Dependent
"4" = Student
"5" = Other

Member's Status	246	1	AN	Y

"A" = Active
"T" = Terminated

This is the **status of membership** with the HealthLink network. In the event the group and membership change from one network product to another, such as PPO to Open Access II, the PPO record should be terminated on one date, and the Open Access II member record with an OA II indicator become active the following date. Without this distinction, claims will not be processed correctly with the correct network access or network product access.

| **Member's Effective Date** | 247 – 254 | 8 | AN | Y |

Format: MMDDYYYY

For example, January 1, 2000 is "01012000" to indicate the 4-digit year. Indicates the effective date with the network or specific network product. This effective date (and termination dates) point our system to the proper claims repricing procedures.

| **Filler (Not Used)** | 255 | 1 | | |

| **Member's Termination Date** | 256 – 263 | 8 | AN | Y |

Format: MMDDYYYY
For example, January 1, 2000 is "01012000".

Note: If a member's network access or network product type is terminated, a termination date is essential. A termination date is used only if the specific record is terminated, and is not used for future or default termination dates. For unions with members in hour banks, terminate the member record when the member moves out of town, or no longer would have network access. The member record should not be changed "on and off", such as when the union member's hours of service temporarily change (the record should stay on the file).

| **Insured's Contract Type** | 264 – 265 | 2 | AN | N |

"S" = Single
"F" = Family
"EC" = Insured and Child
"ES" = Insured and Spouse

It is very helpful if the member number (i.e., 00, 01) assigned to an individual member remains the same, when adding or terminating dependent(s).

- Designate a new number for each new member. This includes the addition of a new spouse or dependent.
- Do not change the number assigned to existing members or reassign the number to a new spouse or dependent.

For example, if an insured is divorced and then remarries, the original spouse is terminated and a new spouse (and member number) is added. The same relationship member number on the new member should not be re-used, as was assigned to the previous member record. Assign the new member the next available member number. In the event that this cannot be accommodated, we should be notified so automated loading of files can function properly. Terminating the primary insured record, doesn't automatically terminate the associated dependent records.

Individual Coverage Flag	266	1	N	N

This flag is used when a submitter (payor) has "Individual Policies"; meaning that the insured does not belong to a specific client group.

HealthLink will place the individual insureds records into a single or **global group** to avoid the confusion of creating an individual group for each insured record. In such situations, the **Individual Coverage Flag** can be used to indicate that, while the different insureds do not have the same group or policy number, they can be treated as one group for HealthLink's purposes. Placing individual insured records into global groups, segregated only when network access or product type are different, provides the best claims repricing service. For example, a payor with some individual health insureds with PPO network access will be placed into one global group, and another global group would be used for those individuals with the Open Access III network program plan.

PCP – Number	267 – 272	6	N	N*

This is the HealthLink six-digit provider number of the member's primary care physician.
Note: This field is optional. It is not necessary for other network products.

PCP Effective Date	273 – 280	8	N	N*

Format: MMDDYYYY
For example, January 1, 2000 is "01012000"
This is the date that the member's primary care physician (PCP) was assigned.
Note: This field is optional. It is not necessary for other network products.

Other Address – Line One	281 – 310	30	AN	N

The other address fields can be used if the member has a second address that should be used for correspondence instead of the regular address.

Other Address – Line Two	311 – 340	30	AN	N
Other Address – City	341 – 355	15	AN	N
Other Address – State	356 – 357	2	AN	N
Other Address – Zip Code	358 – 366	9	N	N

File Layout Specifications-Simple Layout

<u>Field Name</u>	<u>Position</u>	<u>Length</u>	<u>Type</u>	<u>Required?</u>
Payor Group Number	1 – 15	15	AN	Y
Location Codes	16 – 19	4	AN	N
Network ID	20 – 24	5	AN	N
Product Code	25 – 27	3	AN	N
Name of Group	28 – 57	30	AN	Y
Insured's Social Security Number	58 – 66	9	N	Y
Insured's Policy Number	67 – 96	30	AN	N
Member's Number	97 – 98	2	N	Y
Member's Last Name	99 – 123	25	AN	Y
Member's First Name	124 – 138	15	AN	Y
Member's Middle Initial	139	1	AN	N
Member's Address – line one	140 – 169	30	AN	Y
Member's Address – line two	170 – 199	30	AN	N
Member's City	200 – 214	15	AN	Y
Member's State	215 – 216	2	AN	Y
Member's Zip Code	217 – 225	9	N	Y
Member's Phone Number	226 – 235	10	N	Y
Member's Birth Date	236 – 243	8	AN	Y
Member's Gender	244	1	AN	Y
Member's Relationship to Insured	245	1	AN	Y
Member's Status	246	1	AN	Y
Member's Effective Date	247 – 254	8	AN	Y

Filler (Not Used)	255	1		
Member's Termination Date	256 – 263	8	AN	Y
Insured's Contract Type	264 – 265	2	AN	N
Individual Coverage Flag	266	1	N	N
PCP (HMO Only) **Note:** This field is optional.	267 – 272	6	N	N
PCP Effective Date (HMO Only) **Note:** This field is optional.	273 – 280	8	N	N
Other Address – Line One	281 – 310	30	AN	N
Other Address – Line Two	311 – 340	30	AN	N
Other City	341 – 355	15	AN	N
Other State	356 – 357	2	AN	N
Other Zip Code	358 – 366	9	AN	N

HealthLink®

Eligibility Summary Confirmation Report

*This confirmation report is designed to inform the eligibility submitter the status of and
results of loading the latest eligibility file.*

ClientName	"American Health Insurance"
ClientID	1234
Date Received	7/11/2004
Load Date	7/12/2004
Total Records Read	100,000
Client Groups	5
HealthLink Groups	5

Summary Information:

Total Active Subscribers	9111
Unique Active Subscribers	9033
Total Active Members	22007
Unique Active Members	21875

Sort Key

Detail Information:

Client Group	HL Group Num	Total Subscribers	Total Members
1234	PPK334	8977	19005
1234	LYI442	135	563

Wednesday, August 01, 2004

HealthLink®

Email to: eligibility@healthlink.com
HealthLink Enrollment Department

Eligibility Format
New Client/Change Request Sheet

This information is for (check one): ☐   **New Client**

☐   **Current Client, Requesting Changes**

Whether you are a new client or a currently submitting client requesting changes, it is important to complete all fields. Please see the *HealthLink Electronic Eligibility Format Specifications*, available at www.healthlink.com, if you have questions about this form. Please notify us in advance of changes to file format, frequency or transmission methods.

Company (Payor) Name:	
If Source Other Than Payor (Eligibility Vendor):	
I.T. Contact Name:	
Contact Phone & Extension:	
Contact Fax Number:	
Contact Email Address:	
Submission Method: FTP/Email HealthLink	
Type of File:	**Full Eligibility** **With 3 months of termination information**
File Format: (If you are requesting a format other than the HealthLink Standard, please attach a copy of the layout).	☐**HealthLink Standard** ☐**834 with HealthLink Dates**
Frequency of Submission: (Monthly or other. Please specify.)	☐**Monthly** ☐**Other** _____
Week of Submission: (For monthly clients, what week of the month will you send in the file)	☐_____
Confirmation Reports To:	
For use by HealthLink IT Only: **Client's ID:** _____	

834 ENROLLMENT (ELIGIBILITY) REQUIREMENTS

We offer the "ANSI 834 Enrollment Transaction" format to our payors to complement the current enrollment formats and processes.

Additional Requirements for the ANSI 834 Transaction:

Our current systems, processes and procedures are completely compatible with the ANSI 834 enrollment transaction.

- 834-transaction files should be submitted via FTP transmission with encryption.
- Files are to be HIPAA compliant as defined in the 834 <u>Implementation Guide</u>.
- The recommended file submission intervals are: Monthly (at minimum) or weekly (for business blocks above 10,000 lives).
- Full file format.
- HealthLink (or applicable) <u>network access</u> effective and termination dates.
- Both subscriber SSN and payor privacy ID number fields completed.
- Payor's group numbers must be included (except for individual health).

A copy of the "834-Implementation Guide Standards" can be found at <u>www.wpc-edi.com</u> for reference.

FILE TRANSFER PROTOCOL (FTP) WITH PGP ENCRYPTION

The TCP/IP Protocol suite is a set of communication protocols that is used to connect computers and other devices on the Internet. One of these protocols is the **File Transfer Protocol**, commonly referred to as **FTP**.

FTP is a fast and reliable method for transferring files between two remote computers, via the Internet.

A basic FTP connection consists of a remote computer (the client) calling an FTP server. FTP connections transmit information in two ways: the client may upload content from the server or download content to the server.

FTP is an Internet standard, and most computers already have some type of FTP client installed. The most common type of FTP client used today is the multi-purpose web browser, such as Microsoft's Internet Explorer. An advantage of FTP is that for a basic connection, it doesn't really matter what client is used.

In order **to make a connection**, the client is directed to connect to a specific FTP server. For example, to connect to the HealthLink FTP server using Microsoft's Internet Explorer, type the following into the address bar: ftp://ftp.healthlink.com/.

In order to transfer a file (upload or download) through FTP:

- Log in to a remote computer that has been configured as an FTP server.

- Enter a username and password to gain access to the remote system.

- Select the particular directory on the remote system which contains the file you wish to download or upload.

- Transfer the file **to or from** the system in question.

To access the HealthLink FTP server, a payor submits a request form to HealthLink. The request will be forwarded to the Information Technology department, who will work with the payor's designated contact on the FTP implementation and testing processes.

Once FTP transmission testing has been deemed successful, the new process may be placed into "production".

FREQUENTLY ASKED QUESTIONS ABOUT FILE TRANSFER PROTOCOL (FTP)

Q: What is FTP and how does it work?

A: FTP is a method of transferring files between two remote computers. Files are transmitted from one location to another using the Internet.

Q: What types of files can be transmitted via FTP?

A: Payors can *receive* participating provider files and electronic claims via FTP and *send* enrollee eligibility files via FTP.

Q: Is FTP a secure method to send and receive confidential data?

A: Yes, transactions are encrypted to ensure protection of confidential data using PGP encryption.

Q: What is needed to take advantage of the FTP capabilities?

A: In order to use FTP, an FTP client is needed (i.e. Microsoft Internet Explorer), as well as a user name, a password, the directory to which data will be sent or received, and Nippon's/HealthLink's FTP server address.

Q: Who should be contacted for more information about FTP?

A: For more information about FTP, please contact 800-235-0306.

Q: Who should be contacted if our firm is ready to begin sending/receiving files via FTP now?

A: To begin FTP transmissions or submissions, please contact your Account Manager or contact HealthLink's Sales Department.
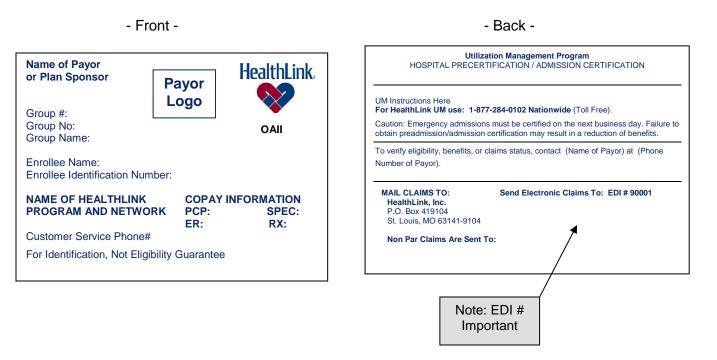
ID CARDS FOR ENROLLEES

To support efficient claims administration, HealthLink's name and logo are required on the front of all Enrollee Identification Cards. The name and logo position HealthLink as the network, and are readily identifiable by HealthLink participating providers as a point of reference in the filing and follow-up of their claims.

The name and logo of the benefit administrator is also noted on the card. This establishes the name of the entity administering benefits on the plan participant's behalf and processing payments to the provider of service. The payor's logo should be larger than the network logo and located on the front of the card.

We educate participating providers about the nature of this network/payor relationship. This helps to direct claims to the proper payor.

Enrollee ID cards produced by payors should conform to HealthLink standards. These standards assist providers in identifying and routing claims for repricing. The information provides enrollees and participating providers with the necessary information for proper service.

Sample ID Card

- Front -   - Back -

Name of Payor or Plan Sponsor
 	
Payor Logo   **HealthLink**
 	
OAII
 	
Group #:
Group No:
Group Name:
 	
Enrollee Name:
Enrollee Identification Number:
 	
NAME OF HEALTHLINK   **COPAY INFORMATION**
PROGRAM AND NETWORK   **PCP:**   **SPEC:**
                    ER: **RX:**
 	
Customer Service Phone#
 	
For Identification, Not Eligibility Guarantee
	Utilization Management Program
	HOSPITAL PRECERTIFICATION / ADMISSION CERTIFICATION
	
	UM Instructions Here
	For HealthLink UM use: 1-877-284-0102 Nationwide (Toll Free).
	
	Caution: Emergency admissions must be certified on the next business day. Failure to obtain preadmission/admission certification may result in a reduction of benefits.
	
	To verify eligibility, benefits, or claims status, contact (Name of Payor) at (Phone Number of Payor).
	
	MAIL CLAIMS TO: **Send Electronic Claims To: EDI # 90001**
	   HealthLink, Inc.
	   P.O. Box 419104
	   St. Louis, MO 63141-9104
	
	   Non Par Claims Are Sent To:

Note: EDI # Important

ID CARDS FOR ENROLLEES *(Continued)*

Requirements for Payor Produced HealthLink ID Cards:

- Payor name*

- Payor logo*

- HealthLink logo and network information on the front of the card*

   For clients with travel networks, the travel network logo is to be positioned on the back of the card with the HealthLink logo remaining on the front of the card.

- Toll-free number for benefit verification, eligibility information and claim inquiries*

- Subscriber name*

- Dependent name

- Subscriber ID number*

- Group name

- Group identification number*

- Most common co-payment amounts (ER, Rx, outpatient visits)

- **HealthLink Utilization Management # Nationwide**: (877)-284-0102. Call HealthLink to precertify outpatient surgery, diagnostic and ancillary services. HealthLink must also be notified prior to any elective hospital admission (if applicable).

- **HealthLink Customer Service** nationwide telephone number for network information

   Nationwide: (800)-624-2356*

- Claim filing address*

- Disclaimer: This card is not a guarantee of coverage. For confirmation of eligibility**,** contact the benefit administrator. *****

- HealthLink EDI vendor numbers for filing PPO claims electronically (EDI# 90001).

- [If applicable, HealthLink EDI vendor number for filing HMO claims is 94675.]

* Required information on the list above is indicated by an asterisk (*).

EXPLANATION OF BENEFITS

Explanation of Benefits forms (EOBs) are sent by payors to both enrollees and providers. These EOBs provide necessary information about claim payment information and patient responsibility amounts. Sample EOBs are provided initially when implementing the payor contract with HealthLink. Compliance is checked periodically thereafter. Payor Relations retains sample copies on file. Patient responsibility amounts are needed for accurate patient balance billing. This is an important aspect of the "Explanation of Benefits" review process.

Both enrollee and provider Explanation of Benefits (EOBs) shall include the following elements:

- **Name and address of payor***
- **Toll-free number of payor***
- Subscriber's name/address*
- Subscriber's identification number*
- Patient's name*
- Provider name*
- Provider tax identification number (TIN)
- Provider's 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 applied, annual out-of-pocket/amount applied, lifetime maximums/amount applied)
- ERISA disclosure (if applicable)
- Discount Remark – "Discount For HealthLink Participation" *

* Required information on the list above is indicated by an asterisk (*).

DIRECTORIES (AND PROVIDER-FINDER ALTERNATIVES)

A listing of HealthLink participating providers is available on our website – www.healthlink.com. This listing is updated each business day and is an easy way to find information about participating providers.

Payors may produce their own directories by requesting a directory PDF (formatted full directory listing) from their HealthLink representative.

PROVIDER (PAR) FILES

Par Files are generally distributed to select payors on a monthly basis by FTP connections. Email and CD versions are also available, but not preferred transmission methods.

The provider file data are used by payors to determine HealthLink provider participation status for claims that may be misdirected to the payor or for the payor's provider finder.

The file contains participating provider elements necessary for the payor to load information in its system.

HealthLink updates "par" files monthly. Full file and change file formats are available.

HealthLink encourages affiliate insurance companies and TPAs to maintain an accurate network "par" file; in part so that misdirected claims can be easily identified and rerouted for network repricing.

For those payors receiving HealthLink and/or affiliated network "par" files, the data will be sent in separate files at the same time each month.

Par file types available:

- HealthLink HMO (used to support Open Access I and II)
- HealthLink PPO
- Combined HealthLink HMO / PPO (used to support Open Access III)
- Combined UniCare/HealthLink (Illinois PPO Expansion)

Current Par File Specifications are located on the HealthLink website, www.HealthLink.com, on the payor pages, under Standards and Requirements.

- **File Types:**

  Clients may receive either a Full File that stores each participating provider record, or a Change File that carries only the changes made (i.e. providers added or terminated) since the previous file was generated.

- **Format Types:**

  The specification documentation will provide both the Fixed-Width and the Comma-Delimited file formats.

- **Naming Convention:**

  File naming conventions are explained in the complete specifications.

  Included is a sample of the naming convention for participating provider files, with details describing it following:

PROVIDER (PAR) FILES (*CONTINUED*)

HL021217PPO.txt

The first set of characters identifies the Provider Plan associated with this file.
- **HL** identifies the file as containing HealthLink providers.

The next six characters identify the date in YYMMDD (year, month, day) format. The **02** corresponds to the year 2002, the **12** corresponds to the twelfth month of the year (December), and the **17** corresponds to the seventeenth day of the month.

The last three characters identify the account (i.e. line of business) that these providers are on. For example, **PPO** identifies that these are PPO providers, or **OA3** would identify Open Access providers.

The file extension will either be **.txt** (denoting a text file) or **.zip** (denoting a zipped file).

- **File Frequency:**

The files are typically transmitted by HealthLink on the third Friday of every month.

- **Transmission Methods:**

The files can be transmitted using several methods including: FTP (File Transfer Protocol), Email or CD.

- **Taxonomy (Specialty Codes):**

A crosswalk table of HealthLink provider specialties with national taxonomy codes is available in the complete specifications.

PROVIDER CREDENTIALING REQUIREMENTS

A primary care physician must be duly licensed and qualified, with board certification or eligibility in internal medicine, pediatrics, obstetrics/gynecology and family practice or shall be a duly licensed and qualified general practitioner. *A specialist physician* shall be duly licensed and qualified, with board certification or eligibility in the area in which the specialist physician practices.

The physician shall at all times:

- Be licensed to practice medicine and maintain a high professional standing in all states in which he or she does business.
- Maintain all required professional credentials and meet all continuing education requirements necessary to retain his or her specialist professional designation.
- Maintain, in good standing, all qualifications for staff membership and admission privileges at one or more participating hospitals.
- Maintain a current narcotic number issued by the Drug Enforcement Administration (DEA) if applicable.

Participating providers contractually agree that all nurse and other health care personnel providing covered services to enrollees under the direction or guidance of a physician are duly licensed and/or certified in accordance with all federal, state and local requirements.

Evidence of such licensing shall be provided to the credentialing unit upon initial application and periodically thereafter (usually every three years) in accordance with our provider credentialing requirements.

Provider Re-Credentialing

Typically, physicians are re-credentialed every three years. Physicians are required to send updated licensing and other credentialing information to HealthLink. HealthLink verifies the credentialing information.

Standard re-credentialing information includes:

- Re-credentialing report update regarding malpractice cases.
- Current Drug Enforcement Administration (DEA) certificate release forms.
- Current state medical licenses.
- Physician practice information.
- Malpractice coverage summary.
- National Practitioner Data Bank (NPDB) report.
- Board eligibility verification.
- Specialty verification.
- Board certification verification.
- Current state controlled substance certification.

All credentialing information obtained by HealthLink from the physician or any other outside source remains confidential. A release from the physician or appropriate court order is required for the release of credentialing information to any third party.

PROVIDER CREDENTIALING OVERVIEW

Goal of Credentialing

The main goal of the credentialing program is to support the development and maintenance of credentialing and re-credentialing standards in accordance with URAC requirements; and to ensure enrollees have adequate access to a qualified provider network. The Medical Director of the Credentialing program and Credentialing department management personnel have responsibility for the development, implementation and oversight of the credentialing program. Credentialing policies and procedures are reviewed and approved on an annual basis by the Credentialing Committee; however, policies may be revised as necessary throughout the year. Such periodic changes are approved on an interim basis by the Medical Director and reported monthly to the Credentialing Committee to obtain formal approval.

Credentialing Committee

The Credentialing Committee meets monthly or as often as necessary to ensure the credentialing process is completed in an efficient and timely manner. The Committee is comprised of physician members. Minutes of each Credentialing Committee meeting are recorded and maintained in a confidential and secure manner within the Credentialing department.

Credentialing Department

The Credentialing associates have responsibility for collecting all of the required documentation and preparing and completing all provider files, including but not limited to obtaining primary source verifications of medical/professional license, medical education, residency, hospital privileges, board certification/board eligibility, professional liability policy/history and disciplinary actions (if applicable). Secondary source verifications include obtaining copies of the provider's medical/professional license, DEA/State Controlled Substance certificates, professional liability coverage certificate and CV/Work History (if applicable). Each provider must also submit a completed, signed and dated Standardized Credentialing Form and Statement of Attestation.

Confidentiality of Credentialing Activities

Any individual engaged in credentialing activities maintains the confidentiality of all information collected and/or presented as part of the credentialing process. All credentialing information received is kept in strictest confidence and maintained in a secure environment. Access to such information is restricted to only those individuals directly involved in achieving the objectives of our credentialing program.

PAYOR RELATIONS
(Carriers with Insured and Self-Funded Business and TPAs)

Account Managers are available to handle contract questions, data requests and to update payors on business strategies and overall network changes.

Network News, the Client-Payor newsletter, covers the latest news on network development, products and services.

PAYOR RELATIONS COMMITMENT

- Understand payors' needs and business strategies.
- Recognize and promote the value of payors' needs and perspectives.
- Promote communication flow between the network and our business partners.
- Maintain solid working relationships for our mutual membership benefits and business growth.

Contact your HealthLink representative regarding:
- Contract questions.
- Data requests.
- HealthLink policies and procedures.
- Changes in Medical Management and/or benefit designs.
- HealthLink network demographics and savings rates.
- Business strategies.
- Needs pertaining to the entire payor block of business.
- ID card, EOB or product design plans or changes.
- ASO contracts (for insurance companies with both fully insured and ASO business under contract).
- Anticipated changes in electronic eligibility formats.
- Camera-ready logos for ID cards.
- Changes in the "par" file processes.

Hours: 8 A.M. to 5 P.M. Central Time each business day.

Payor problem claims are emailed to CCRU@HealthLink.com with special instructions for handling.

CUSTOMER SERVICE DEPARTMENT

Our customer service department handles inquiries originating from PPO providers, enrollees, payor partners and others needing both general and detailed information.

The Customer Service department provides general information about the network and assists callers in locating suitable HealthLink network facilities, specialists and primary care physicians.

Some of our payors are connected via a "hotlink" to easily transfer the caller when necessary to the appropriate payor.

Calls, follow-up items, outcomes and statistical analyses are reported for reference and optional business management.

CUSTOMER SERVICE COMMITMENT

- Meet our customers' service expectations;
- Create a lasting impression of exceptional customer service and customer care;
- Develop strategies and internal training that furthers our service commitments.

Contact Customer Service Regarding:
- Claims Repricing Status & Questions
- Eligibility Questions
- Participating Provider Status
- Provider Demographics

Hours: 8:00 A.M. to 5:00 P.M. Central Time each business day.

Phone:
- Toll Free: (800) 624-2356
- FAX: (314) 925-6301 **(not for payor claims)**.

Payor problem claims are emailed to CCRU@HealthLink.com with special instructions for handling.

GRIEVANCES AND APPEALS

HealthLink has established and maintains a provider complaint, grievance and appeals process as well as a process for handling enrollee inquiries, complaints and grievances.

In the event of enrollee complaints, grievances and/or appeals regarding issues outside the scope of HealthLink's contractual responsibility, HealthLink directs the enrollee to the appropriate claims administrator or payor. HealthLink acknowledges complaints and refers them to the claims administrator or payor, unless the complaint deals with the quality of participating provider service or administrative services of the network, which are handled by HealthLink. Issues pertaining to eligibility and benefits are referred to the payor of record.

HealthLink's complaint, grievance and appeal resolution procedure is described below:

Complaint

When an enrollee contacts the HealthLink Customer Service department to verbally express dissatisfaction, the Customer Service department will make every attempt to resolve the issue by phone contact if it involves HealthLink's networks or administrative services. If the complaint involves a matter handled by the claims administrator or payor, HealthLink's Customer Service representative will assist the enrollee by referral to the claims administer or payor.

If the Customer Service representative, manager or team lead cannot resolve the HealthLink-related issue of dissatisfaction by phone; the representative may offer the formal grievance process by sending the enrollee a prepared form or advising the enrollee to submit his or her complaint in writing, if preferred.

Grievance

A grievance is a formal written complaint that involves a matter other than an adverse benefit determination.

HealthLink will allow issues such as the following to be addressed in grievances:

- The availability, delivery or quality of health care.
- The contractual relationship between the provider and HealthLink; or
- The quality of service received by a HealthLink associate, network provider or other affiliated party.

A grievance is not related to the denial of benefits for healthcare services.

Upon receipt of a grievance or a prepared grievance form, HealthLink will acknowledge, or formally respond to, the grievance within ten calendar days. The acknowledgement letter is sent to the complainant acknowledging receipt of the complaint and stating the timeframe of an expected HealthLink response. The grievance is investigated within 20 days and a written response stating the determination will be sent to the complainant in 30 days.

GRIEVANCES AND APPEALS *(Continued)*

HealthLink provides a single-level standard and an expedited appeal process only if HealthLink performs medical necessity review/medical utilization management. The purpose of utilization management and first level clinical appeal review is to assist the claims administrator or payor in determining benefits available under the plan. The Plan retains fiduciary authority to determine benefits.

Standard Appeal

A standard appeal regards an adverse medical necessity recommendation from HealthLink's Utilization Management and may be submitted to HealthLink in writing by the provider, enrollee or his or her authorized representative. A standard appeal will be processed within 15 days for pre-service appeals and 30 days for post-service appeals. The clinical review will be based upon relevant medical information submitted for review and performed by clinical staff who were not involved in the original adverse medical necessity recommendation. The letter of response will include the recommendation, a statement of the clinical rationale, and a statement directing the enrollee to the claims administrator or payor for further appeal rights and determinations of benefits. The claims administrator or payor receives a copy of the appeal response letter.

Expedited Appeal

An expedited clinical appeal is offered when the standard procedure time frame would seriously jeopardize the life or health of an enrollee or would jeopardize an enrollee's ability to regain maximum function or a request for an expedited review can be submitted.

An expedited review request may be verbal or in writing. A decision shall be made within seventy-two (72) hours after receiving the request. Written confirmations of the recommendations will be issued within three working days of the medical necessity review determination. As with the standard review process, the clinical review will be based upon relevant medical information submitted for review and performed by clinical staff who were not involved in the original adverse medical necessity recommendation. The letter of response will include the recommendation, a statement of the clinical rationale, and a statement directing the enrollee to the claims administrator or payor for further appeal rights and determinations of benefits. The claims administrator or payor receives a copy of the appeal response letter.

LEGISLATIVE ISSUES

HealthLink has a long-held strategic goal to ensure the timely payment of claims and to work closely with its participating providers and affiliated carriers to improve claims efficiency and to promote clear communications between providers, patients and payors.

HealthLink's participating provider agreement typically addresses prompt pay as an expectation of payments of "clean claims" within 30 days of receipt unless the health carrier or TPA provides notification to the provider of services regarding additional information necessary to perfect and adjudicate the claim, or unless a shorter time period is required by law. Various state laws govern prompt claim payment within the HealthLink Service Area. For your convenience, these state requirements may be accessed electronically via the NAIC website by clicking on the hyperlink below.

http://www.naic.org/state_web_map.htm

The statutes govern health insurance companies, non-profit health service plans and health maintenance organizations serving insured group/individual policies. The statutes do not preempt group contracts governed by the Employee Retirement Income Security Act of 1974 (ERISA) or exempt groups.

If your organization's regulatory compliance department has any questions regarding your organization's business relationship with HealthLink and its relationship to these prompt payment requirements, please do not hesitate to contact your Payor Relations representative.

Department of Labor Regulations (for ERISA plans only)

This claims procedure regulation creates patient protections that will ensure that group health plan participants have access to a fair process for benefit determinations including:

Decisions on initial claims - requires decisions (in most cases) *not later than*:

- 72 hours for urgent care claims
- 15 days for pre-service claims
- 30 days for post-service claims
- One 15 day extension for pre- and post-service claims

Decisions on appeal of denied claims –requires decisions (in most cases) *not later than*:

- 72 hours for urgent care claims
- 30 days for pre-service claims
- 60 days for post-service claims

Utilization management decisions and appeal notification letters contain diagnosis information (as well as identify if the claim was an urgent care claim). This modification has been made to provide affiliated payor partners with timely information to adequately make benefit and payment decisions. Utilization review letters are recommendations based upon criteria for medical necessity and are not benefit determinations.

HEALTHLINK'S WEBSITE

HealthLink has developed a website to provide members, providers and payors access to our provider network, programs and services. Log on to www.healthlink.com for researching providers or to learn about:

Find a Doctor
- Provider Information (names, service locations)
- Provider specialty information
- Provider board certification information

Programs and Services
- Health Care Programs
- Medical Care Management
- Discount Programs

TPA Resources
- Payor Administrative Manual
- Support Contacts and quick reference numbers
- Service Area Maps

Request a Quote
- Request a no obligation quote

Web Site Designed To Meet Customer Needs

HealthLink's web site includes the following information for payors:

- Specifications for outbound claims, eligibility and par files (in download versions);
- Most current version of the Payor Administrative Manual;
- Service reference addresses, phone and fax numbers;
- Product and service explanations;
- Personalized directories;
- Technical Tips documents;
- Credentialing overview; and
- Accreditation information.

Customized, Personal Provider Directories
From the home page of the website, individual enrollees, brokers, providers and payors may create and print personalized directories for:

- HealthLink PPO
- Open Access II (HMO Network)
- Open Access III
    - Tier I (HMO)
    - Tier II (PPO)

HEALTHLINK MEDICAL MANAGEMENT

KEY FEATURES

- **URAC Accreditation**
- **Preadmission and emergency admission pre-certification**
- **Concurrent review**
- **Specialty care referral**
- **Discharge planning**
- **Referral to Case Management**
- **Ambulatory / Outpatient review (optional)**
- **Second opinion surgical review (optional)**
- **Physician and RN reviewer staff**
- **Integration with HealthLink managed care programs**

HealthLink's Medical Management program is designed to assist payors in determining eligible benefits based on the medical necessity of covered health care services for their enrollees who are enrolled in one of our managed care networks. A staff of registered nurses and licensed physicians provides utilization management services. Medical management services adhere to the strictest rules for managing services for payors (and group clients and enrollees) confidentiality. Changes that result from HealthLink's focused approach to medical management include:

- Narrowing pre-certification of outpatient procedures to those procedures with high variability and high cost for those carriers that select this optional HealthLink ambulatory review program;
- Reviewing length of concurrent hospital stays by facility and diagnosis;
- Performing retrospective review of claims as determined by the payor.

Certification Review is conducted to determine the medical appropriateness, utilizing clinical criteria specific to the condition or service under review. Clinical criteria used to review are evaluated at least annually and are subject to approval by the Medical Director and the Healthcare Advisory Committee. The committee validates the current status and appropriateness of the criteria. Certification review is conducted on a focused review basis.

Cases not meeting criteria are referred to a physician advisor or the medical director. A physician advisor's review and consultation with the ordering provider are required prior to any negative recommendation.

Concurrent Review is conducted during the course of a hospitalization or treatment in order to determine the medical necessity for continuation of inpatient service.

Specialty Care Referral is made if a patient requires additional care from a specialist. The referring physician attempts to direct the patient to a participating provider. HealthLink is available to assist in the identification of the appropriate specialist, if necessary.

Coordinates Discharge Planning in cooperation with physicians, hospital nurses and social service organizations.

HEALTHLINK MEDICAL MANAGEMENT *(Continued)*

Case Management is designed to identify and assist benefit administrators and physicians treating patients with chronic or catastrophic illness and injury. These cases are usually referred to the payor or the payors' designated case management vendor for handling. It is important for the affiliate insurance company to provide HealthLink with their case management reference phone numbers, which HealthLink relays to providers for reference for specific cases upon request.

Ambulatory Review is an optional service for our PPO. Review of outpatient surgeries or procedures is conducted prior to the service. This review is conducted for medical necessity and appropriateness of the health care setting. There is an additional access fee for Ambulatory Review. Ambulatory Review is performed using a standardized, select list of diagnoses and procedures (periodically modified, but standardized for the provider network).

Appeals - Letters of non-certification include the principal reason(s) for the recommendation, the instructions for initiating an appeal and the instructions for requesting a written statement of the clinical rationale, including the clinical criteria used to make the recommendation. The physician, hospital, enrollee or enrollee representative may make requests for clinical rationale and/or appeal. The payor of records has the final decision-making authority related to benefit coverage under the plan.

Clinical Consultation Review – Review of a select list of cosmetic, experimental and investigational procedures is available, as an additional program.

Convenient Access - The Utilization Management department is open from 8:00 A.M. to 5:00 P.M. CST each working day. A toll-free voice mail system is available for messages outside of regular business hours. All messages are returned the next day. The Utilization Management number is: (877) 284-0102.

HealthLink's Utilization Management Program consists of the following elements:

- pre-admission medical necessity certification;
- emergency admission medical necessity certification;
- concurrent medical necessity review;
- specialty care notification from referring physician;
- appeals process.

Utilization Management is the process by which HealthLink reviews medical services or supplies, provided or to be provided to a Covered Person, for the purpose of making a recommendation to the Company or Plan regarding the medical necessity of such proposed services or supplies. Utilization management determinations are not medical treatment decisions and no patient-provider relationship exists between the HealthLink reviewer and the Covered Person. HealthLink's medical necessity recommendations are used by the Company or Plan to make benefit determinations. The provision of benefits to Covered Persons will be determined in accordance with the provisions of the applicable Plan and the administrator of the Plan retains authority with respect to eligibility, coverage and the benefits under the Plan.

HealthLink may upon its discretion modify the listing of procedures and services subject to medical necessity review.

HEALTHLINK MEDICAL MANAGEMENT *(Continued)*

**I.   PRE-ADMISSION MEDICAL NECESSITY CERTIFICATION OF PLANNED HOSPITAL
        ADMISSION**

The process for medical necessity certification of a patient's non-emergent
hospitalization is as follows:

A.   The admitting physician and admitting hospital call HealthLink for medical
      necessity certification prior to the actual admission.
B.   HealthLink Utilization Management staff compares patient information with
      admission standards.
C.   HealthLink Utilization Management staff may certify the medical necessity of the
      admission, or refer the case to the medical director of HealthLink ("Medical
      Director") or a physician advisor of HealthLink ("Physician Advisor").
D.   The Medical Director or Physician Advisor may approve, deny, or refer the
      admission medical necessity request to a peer for review.
E.   If admitted, HealthLink Utilization Management staff documents the notification
      and the next review date for concurrent hospital stay medical necessity review.
F.   The appeals process set forth below is available for adverse medical necessity
      recommendations of an admission.

II.   EMERGENCY ADMISSION MEDICAL NECESSITY CERTIFICATION

The process for medical necessity certification of a patient's emergency hospitalization is
as follows:

A.   The admitting physician and admitting hospital notify HealthLink of the admission
      on the next business day following hospitalization.
B.   The Utilization Management staff reviews patient admission information to
      determine if the medical necessity criteria for inpatient care are met.
C.   The Utilization Management staff may certify the medical necessity of the
      emergency admission or refer the case to the Medical Director or Physician
      Advisor.
D.   The Medical Director or Physician Advisor may approve, deny, or refer the
      emergency admission medical necessity certification to a peer for review.
E.   HealthLink Utilization Management staff documents the notification and the next
      review date for concurrent hospital stay medical necessity review.
F.   The appeals process set forth below is available for adverse medical necessity
      recommendations of an admission.

HEALTHLINK MEDICAL MANAGEMENT *(Continued)*

III.   CONCURRENT MEDICAL NECESSITY REVIEW

The process for concurrent medical necessity review is as follows:

A.   The patient is admitted to a hospital and the Utilization Management staff reviews patient information.

B.   The medical necessity of the duration of the stay is reviewed on site or telephonically according to facility and diagnosis to assess if clinical criteria are met for certification of the medical necessity of continued inpatient care.

C.   The Utilization Management staff contacts the attending physician for further information on patients who do not meet the medical necessity criteria for continued stay and refers this information to the Medical Director or Physician Advisor for review.

D.   The Medical Director or Physician Advisor contacts the attending physician for discussion of the case.

E.   The Medical Director or Physician Advisor may approve or deny the medical necessity certification, or refer the request to a peer for review.

F.   The appeals process is available for adverse medical necessity recommendations.

IV.   MATERNITY REVIEW

Pre-notification of maternity inpatient admissions for purpose of medical necessity certification recommendations is not required. HealthLink conducts concurrent medical necessity review if the Covered Person is hospitalized more than three (3) days for vaginal delivery or more than five (5) days for cesarean section delivery.

V.   SPECIALTY CARE REFERRALS

The process for specialty care referral by a referring physician is as follows:

A.   If a patient requires additional care from a specialist, the referring physician attempts to refer the patient to a Participating Provider.

B.   The patient is referred to an appropriate specialist via HealthLink's referral protocols in accordance with the program type.

C.   HealthLink is available to assist in the identification of specialist(s), if necessary.

HEALTHLINK MEDICAL MANAGEMENT *(Continued)*

VI.   **APPEALS PROCESS**

The process for appeal is as follows:

A.   The provider, patient or patient's representative may appeal the initial adverse medical necessity certification recommended by the Medical Director or Physician Advisor by contacting HealthLink's Utilization Management Department by fax, telephone or mail. An adverse certification is when days, procedures or services are not certified as medically necessary.

B.   A qualified physician reviews the case and may uphold or overturn the original recommendation based on supplemental information received from a provider.

C.   If the physician reviewer overturns the original recommendation, HealthLink notifies the applicable provider and the Company of the medical necessity recommendation considered in the appeal review.

D.   If the physician reviewer upholds the original recommendation, HealthLink notifies the applicable provider and the Company of the decision to uphold the original recommendation of denied medical necessity certification and directs the appellant to the Company to pursue the Plan's benefit appeal process, if desired.

E.   HealthLink is not assuming any fiduciary obligation to provide a full and fair review of claims denials when it provides an appeal process for HealthLink's utilization review recommendations. The Plan or Company has final authority, with respect to HealthLink's recommendation, to uphold or overturn a recommendation of denied medical necessity certification and to make the final benefit determination.

ONE OR MORE OF THE FOLLOWING ELEMENTS ARE ONLY INCLUDED IN THE MEDICAL MANAGEMENT PROGRAM IF AGREED UPON BY APPROPRIATE REPRESENTATIVES OF BOTH PARTIES.

VII.   **AMBULATORY/OUTPATIENT MEDICAL NECESSITY REVIEW**

The process for ambulatory/outpatient medical necessity review is as follows (services are subject to change):

A.   The treating physician and facility contact HealthLink for certification of the medical necessity of ambulatory services performed in an outpatient hospital, facility or facility-related setting prior to the performance of such services. Such ambulatory or outpatient services include: Cholecystectomy (Laparoscopic), M.R.I. of the Head and/or Neck, M.R.I. of the Brain and/or Spine, PET Scans, Hysterectomy (<age 30), and Nasal Septoplasty/Rhinoplasty.

B.   The Utilization Management staff may certify the medical necessity of the procedure or treatment or refer the request to the Medical Director or Physician Advisor for review.

C.   The Medical Director or Physician Advisor consults with the physician and may approve or deny the medical necessity certification or refer the ambulatory/outpatient service certification request to a peer for review.

D.   The appeals process is available for adverse medical necessity recommendations.

HEALTHLINK MEDICAL MANAGEMENT *(Continued)*

VIII.   <u>**ANCILLARY SERVICE MEDICAL NECESSITY REVIEW**</u>

The process for ancillary medical necessity review is as follows (services are subject to change):

A.   The treating physician or health professional and facility contact HealthLink for certification of the medical necessity of ancillary services, which include:

- Outpatient Physical Therapy
- Outpatient Speech Therapy
- Outpatient Occupational Therapy
- Home Infusion Care
- Home Health Service
- Durable Medical Equipment (DME) (TENS Units, Bone Growth Stimulators, Neuromuscular Stimulators, Functional Electrical Stimulator Bikes, Custom Wheelchairs, Cooling Devices ["Polar Care"], Limb Prosthetics, Wound Vacs, and Electric Scooters.

B.   The Utilization Management staff may certify the medical necessity of the procedure or treatment or refer the request to the Medical Director or Physician Advisor for review.

C.   The Medical Director or Physician Advisor consults with the physician or health professional and may approve or deny the medical necessity certification or refer the ancillary service certification request to a peer for review.

D.   The appeals process is available for adverse medical necessity recommendations.

REQUESTS FOR INFORMATION (RFI's) REPLIES FOR PAYORS

Requests for information (RFIs) are submitted by current and prospective payors for the purposes of obtaining PPO network information to sell new business and/or to perform an internal analysis of the HealthLink network.

RFIs may be sent to the RFI Unit for requests pertaining to HealthLink PPO, HMO and Open Access (combined) networks.

Requests should be submitted on company letterhead with the requesting contact party indicated (with title) and the contact party's email address, mailing address and phone number. Requests should specify the purpose of the request, intended uses of the information and the proposed date the information is needed.

Payors or payor's vendors without active contracts (prospective payors, TPAs for which the network contracts directly with the self-funded group client, reinsurers, claims management vendors or consulting houses) will need to sign a HealthLink confidentiality agreement to obtain information that we consider is proprietary in nature (which includes overall network savings rates). Contracted payors who need the information to disclose to a third party (the third party may be a prospective group, actuarial firm or consultant) will need to sign a special confidentiality agreement, which includes the third party receiver of the information.

Standardized marketing materials may already be available to assist a payor or prospective payor with their network or network product analyses. For example, a standardized GeoAccess accessibility report is available (without an RFI), by contacting your Account Manager. This report includes the entire network area maps and accessibility charts which use the "default" parameter of one enrollee in each zip code of the geographical area the network serves. Many payors use this standardized "GeoAccess maps and reports" document in order to internally produce and rapidly turnaround their own group quotations and proposal requests.

Contracted insurance companies can receive Premium Pricing Packets (CDs) for their actuarial staff, which contain all necessary network pricing details for the insurer's financial analysis and network comparison, upon request.

RFP/RFI requests should be sent to:

> HealthLink
> RFI Unit
> 1831 Chestnut Street
> St. Louis, MO 63103
> **Or by email to: RFI@healthlink.com**

PREMIUM PRICING PACKET (FOR REINSURERS ONLY)

HealthLink can provide contracted payor partner reinsurers with network updates and premium pricing information in a comprehensive **Premium Pricing Packet**. The packet is a valuable set of confidential, proprietary information.

The packet includes the following:

- Network composition and accessibility.
- Savings rates from claims for the entire block of business.
- Other information for actuaries to "price" our network.
- Benchmark data (% of Medicare).

The multiple fee schedules utilized by HealthLink are described in the packet. (A market basket of the most frequent CPT codes is used for physician fee maximum analyses.)

HealthLink encourages actuaries to consult this pricing packet to select areas for selling HealthLink and for setting premium pricing rates.

The premium pricing packet is produced annually which includes claims data for the prior calendar year.

QUERY ACCESS INTO HEALTHLINK SYSTEM

HealthLink's Query Access service is designed to provide a "real time" window in to HealthLink's claims system. Query Access allows affiliated payors to research various claims and customer service related items including:

- Claim repricing status;
- HealthLink member network eligibility status;
- Network provider "par" status; and
- Utilization management authorizations

QUERY ACCESS SPECIFICATIONS

Query Access is a service that allows payors to have a window into HealthLink's system. We encourage utilization of this service to allow payor's to view the following:

- Claims repricing information, including the ability to print this information.
- Provider status information to determine network participation.
- Pre-certification information for active enrollees.
- HealthLink eligibility status for active enrollees.

Equipment

To use Query Access a PC with the following is needed:

- Windows 95B, WinNT 4, or higher
- 50 MB of free hard drive or more
- 28800 baud modem or better
- ANITA software (provided by HealthLink)
- Pentium 133 or better
- 32 MB of RAM
- Laser Jet Printer (optional for printing adjudication sheets)

The VPN connection option is preferred.

Cost

To use Query Access, ANITA software is needed. ANITA is provided free of charge by HealthLink.

Set Up Time

Query Access can be set up in approximately two weeks, after notification to HealthLink that the system interface is configured appropriately. A training session will be arranged to assist the payor's staff members to use query service into the HealthLink system.

HealthLink Query Access
Customer Service Phone Number: **1-800-624-2356**

Query Access is a service that allows HealthLink's payor partners to view into a "window" to HealthLink's system. This service allows payors to look-up HealthLink data on PCs in their own offices. We encourage utilization of this service for high volume payors to view the following network data:

- Claims repricing information, which includes the ability to re-print repricing sheets.

- Provider status information to determine network participation.

- Pre-certification or other utilization management information (if applicable).

- HealthLink network eligibility status for active members and groups.

A "screen print" function allows repricing information to be printed at the affiliated payors' sites. This allows payors to print a missing HealthLink repricing sheet and process the claim immediately without having to make a call to the HealthLink Customer Service department.

Payors with Query Access service may continue to contact HealthLink's Customer Service department for assistance with claims repricing, provider status, utilization management authorizations or HealthLink network eligibility status.

Query Access can be set up, at the payor's designated workstation(s), in approximately two weeks after notification to HealthLink that the system interface is configured appropriately. HealthLink will provide onsite or web cast training on the various functions of the system. A reference guide is provided which includes information on frequently used features of Query Access.

Necessary Equipment:

A personal computer with:

- Windows 95B or WinNT 4, or higher

- 50 MB of free hard drive or more

- 28800 baud modem or better

- Pentium 133 or better

- 32 MB of RAM

- Anita (HealthLink CD) – provided by HealthLink

- Laser Jet Printer (optional for printing repricing sheets)

- VPN Set-Up (for system access)

For more information about Query Access, please contact your Sales/Account Manager or email Sales-AcctMgmt@healthlink.com.

HEALTHLINK REFERENCE NUMBERS

Customer Service Call Center	Open 8:00 A.M. – 5:00 P.M. CST Weekdays Toll Free: (800) 624-2356 FAX: (314) 925-6301
RFI & RFP Submission	RFI Unit 1831 Chestnut Street St. Louis, MO 63103 or Email: RFI@healthlink.com
New Claims	HealthLink, Inc. P.O. Box 419104 St. Louis, MO 63141 Email:CSC-HL@HealthLink.com FAX: (314) 925-6662 Misdirected claims should be rejected and returned to the provider to redirect the claim to HealthLink.
Claim Adjustments/Issues	CCRU@HealthLink.com FAX: 314-925-6632
Eligibility	PPOElig@HealthLink.com (Individual Member) Eligibility@HealthLink.com (Payor File) FAX PPO: (314) 925-6625 FAX HMO: (314) 925-6201
Group Notifications (New Groups and Terminations)	Sales-AcctMgmt@HealthLink.com
Medical Management	Toll Free: (877) 284-0102 FAX: 800-510-2162
EDI Help Desk	edi-ops@healthlink.com